

**DISTRICT OF COLUMBIA PAIN-CAPABLE  
UNBORN CHILD PROTECTION ACT**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON THE CONSTITUTION  
AND CIVIL JUSTICE  
OF THE  
COMMITTEE ON THE JUDICIARY  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

ON

**H.R. 1797**

MAY 23, 2013

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## DISTRICT OF COLUMBIA PAIN-CAPABLE UNBORN CHILD PROTECTION ACT

THURSDAY, MAY 23, 2013

HOUSE OF REPRESENTATIVES  
SUBCOMMITTEE ON THE CONSTITUTION  
AND CIVIL JUSTICE

COMMITTEE ON THE JUDICIARY

*Washington, DC.*

The Subcommittee met, pursuant to call, at 10:04 a.m., in room 2141, Rayburn House Office Building, the Honorable Trent Franks (Chairman of the Subcommittee) presiding.

Present: Representatives Franks, Jordan, Goodlatte, Chabot, King, Gohmert, DeSantis, Nadler, and Conyers.

Staff Present: (Majority) Paul Taylor, Majority Counsel; Sarah Vance, Clerk; (Minority) David Lachmann, Subcommittee Staff Director; and Veronica Eligan, Professional Staff Member.

Mr. FRANKS. The Subcommittee on the Constitution and Civil Justice will come to order.

Without objection, the Chair is authorized to declare recesses of the Committee at any time.

Thank you all for being here.

I will now recognize myself for an opening statement.

When innocent children are buried under the rubble caused by tornadoes or are shot by crazed monsters, evil monsters in schools or theaters, none of us consider that to be a partisan issue. Likewise, protecting pain-capable unborn babies is not a Republican issue or a Democrat issue. It is, rather, a test of our basic humanity and who we are as a human family.

For the sake of all the Founding Fathers of this Nation once dreamed America could someday be and for the sake of all those since then who have died in darkness that we might all walk in the light of liberty, it is important for those of us who are privileged to be Members of Congress to pause from time to time and remind ourselves why we are really all here.

Thomas Jefferson said the care of human life and its happiness, and not its destruction, is the chief and only object of good government. The phrase in the 14th Amendment and the Fifth Amendment capsulize our entire Constitution. No person shall be deprived of life, liberty, or property without due process of law.

Ladies and gentlemen, protecting the lives of all Americans and their constitutional rights is why we are all here. The bedrock

foundation of this republic is that clarion declaration of the self-evident truth that all human beings are created equal and endowed by their creator with uncertain unalienable rights, the rights of life and liberty and the pursuit of happiness.

Every conflict and every battle our Nation has ever faced can be traced to our commitment to this core self-evident truth. It has made us the beacon of hope for the entire world. It is who we are.

Yet today, a great conundrum looms before America. When authorities entered the clinic of Dr. Kermit Gosnell, they found a torture chamber for little babies that I do not have the words or the stomach to adequately describe. According to the grand jury report, Dr. Kermit Gosnell had a simple solution for unwanted babies. He simply killed them.

He didn't call it that. He called it "ensuring fetal demise." The way he ensured fetal demise was by sticking scissors in the back of the baby's neck and cutting the spinal cord. He called it snipping. Over the years, there were hundreds of snippings.

Ashley Baldwin, one of Dr. Gosnell's employees, said she saw babies breathing. She described one as 2 feet long that no longer had eyes or a mouth, but in her words was like "making this screeching noise, and it sounded like a little alien." And I just wonder, for God's sake, sometimes is this really who we are?

If Dr. Gosnell had killed the children he now stands convicted of murdering only 5 minutes earlier and before they had passed through the birth canal, it would have all been perfectly legal in many of the United States of America. More than 325 late-term unborn babies are torturously killed without anesthesia every day in the land of the free and the home of the brave.

If there is one thing that we must not miss about this unspeakably evil episode, it is that Kermit Gosnell is not an anomaly in this gruesome Fortune 500 enterprise of killing unborn children. Rather, Kermit Gosnell is actually the true face of abortion on demand in America, and every American with the slightest shred of compassion for the innocent should go to [paincapable.com](http://paincapable.com) and learn the truth of this case and others like it for themselves.

Not long ago, I heard Barack Obama speak very noble and poignant words that whether he knows it or not apply so profoundly to the real subject of this hearing. Let me quote excerpted portions of his comments.

He said, "This is our first task, caring for our children. It is our first job. If we don't get that right, we don't get anything right. That is how as a society we will be judged."

The President asked the question that so many of us have asked for such a long time on this issue. He asked it on another issue. He said, "Are we really prepared to say that we are powerless in the face of such carnage, that the politics are too hard? Are we prepared to say that such violence visited on our children year after year after year is somehow the price of our freedom?"

Again, that sounds exactly what many of us have said for so many years regarding the children we are discussing here today.

The President also said, "Our journey is not complete until all our children are cared for and cherished and always safe from harm. This is our generation's task," he said, "to make these words,

these rights, these values of life, liberty, and the pursuit of happiness real for every American.”

Never have I so deeply agreed with any words ever spoken by President Obama as those I have just quoted. And yet in the most merciless distortion of logic and reason and humanity itself, this President refuses to apply these incontrovertible words to helpless victims like those of Dr. Kermit Gosnell.

How I wish somehow that Mr. Obama would open his heart and his ears to his own words and ask himself in the core of his soul why his words that should apply to all children cannot include the most helpless and vulnerable of all children. He is their President, and they need him so desperately.

And my friends on this Committee, those helpless children that we speak of today need all of us as well. Indeed, they are why we are all here.

And with that in mind, I would like to end my opening statement with two short video clips taken from today’s headlines. The first part is of the Live Action organization’s undercover expose of the late-term abortion industry. It shows a late-term abortion counselor in my own State of Arizona advising a pregnant woman on the need to address the unborn child’s pain.

The second is part of a testimony delivered by the Philadelphia district attorney’s office describing the horrors uncovered in Dr. Kermit Gosnell’s late-term abortion clinic.

So please go ahead.

[Video shown.]

[The bill, H.R. 1797, follows:]

113TH CONGRESS  
1ST SESSION

# H. R. 1797

To amend title 18, United States Code, to protect pain-capable unborn children in the District of Columbia, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 26, 2013

Mr. FRANKS of Arizona (for himself, Mr. SMITH of New Jersey, Mr. SCALISE, Mr. GOSAR, Mr. SCHWEIKERT, Mr. SALMON, Mr. JONES, Mr. CONAWAY, Mr. CRAWFORD, Mr. NUNNELEE, Mr. CRAMER, Mr. KING of Iowa, Mr. FLEMING, Mr. GARRETT, Mr. ROE of Tennessee, Mr. CARTER, Mr. NEUGEBAUER, Mrs. ROBY, Mr. COLE, Mr. HUIZENGA of Michigan, Mr. HARPER, Mr. MASSIE, Mr. PEARCE, Mrs. BLACKBURN, Mr. BOUSTANY, Mrs. HARTZLER, Mr. BRIDENSTINE, Mr. KINGSTON, Mr. GUTHRIE, Mr. HOLDING, Mr. GRIFFIN of Arkansas, Mr. ROGERS of Alabama, Mr. ADERHOLT, Mr. AMASH, Mr. BUCHANAN, Mr. DUNCAN of South Carolina, Mr. SIMPSON, Mr. MARINO, Mr. CASSIDY, Mr. BRADY of Texas, Mr. DUNCAN of Tennessee, Mr. GOWDY, Mr. BACHUS, Mr. LATTA, Mrs. BLACK, Mrs. NOEM, Ms. ROS-LEHTINEN, Mr. YOUNG of Indiana, Mr. POMPEO, Mr. STOCKMAN, Mr. WILSON of South Carolina, Mr. ALEXANDER, Mr. HUELSKAMP, Mr. SHUSTER, Mr. STIVERS, Mr. BARR, Mr. GOHMERT, Mr. FINCHER, Mr. MULLIN, Mr. BROUN of Georgia, Mr. LIPINSKI, Mr. BENISHEK, Mr. ROSS, Mr. TIBERI, Mr. WESTMORELAND, Mr. ROTIUFUS, Mr. PALAZZO, Mr. LONG, Mr. BONNER, Mr. PITTS, Mr. PRICE of Georgia, Mr. MCKINLEY, Mr. CALVERT, Mr. JORDAN, Mr. WALBERG, Mr. STEWART, Mr. YODER, Mr. HULTGREN, Mr. LANKFORD, Mr. OLSON, Mr. SMITH of Nebraska, Mr. DESANTIS, Mr. MEADOWS, Mr. ROKITA, Mr. HALL, Mr. NUGENT, Mr. MULVANEY, Mr. MILLER of Florida, Mrs. WAGNER, Mr. RODNEY DAVIS of Illinois, Mr. JOHNSON of Ohio, Mr. FORTENBERRY, Mr. SCHOCK, and Mr. POSEY) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

## A BILL

To amend title 18, United States Code, to protect pain-capable unborn children in the District of Columbia, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “District of Columbia  
5 Pain-Capable Unborn Child Protection Act”.

6 **SEC. 2. LEGISLATIVE FINDINGS.**

7 Congress finds and declares the following:

8 (1) Pain receptors (nociceptors) are present  
9 throughout the unborn child’s entire body and  
10 nerves link these receptors to the brain’s thalamus  
11 and subcortical plate by no later than 20 weeks after  
12 fertilization.

13 (2) By 8 weeks after fertilization, the unborn  
14 child reacts to touch. After 20 weeks, the unborn  
15 child reacts to stimuli that would be recognized as  
16 painful if applied to an adult human, for example,  
17 by recoiling.

18 (3) In the unborn child, application of such  
19 painful stimuli is associated with significant in-  
20 creases in stress hormones known as the stress re-  
21 sponse.

1           (4) Subjection to such painful stimuli is associ-  
2           ated with long-term harmful neurodevelopmental ef-  
3           fects, such as altered pain sensitivity and, possibly,  
4           emotional, behavioral, and learning disabilities later  
5           in life.

6           (5) For the purposes of surgery on unborn chil-  
7           dren, fetal anesthesia is routinely administered and  
8           is associated with a decrease in stress hormones  
9           compared to their level when painful stimuli are ap-  
10          plied without such anesthesia.

11          (6) The position, asserted by some medical ex-  
12          perts, that the unborn child is incapable of experi-  
13          encing pain until a point later in pregnancy than 20  
14          weeks after fertilization predominately rests on the  
15          assumption that the ability to experience pain de-  
16          pends on the cerebral cortex and requires nerve con-  
17          nections between the thalamus and the cortex. How-  
18          ever, recent medical research and analysis, especially  
19          since 2007, provides strong evidence for the conclu-  
20          sion that a functioning cortex is not necessary to ex-  
21          perience pain.

22          (7) Substantial evidence indicates that children  
23          born missing the bulk of the cerebral cortex, those  
24          with hydranencephaly, nevertheless experience pain.

1           (8) In adult humans and in animals, stimula-  
2           tion or ablation of the cerebral cortex does not alter  
3           pain perception, while stimulation or ablation of the  
4           thalamus does.

5           (9) Substantial evidence indicates that struc-  
6           tures used for pain processing in early development  
7           differ from those of adults, using different neural  
8           elements available at specific times during develop-  
9           ment, such as the subcortical plate, to fulfill the role  
10          of pain processing.

11          (10) The position, asserted by some commenta-  
12          tors, that the unborn child remains in a coma-like  
13          sleep state that precludes the unborn child experi-  
14          encing pain is inconsistent with the documented re-  
15          action of unborn children to painful stimuli and with  
16          the experience of fetal surgeons who have found it  
17          necessary to sedate the unborn child with anesthesia  
18          to prevent the unborn child from engaging in vig-  
19          orous movement in reaction to invasive surgery.

20          (11) Consequently, there is substantial medical  
21          evidence that an unborn child is capable of experi-  
22          encing pain at least by 20 weeks after fertilization,  
23          if not earlier.

24          (12) It is the purpose of the Congress to assert  
25          a compelling governmental interest in protecting the

1 lives of unborn children from the stage at which sub-  
2 stantial medical evidence indicates that they are ca-  
3 pable of feeling pain.

4 (13) The compelling governmental interest in  
5 protecting the lives of unborn children from the  
6 stage at which substantial medical evidence indicates  
7 that they are capable of feeling pain is intended to  
8 be separate from and independent of the compelling  
9 governmental interest in protecting the lives of un-  
10 born children from the stage of viability, and neither  
11 governmental interest is intended to replace the  
12 other.

13 (14) The District Council of the District of Co-  
14 lumbia, operating under authority delegated by Con-  
15 gress, repealed the entire District law limiting abor-  
16 tions, effective April 29, 2004, so that in the Dis-  
17 trict of Columbia, abortion is now legal, for any rea-  
18 son, until the moment of birth.

19 (15) Article I, section 8 of the Constitution of  
20 the United States of America provides that the Con-  
21 gress shall “exercise exclusive Legislation in all  
22 Cases whatsoever” over the District established as  
23 the seat of government of the United States, now  
24 known as the District of Columbia. The constitu-  
25 tional responsibility for the protection of pain-cap-

1 ble unborn children within the Federal District re-  
2 sides with the Congress.

3 **SEC. 3. DISTRICT OF COLUMBIA PAIN-CAPABLE UNBORN**  
4 **CHILD PROTECTION.**

5 (a) IN GENERAL.—Chapter 74 of title 18, United  
6 States Code, is amended by inserting after section 1531  
7 the following:

8 **“§ 1532. District of Columbia pain-capable unborn**  
9 **child protection**

10 “(a) UNLAWFUL CONDUCT.—Notwithstanding any  
11 other provision of law, including any legislation of the Dis-  
12 trict of Columbia under authority delegated by Congress,  
13 it shall be unlawful for any person to perform an abortion  
14 within the District of Columbia, or attempt to do so, un-  
15 less in conformity with the requirements set forth in sub-  
16 section (b).

17 “(b) REQUIREMENTS FOR ABORTIONS.—

18 “(1) The physician performing or attempting  
19 the abortion shall first make a determination of the  
20 probable post-fertilization age of the unborn child or  
21 reasonably rely upon such a determination made by  
22 another physician. In making such a determination,  
23 the physician shall make such inquiries of the preg-  
24 nant woman and perform or cause to be performed  
25 such medical examinations and tests as a reasonably

1 prudent physician, knowledgeable about the case and  
2 the medical conditions involved, would consider nec-  
3 essary to make an accurate determination of post-  
4 fertilization age.

5 “(2)(A) Except as provided in subparagraph  
6 (B), the abortion shall not be performed or at-  
7 tempted, if the probable post-fertilization age, as de-  
8 termined under paragraph (1), of the unborn child  
9 is 20 weeks or greater.

10 “(B) Subject to subparagraph (C), subpara-  
11 graph (A) does not apply if, in reasonable medical  
12 judgment, the abortion is necessary to save the life  
13 of a pregnant woman whose life is endangered by a  
14 physical disorder, physical illness, or physical injury,  
15 including a life-endangering physical condition  
16 caused by or arising from the pregnancy itself, but  
17 not including psychological or emotional conditions.

18 “(C) Notwithstanding the definitions of ‘abor-  
19 tion’ and ‘attempt an abortion’ in this section, a  
20 physician terminating or attempting to terminate a  
21 pregnancy under the exception provided by subpara-  
22 graph (B) may do so only in the manner which, in  
23 reasonable medical judgment, provides the best op-  
24 portunity for the unborn child to survive, unless, in  
25 reasonable medical judgment, termination of the

1 pregnancy in that manner would pose a greater risk  
2 of—

3 “(i) the death of the pregnant woman; or

4 “(ii) the substantial and irreversible phys-  
5 ical impairment of a major bodily function, not  
6 including psychological or emotional conditions,  
7 of the pregnant woman;

8 than would other available methods.

9 “(c) CRIMINAL PENALTY.—Whoever violates sub-  
10 section (a) shall be fined under this title or imprisoned  
11 for not more than 2 years, or both.

12 “(d) BAR TO PROSECUTION.—A woman upon whom  
13 an abortion in violation of subsection (a) is performed or  
14 attempted may not be prosecuted under, or for a con-  
15 spiracy to violate, subsection (a), or for an offense under  
16 section 2, 3, or 4 based on such a violation.

17 “(e) CIVIL REMEDIES.—

18 “(1) CIVIL ACTION BY WOMAN ON WHOM THE  
19 ABORTION IS PERFORMED.—A woman upon whom  
20 an abortion has been performed or attempted in vio-  
21 lation of subsection (a), may in a civil action against  
22 any person who engaged in the violation obtain ap-  
23 propriate relief.

24 “(2) CIVIL ACTION BY RELATIVES.—The father  
25 of an unborn child who is the subject of an abortion

1 performed or attempted in violation of subsection  
2 (a), or a maternal grandparent of the unborn child  
3 if the pregnant woman is an unemancipated minor,  
4 may in a civil action against any person who en-  
5 gaged in the violation, obtain appropriate relief, un-  
6 less the pregnancy resulted from the plaintiff's  
7 criminal conduct or the plaintiff consented to the  
8 abortion.

9 “(3) APPROPRIATE RELIEF.—Appropriate relief  
10 in a civil action under this subsection includes—

11 “(A) objectively verifiable money damages  
12 for all injuries, psychological and physical, occa-  
13 sioned by the violation of this section;

14 “(B) statutory damages equal to three  
15 times the cost of the abortion; and

16 “(C) punitive damages.

17 “(4) INJUNCTIVE RELIEF.—

18 “(A) IN GENERAL.—A qualified plaintiff  
19 may in a civil action obtain injunctive relief to  
20 prevent an abortion provider from performing  
21 or attempting further abortions in violation of  
22 this section.

23 “(B) DEFINITION.—In this paragraph the  
24 term ‘qualified plaintiff’ means—

1           “(i) a woman upon whom an abortion  
2           is performed or attempted in violation of  
3           this section;

4           “(ii) any person who is the spouse,  
5           parent, sibling or guardian of, or a current  
6           or former licensed health care provider of,  
7           that woman; or

8           “(iii) the United States Attorney for  
9           the District of Columbia.

10           “(5) ATTORNEYS FEES FOR PLAINTIFF.—The  
11           court shall award a reasonable attorney’s fee as part  
12           of the costs to a prevailing plaintiff in a civil action  
13           under this subsection.

14           “(6) ATTORNEYS FEES FOR DEFENDANT.—If a  
15           defendant in a civil action under this section prevails  
16           and the court finds that the plaintiff’s suit was friv-  
17           olous and brought in bad faith, the court shall also  
18           render judgment for a reasonable attorney’s fee in  
19           favor of the defendant against the plaintiff.

20           “(7) AWARDS AGAINST WOMAN.—Except under  
21           paragraph (6), in a civil action under this sub-  
22           section, no damages, attorney’s fee or other mone-  
23           tary relief may be assessed against the woman upon  
24           whom the abortion was performed or attempted.

1       “(f) PROTECTION OF PRIVACY IN COURT PRO-  
2 CEEDINGS.—

3           “(1) IN GENERAL.—Except to the extent the  
4 Constitution or other similarly compelling reason re-  
5 quires, in every civil or criminal action under this  
6 section, the court shall make such orders as are nec-  
7 essary to protect the anonymity of any woman upon  
8 whom an abortion has been performed or attempted  
9 if she does not give her written consent to such dis-  
10 closure. Such orders may be made upon motion, but  
11 shall be made sua sponte if not otherwise sought by  
12 a party.

13           “(2) ORDERS TO PARTIES, WITNESSES, AND  
14 COUNSEL.—The court shall issue appropriate orders  
15 under paragraph (1) to the parties, witnesses, and  
16 counsel and shall direct the sealing of the record and  
17 exclusion of individuals from courtrooms or hearing  
18 rooms to the extent necessary to safeguard her iden-  
19 tity from public disclosure. Each such order shall be  
20 accompanied by specific written findings explaining  
21 why the anonymity of the woman must be preserved  
22 from public disclosure, why the order is essential to  
23 that end, how the order is narrowly tailored to serve  
24 that interest, and why no reasonable less restrictive  
25 alternative exists.

1           “(3) PSEUDONYM REQUIRED.—In the absence  
2 of written consent of the woman upon whom an  
3 abortion has been performed or attempted, any  
4 party, other than a public official, who brings an ac-  
5 tion under paragraphs (1), (2), or (4) of subsection  
6 (e) shall do so under a pseudonym.

7           “(4) LIMITATION.—This subsection shall not be  
8 construed to conceal the identity of the plaintiff or  
9 of witnesses from the defendant or from attorneys  
10 for the defendant.

11          “(g) REPORTING.—

12           “(1) DUTY TO REPORT.—Any physician who  
13 performs or attempts an abortion within the District  
14 of Columbia shall report that abortion to the rel-  
15 evant District of Columbia health agency (herein-  
16 after in this section referred to as the ‘health agen-  
17 cy’) on a schedule and in accordance with forms and  
18 regulations prescribed by the health agency.

19           “(2) CONTENTS OF REPORT.—The report shall  
20 include the following:

21           “(A) POST-FERTILIZATION AGE.—For the  
22 determination of probable postfertilization age  
23 of the unborn child, whether ultrasound was  
24 employed in making the determination, and the

1 week of probable post-fertilization age that was  
2 determined.

3 “(B) METHOD OF ABORTION.—Which of  
4 the following methods or combination of meth-  
5 ods was employed:

6 “(i) Dilation, dismemberment, and  
7 evacuation of fetal parts also known as ‘di-  
8 lation and evacuation’.

9 “(ii) Intra-amniotic instillation of sa-  
10 line, urea, or other substance (specify sub-  
11 stance) to kill the unborn child, followed by  
12 induction of labor.

13 “(iii) Intracardiac or other intra-fetal  
14 injection of digoxin, potassium chloride, or  
15 other substance (specify substance) in-  
16 tended to kill the unborn child, followed by  
17 induction of labor.

18 “(iv) Partial-birth abortion, as defined  
19 in section 1531.

20 “(v) Manual vacuum aspiration with-  
21 out other methods.

22 “(vi) Electrical vacuum aspiration  
23 without other methods.

1           “(vii) Abortion induced by use of  
2           mifepristone in combination with  
3           misoprostol.

4           “(viii) If none of the methods de-  
5           scribed in the other clauses of this sub-  
6           paragraph was employed, whatever method  
7           was employed.

8           “(C) AGE OF WOMAN.—The age or approx-  
9           imate age of the pregnant woman.

10          “(D) COMPLIANCE WITH REQUIREMENTS  
11          FOR EXCEPTION.—The facts relied upon and  
12          the basis for any determinations required to es-  
13          tablish compliance with the requirements for  
14          the exception provided by subsection (b)(2).

15          “(3) EXCLUSIONS FROM REPORTS.—

16               “(A) A report required under this sub-  
17               section shall not contain the name or the ad-  
18               dress of the woman whose pregnancy was ter-  
19               minated, nor shall the report contain any other  
20               information identifying the woman.

21               “(B) Such report shall contain a unique  
22               Medical Record Number, to enable matching  
23               the report to the woman’s medical records.

24               “(C) Such reports shall be maintained in  
25               strict confidence by the health agency, shall not

1 be available for public inspection, and shall not  
2 be made available except—

3 “(i) to the United States Attorney for  
4 the District of Columbia or that Attorney’s  
5 delegate for a criminal investigation or a  
6 civil investigation of conduct that may vio-  
7 late this section; or

8 “(ii) pursuant to court order in an ac-  
9 tion under subsection (e).

10 “(4) PUBLIC REPORT.—Not later than June 30  
11 of each year beginning after the date of enactment  
12 of this paragraph, the health agency shall issue a  
13 public report providing statistics for the previous  
14 calendar year compiled from all of the reports made  
15 to the health agency under this subsection for that  
16 year for each of the items listed in paragraph (2).  
17 The report shall also provide the statistics for all  
18 previous calendar years during which this section  
19 was in effect, adjusted to reflect any additional in-  
20 formation from late or corrected reports. The health  
21 agency shall take care to ensure that none of the in-  
22 formation included in the public reports could rea-  
23 sonably lead to the identification of any pregnant  
24 woman upon whom an abortion was performed or at-  
25 tempted.

1 “(5) FAILURE TO SUBMIT REPORT.—

2 “(A) LATE FEE.—Any physician who fails  
3 to submit a report not later than 30 days after  
4 the date that report is due shall be subject to  
5 a late fee of \$1,000 for each additional 30-day  
6 period or portion of a 30-day period the report  
7 is overdue.

8 “(B) COURT ORDER TO COMPLY.—A court  
9 of competent jurisdiction may, in a civil action  
10 commenced by the health agency, direct any  
11 physician whose report under this subsection is  
12 still not filed as required, or is incomplete, more  
13 than 180 days after the date the report was  
14 due, to comply with the requirements of this  
15 section under penalty of civil contempt.

16 “(C) DISCIPLINARY ACTION.—Intentional  
17 or reckless failure by any physician to comply  
18 with any requirement of this subsection, other  
19 than late filing of a report, constitutes suffi-  
20 cient cause for any disciplinary sanction which  
21 the Health Professional Licensing Administra-  
22 tion of the District of Columbia determines is  
23 appropriate, including suspension or revocation  
24 of any license granted by the Administration.

1           “(6) FORMS AND REGULATIONS.—Not later  
2 than 90 days after the date of the enactment of this  
3 section, the health agency shall prescribe forms and  
4 regulations to assist in compliance with this sub-  
5 section.

6           “(7) EFFECTIVE DATE OF REQUIREMENT.—  
7 Paragraph (1) of this subsection takes effect with  
8 respect to all abortions performed on and after the  
9 first day of the first calendar month beginning after  
10 the effective date of such forms and regulations.

11          “(h) DEFINITIONS.—In this section the following  
12 definitions apply:

13           “(1) ABORTION.—The term ‘abortion’ means  
14 the use or prescription of any instrument, medicine,  
15 drug, or any other substance or device—

16           “(A) to intentionally kill the unborn child  
17 of a woman known to be pregnant; or

18           “(B) to intentionally prematurely termi-  
19 nate the pregnancy of a woman known to be  
20 pregnant, with an intention other than to in-  
21 crease the probability of a live birth or of pre-  
22 serving the life or health of the child after live  
23 birth, or to remove a dead unborn child.

24           “(2) ATTEMPT AN ABORTION.—The term ‘at-  
25 tempt’, with respect to an abortion, means conduct

1 that, under the circumstances as the actor believes  
2 them to be, constitutes a substantial step in a course  
3 of conduct planned to culminate in performing an  
4 abortion in the District of Columbia.

5 “(3) FERTILIZATION.—The term ‘fertilization’  
6 means the fusion of human spermatozoon with a  
7 human ovum.

8 “(4) HEALTH AGENCY.—The term ‘health  
9 agency’ means the Department of Health of the Dis-  
10 trict of Columbia or any successor agency respon-  
11 sible for the regulation of medical practice.

12 “(5) PERFORM.—The term ‘perform’, with re-  
13 spect to an abortion, includes induce an abortion  
14 through a medical or chemical intervention including  
15 writing a prescription for a drug or device intended  
16 to result in an abortion.

17 “(6) PHYSICIAN.—The term ‘physician’ means  
18 a person licensed to practice medicine and surgery  
19 or osteopathic medicine and surgery, or otherwise li-  
20 censed to legally perform an abortion.

21 “(7) POST-FERTILIZATION AGE.—The term  
22 ‘post-fertilization age’ means the age of the unborn  
23 child as calculated from the fusion of a human  
24 spermatozoon with a human ovum.

1           “(8) PROBABLE POST-FERTILIZATION AGE OF  
2 THE UNBORN CHILD.—The term ‘probable post-fer-  
3 tilization age of the unborn child’ means what, in  
4 reasonable medical judgment, will with reasonable  
5 probability be the postfertilization age of the unborn  
6 child at the time the abortion is planned to be per-  
7 formed or induced.

8           “(9) REASONABLE MEDICAL JUDGMENT.—The  
9 term ‘reasonable medical judgment’ means a medical  
10 judgment that would be made by a reasonably pru-  
11 dent physician, knowledgeable about the case and  
12 the treatment possibilities with respect to the med-  
13 ical conditions involved.

14           “(10) UNBORN CHILD.—The term ‘unborn  
15 child’ means an individual organism of the species  
16 homo sapiens, beginning at fertilization, until the  
17 point of being born alive as defined in section 8(b)  
18 of title 1.

19           “(11) UNEMANCIPATED MINOR.—The term  
20 ‘unemancipated minor’ means a minor who is sub-  
21 ject to the control, authority, and supervision of a  
22 parent or guardian, as determined under the law of  
23 the State in which the minor resides.

1           “(12) WOMAN.—The term ‘woman’ means a fe-  
2           male human being whether or not she has reached  
3           the age of majority.”.

4           (b) CLERICAL AMENDMENT.—The table of sections  
5           at the beginning of chapter 74 of title 18, United States  
6           Code, is amended by adding at the end the following new  
7           item:

          “1532. District of Columbia pain-capable unborn child protection.”.

8           (c) CHAPTER HEADING AMENDMENTS.—

9           (1) CHAPTER HEADING IN CHAPTER.—The  
10           chapter heading for chapter 74 of title 18, United  
11           States Code, is amended by striking “**PARTIAL-**  
12           **BIRTH ABORTIONS**” and inserting “**ABOR-**  
13           **TIONS**”.

14           (2) TABLE OF CHAPTERS FOR PART I.—The  
15           item relating to chapter 74 in the table of chapters  
16           at the beginning of part I of title 18, United States  
17           Code, is amended by striking “Partial-Birth Abor-  
18           tions” and inserting “Abortions”.

○

Mr. FRANKS. I would now yield to the Ranking Member, Mr. Nadler from New York, for his opening statement.

Mr. NADLER. Thank you, Mr. Chairman.

We are back once again considering legislation that would curtail women's reproductive rights. I understand how personally important this is to some of my colleagues, and they are certainly entitled to their beliefs. But the many Americans who see the world very differently, including millions of women who value their personal autonomy, can be forgiven if this looks like just another battle in the Republican war on women.

I accept that on this one we are going to have to agree to disagree. In this case, my colleagues appear, through the operation of the criminal code, to be trying to settle a scientific question on which there is no consensus within the field. That is an exercise of raw political power, not of dispassionate fact-finding.

Some of the views we are going to hear today are, in fact, viewed by many scientists in the field as outliers, not as mainstream scientific thought. The fact that the majority has allowed two individuals to purport to present—to purport to present as clearly established science views that are clearly marginal in their fields will create a false and misleading record.

The fact that the minority has been limited to only one witness demonstrates just what a farce these hearings are. Yes, I know we could have invited our own medical expert, but at the expense of hearing from an actual woman who can provide a real-world look at the impact this legislation will have on real families. We could not do both.

The bill, as introduced, would prohibit nearly all abortions beginning at 20 weeks. That, as every first-year law student knows, is facially unconstitutional.

Just this week, the U.S. Court of Appeals for the Ninth Circuit struck down a similar Arizona statute, saying, "Since *Roe v. Wade*, the Supreme Court case law concerning the constitutional protection accorded women with the respect to the decision whether to undergo an abortion has been unalterably clear regarding one basic point. A woman has a constitutional right to choose to terminate her pregnancy before the fetus is viable. A prohibition on the exercise of that right is, per se, unconstitutional."

That, of course, is what this bill would do, and voting for it would violate our oaths to uphold the Constitution. Nonetheless, despite that, this bill would prohibit nearly all abortions, including those involving threats to a woman's health and in cases of rape or incest and where the woman may have become suicidal.

Exceptions to protect the woman where her life and health are at risk, as is not included in this bill, are required throughout pregnancy, even post viability, if the bill is to be constitutional. But such exceptions are not in this bill.

I hope that in addition to the many statements of concern we will hear today for fetuses, we can also hear a few words of concern for women and their families. The bill, as introduced, would, as in the case in the last Congress, apply only to the residents of the District of Columbia. I understand from the Chairman's public statements that he intends to expand the bill, to amend it to apply to the entire country.

While I had previously objected to the singling out of the people of the District of Columbia, who are, after all, taxpaying Americans who serve in our military, respond when one of us has an emergency requiring police, fire, or EMT services, and serve as congressional staff, I must now extend my objections on behalf of my constituents and on behalf of the women in the entire country.

This legislation represents an extreme view of the abortion question and is at odds with the science. That is why people in many States have firmly rejected it, including the people I represent. Just as it is an outrage for Congress to impose its will on the people of the District of Columbia, in this case, so, too, I will fight any such usurpation of the rights of my constituents.

I am not going to sit here and debate the question of fetal pain, except to note that even Dr. Anand, who was cited in the majority's witness testimony and hearing memo and who was called by the majority to testify before this Subcommittee in 2005, told us, "I think the evidence for and against fetal pain is very uncertain at the present time. There is consensus in the medical and scientific research community that there is no possibility of pain perception in the first trimester. There is uncertainty in the second trimester."

The Journal of the American Medical Association concluded that, "Evidence regarding the capacity for fetal pain is limited but indicates that fetal perception of pain is unlikely before the third trimester."

The Royal Academy of Obstetricians and Gynecologists concluded, "It can be concluded that the fetus cannot experience pain in any sense prior to 24 weeks gestation."

Are we really going to take sides in this scientific debate by jailing and bankrupting people who don't agree because we, as an all-knowing Committee of Congress, are going to decide what the science is? That is what this bill would do.

Similarly, the claim that an abortion is never necessary to protect a woman's health is simply not one that is widely held in the medical profession, and the idea that we should be enshrining this marginal view into the criminal code defies reason. I hope that our medical witnesses will at least agree that a woman can become pregnant as a result of rape, something that some Members of this body seem to question.

I find it deeply disturbing that when it comes to issues like this, some people think there is nothing wrong with making families in crisis have the courage of legislators' convictions. That is also wrong.

I know that we will hear a lot about the Gosnell case today, and I would like to address it at the outset. Dr. Gosnell has been proven a criminal. He is going to jail, and deservedly so.

Colleagues who were here at the time may recall that I actively supported passage of the Born-Alive Infants Protection Act—I think this was about 12 years ago—which made it a crime to kill an infant once it is born alive. As I said at the time, that was already illegal everywhere, and even if it was duplicated, we should support it now. I am confident that it was the right thing to do.

What Dr. Gosnell did had nothing to do with abortion. It was murder and infanticide, pure and simple. That Born-Alive Infants Protection Act was not about abortion because it involved live

births and affirmatively killing a newborn. It was about classic murder.

Similarly, Dr. Gosnell's practice of snipping a newborn's spine following a live birth is indefensible, clearly murder, and obviously illegal. That is why he was convicted.

What the Gosnell case does not illustrate, no matter how many times activists insist it should, is anything regarding the practice of abortion generally. The fact is that 40 years after *Roe*, it is hard to find another practitioner like Gosnell really—the fact that 40 years after *Roe* it is hard to find another practitioner like Gosnell really speaks to the actual state of that practice.

I am sorry that some on the other side of this debate seem so gleeful that this has happened. It is a tragedy for these women, and it is a disgrace that any medical practitioner should have acted in such a manner.

I would urge my colleagues to think about the extent to which he, Dr. Gosnell, represented the poor quality of healthcare services available in poorer communities. We should be working to make sure that high-quality healthcare is provided to the uninsured, to make sure that the full range of healthcare services, including family planning services, that are available to people with money are available to the poor and uninsured as well.

If that means funding a Planned Parenthood clinic in every neighborhood to put guys like Gosnell out of business, so be it. If it means closer regulation of the medical profession, so be it. If it means an end to the constant efforts by my Republican colleagues to limit the rights of injured patients to sue, so be it.

But let us not pretend that this is about the practice of abortion in America today. If it were, our prisons would be filled with Gosnells. I don't think the Chairman has stopped going to the dentist because one dentist in Oklahoma was found to have infected thousands of patients, and I don't think we should outlaw abortions because a bad actor committed crimes against his patients.

Mr. Chairman, I yield back the balance of my time.

Mr. FRANKS. I thank the gentleman and would just suggest to him that there is no one on either side of this aisle that is gleeful about the actions of Dr. Kermit Gosnell.

And I would yield now to the distinguished Chairman of the full Committee, Mr. Goodlatte from Virginia.

Mr. GOODLATTE. Thank you, Mr. Chairman. I very much appreciate your holding this hearing and for your leadership on this issue.

Since the Supreme Court's controversial decision in *Roe v. Wade* in 1973, medical knowledge regarding the development of unborn babies and their capacities at various stages of growth has advanced dramatically. Even the New York Times has reported on the latest research on unborn pain, focusing in particular on the research of Dr. Sunny Anand, an Oxford-trained neonatal pediatrician who has held appointments at Harvard Medical School and other distinguished institutions.

According to the New York Times, 25 years ago, doctors were convinced that newborns' nervous systems were too immature to sense pain. Anand resolved to find out if this was true.

In a series of clinical trials, he demonstrated that operations performed under minimal or no anesthesia produced a massive stress response in newborn babies, releasing a flood of fight or flight hormones like adrenaline and cortisol. Potent anesthesia, he found, could significantly reduce this reaction. But Anand was not through with making observations. He noticed that even the most premature babies grimaced when pricked by a needle.

New evidence, however, has persuaded him that fetuses can feel pain by 20 weeks gestation and possibly earlier. As Dr. Anand would later testify, "If the fetus is beyond 20 weeks of gestation, I would assume that there will be pain caused to the fetus, and I believe it will be severe and excruciating pain."

Congress has the power to acknowledge these developments by enacting H.R. 1797 and prohibiting abortions after the point at which scientific evidence shows the unborn can feel pain with limited exceptions. The terrifying facts uncovered during the course of the trial of late-term abortionist Kermit Gosnell and successive reports of similar atrocities committed across the country remind us how an atmosphere of insensitivity can lead to horrific brutality.

The grand jury report in the Gosnell case itself contains references to a neonatal expert who reported that the cutting of the spinal cords of babies intended to be late-term aborted would cause them, and I quote, "a tremendous amount of pain." These facts justify expanding the application of this bill Nationwide, and I fully support Constitution Subcommittee Chairman Franks' intention to do so.

Indeed, the Polling Company recently found that 64 percent of Americans would support a law such as the Pain-Capable Unborn Child Protection Act. Only 30 percent would oppose it. And supporters include 47 percent of those who identify themselves as pro choice in the poll.

In the 2007 case of *Gonzalez v. Carhart*, the Supreme Court made clear that, and I quote, "The Government may use its voice and its regulatory authority to show its profound respect for the life within the woman and that Congress may show such respect for the unborn through 'specific regulation' because it implicates additional ethical and moral concerns that justify a special prohibition."

Justice Kennedy, who wrote the majority opinion in the Carhart case, also wrote that the Government has "an interest in forbidding medical procedures, which, in the Government's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful to life, including life in the human fetus, even life which cannot survive without the assistance of others."

As the New York Times story concluded, throughout history, a presumed insensitivity to pain has been used to exclude some of humanity's privileges and protections. Over time, the charmed circle of those considered alive to pain and, therefore, fully human has widened to include members of other religions and races, the poor, the criminal, the mentally ill, and thanks to the work of Sunny Anand and others, the very young.

The Gosnell trial reminds us that when newborn babies are cut with scissors, they whimper and cry and flinch from pain. But it

takes only a moment's thought to realize that wherever babies are cut, they whimper and cry and flinch from pain. Delivered or not, babies are babies, and they can feel pain at 20 weeks.

It is time to welcome young children who can feel pain into the human family, and this bill at least will do just that. I congratulate Chairman Franks and yield back.

Mr. FRANKS. And I thank the gentleman.

And I will now yield to the Ranking Member of the Committee, Mr. Conyers from Michigan.

Mr. CONYERS. Thank you, sir.

Ladies and gentlemen, it has been said by one of our esteemed Members of this Judiciary Committee that when Members of Congress attempt to play doctor, it is bad medicine for women, and that is what brings us here today.

Could I just ask the ladies from Planned Parenthood that are in the audience, and we welcome everyone that is in this room, but could those women just stand up for a moment?

Thank you. Thank you very much for coming.

What I see us doing here this morning is undermining the basic reproductive rights of women by prohibiting any abortion after 20 weeks, with only limited exception and imposing criminal penalties, among other sanctions. This subject is an extremely difficult one because every pregnancy is unique and different.

Some women, unfortunately, must face the emotionally devastating decisions in the course of their pregnancies that require them to consider abortion as a health option. But if this bill became law, Congress would be able to impose its will with respect to one of the greatest tragedies that these women and their families may ever endure by using the threat of prison and lawsuits to coerce them into making decisions that may be bad for their health, their families, and deny them essential medical care.

Now the problem, of course, is this. Is that any attempt, as in 1793, to ban pre-viability abortions is patently unconstitutional under *Roe v. Wade*. It has been the law for more than 40 years, and even after viability, the court has required any abortion prohibition to include an exception to protect the woman's life and health, which this bill fails to do.

It has already been mentioned that the Court of Appeals has struck down a similar attempt that is embodied in H.R. 1793 by saying since *Roe v. Wade*, the Supreme Court case law concerning the constitutional protection accorded women with respect to the decision whether to undergo an abortion has been unalterably clear regarding one basic point. A woman has a constitutional right to choose to terminate her pregnancy before the fetus is viable. A prohibition on the exercise of that right is, per se, unconstitutional.

That very clearly identify the problem with this attempt in 1793 before us today. And then, to add insult to injury, 1793 explicitly states that a risk of suicide is insufficient cause to allow a woman to end a pregnancy.

So, ladies and gentlemen, this is a sad day, and I know that there are other views. But when we have a measure this draconian that fails to include any exceptions for cases involving rape and incest, this, of course, would force a person to bear her abuser's child. So keep in mind that 25,000 women in the United States become

pregnant as a result of rape, and 30 percent of these rapes tragically involve women under the age of 18.

And so, I thank the Chairman for allowing me to express my opinion on this measure.

Mr. FRANKS. And I thank the gentleman, and I would just suggest for the record that, indeed, there is an exception to save the life of the mother in this. And any issues regarding rape or incest are usually dealt with before the beginning of the sixth month of pregnancy.

And I would now—

Mr. NADLER. Mr. Chairman, maybe I could speak out of order for a moment for 30 seconds?

Mr. FRANKS. Sure.

Mr. NADLER. Thank you, Mr. Chairman.

I just wanted to clarify that in my opening remarks, I had no intention of suggesting that the Chairman or any Member of this panel was gleeful about the Gosnell case in any way.

Mr. FRANKS. I sincerely appreciate that, Mr. Nadler.

And I would now introduce our witnesses, would now welcome you here. I know that there is never anything easy about what you are doing today, but I am grateful to all of you here, and we are grateful to every last person in the audience as well for being here.

And I will now introduce our witnesses. Now I will suggest to you that the Speaker failed to check with us when he scheduled votes. And so, I will introduce—I will be giving the introduction here, and then we will have to adjourn for a few moments, and we will go vote. And we will come back, and then we will hear your testimony.

But thank you for your patience.

Dr. Anthony Levatino is a board-certified obstetrician/gynecologist. Over the course of his career, Dr. Levatino has practiced obstetrics and gynecology in both private and university settings, including as an associate professor of OB/GYN at the Albany Medical College. And I thank you for being here, sir.

Dr. Maureen Condic is an associate professor of neurobiology and an adjunct professor of pediatrics at the University of Utah School of Medicine. Dr. Condic is the director of human embryology for that medical school, and I thank you for being here.

Ms. Christy Zink is a resident of Washington, D.C., and I thank you, Ms. Zink, for being here as well.

Our final witness is Jill Stanek, a nurse turned speaker, columnist, and blogger, and a National figure in the effort to protect both preborn and post born innocent human life. And Ms. Stanek, I thank you for being here as well.

And with that, we will recess and we will return, hopefully, in 25 to 30 minutes. And again, I apologize for the interruption.

[Recess.]

Mr. FRANKS. The Constitution Committee will come to order.

I start out by telling you that it seems that we are going to have another vote in approximately an hour. So we are going to go ahead and get started as soon as possible, and I want to thank everyone again for their attendance.

And I especially want to thank the witnesses for their presence here. I know each of you took great pains to be here.

So each of your statements will be entered into the record in its entirety, and I will ask that each of you summarize your testimony in 5 minutes or less. To help you stay within that time, there is a timing light in front of you. The light will switch from green to yellow, indicating that you have 1 minute to conclude your testimony. When the light turns red, it indicates that the witness' 5 minutes have expired.

And before I recognize the witnesses, it is the tradition of the Subcommittee that they be sworn. So if you would please stand to be sworn.

[Witnesses sworn.]

Mr. FRANKS. Please be seated. Let the record reflect that the witnesses answered in the affirmative.

I now recognize our first witness, and please turn on your microphone, Dr. Levatino, and please proceed, sir.

**TESTIMONY OF ANTHONY LEVATINO, OBSTETRICS AND  
GYNECOLOGY, LAS CRUCES, NM**

Dr. LEVATINO. Good morning. Chairman Franks and distinguished Members of the Subcommittee, thank you for inviting me.

My name is Anthony Levatino. I'm a board-certified obstetrician/gynecologist. I have served in both academic and clinical settings. Currently, I practice in Las Cruces, New Mexico.

I've been a board—I've been an obstetrician/gynecologist for 33 years, and the early part of my career, I performed over 1,200 abortions. Over 100 of them in the second trimester, up to 24 weeks of gestation.

Imagine, if you can, that you're an obstetrician/gynecologist and a pro-choice obstetrician/gynecologist like I was, and your patient today is 17 years old. She's 24 weeks pregnant from last period. Her uterus is two finger breadths above her umbilicus. She has been feeling her baby kick for over a month. She is asleep on an operating room table, and you are there to help her with her problem.

The first thing you do is withdraw the laminaria that was placed in the cervix. The dilation of the cervix that's required for a D&E abortion at that level takes at least 36 hours. Later abortions can—dilation of the cervix can necessitate almost 3 days of preparation prior to performance of the procedure.

The first thing you are going to reach is for a suction catheter. This is a 14-French suction catheter. It's about 9, 10 inches long. It's about  $\frac{3}{4}$ -inch in diameter. And picture yourself, if you can, placing this through the cervix and instructing your circulating nurse to turn on the suction machine.

What you'll see is pale yellow fluid running through this into the suction bottles of the machine. That was the amniotic fluid that was there to protect the baby.

If this was a first trimester abortion, when her child would be that size or smaller, you could essentially do the entire abortion with this one instrument. A 24-week baby that we're describing here from last period is the length of your hand and a half again from head to rump, not counting the legs. Babies that size don't fit through catheters this size.

When you're done, reach for a Sopher clamp. This is one that I brought along so you could see what we're talking about. It's about 13 inches long. It's stainless steel.

The business end on this clamp is about ½-inch wide and about 2½ inches long. And there are rows of sharp teeth on this instrument. It's a grasping instrument. When it gets a hold of something, it does not let go.

A second trimester abortion at that stage is a blind procedure. You can't really see anything. Everything has to be done by feel.

Picture yourself, if you can, reaching in with this instrument and grasping blindly anything you can and pull hard. And when it finally pops free, out comes a leg that big, which you put down on the table next to you.

Reach in with this again and grasp and pull hard. Out comes an arm about the same length, which you put down on the table next to you. And reach in with this instrument again and again and tear out the spine, the intestines, heart, and lungs.

Head of a baby about that age is maybe the size of a large plum. Again, the procedure is blind. You reach in, being careful not to perforate the uterus, and you have a pretty good idea you have it, if you have your clamp around something and your fingers are spread about as far as they will go.

You know you did it right if you crush down on the clamp, and white material runs out of the cervix. That was the baby's brains. Then you can pull out skull pieces. If you had a day like I had a lot of days, sometimes a face comes back and stares back at you.

Congratulations, you just successfully performed a second trimester D&E abortion. You just affirmed her right to choose.

These procedures are brutal by their nature. In later abortions, when you are preparing that cervix for even more extended periods of time, you can have situations where you will get into preterm labor or even precipitous deliveries of these children. The Gosnell situation is a situation that has, I think, brought to the public's attention what we're talking about when we're talking about this level of abortion.

It was mentioned earlier that the idea that abortion is not—is needed to save women's lives is one that must be under consideration. As a faculty member at the Albany Medical College, I have treated hundreds of women with severe problems with their pregnancies. Pregnancies that were life-threatening to them. Cardiac disease, diabetes, cancers, toxemia, elevated blood pressure in pregnancy.

I'll illustrate with one case that I dealt with personally. A patient came in at 27 weeks of gestation, blood pressure 220 over 140. You know a normal blood pressure is 120 over 80. This woman is moments or hours away from a stroke.

We stabilized her, delivered her. She had a healthy baby in the end, and she did well as well. But I was able to stabilize and deliver her within an hour because that was required when you have an emergency of that magnitude.

Abortion would be worthless in that situation. As I told you, at 27 weeks of gestation, it would have taken at least 3 days to even prepare her to be able to go through the procedure, and this is an

important point when we talk about abortion in terms of saving women's lives.

I appreciate your attention. I guess I'll just end, Chairman Franks quoted President Obama earlier. I'm going to quote him one more time.

He said recently, "If there is just one thing, one thing that we could do that would save just one child, don't we have an obligation to try?"

Thank you.

[The prepared statement of Dr. Levatino follows:]

**Testimony of Anthony Levatino, MD before the Subcommittee on the Constitution  
and Civil Justice  
U.S. House of Representatives  
May 23, 2013**

Chairman Franks and distinguished members of the subcommittee, my name is Anthony Levatino. I am a board-certified obstetrician gynecologist. I received my medical degree from Albany Medical College in Albany, NY in 1976 and completed my OB-GYN residency training at Albany Medical Center in 1980. In my 33-year career, I have been privileged to practice obstetrics and gynecology in both private and university settings. From June 1993 until September 2000, I was associate professor of OB-GYN at the Albany Medical College serving at different times as both medical student director and residency program director. I have also dedicated many years to private practice and currently operate a solo gynecology practice in Las Cruces, NM. I appreciate your kind invitation to address issues related to the District of Columbia Pain-Capable Unborn Child Protection Act (H.R. 1797).

During my residency training and during my first five years of private practice, I performed both first and second trimester abortions. During my residency in the late 1970s, second trimester abortions were typically performed using saline infusion or, occasionally, prostaglandin instillation techniques. These procedures were difficult, expensive and necessitated that patients go through labor to abort their pre-born children. By 1980, at the time I entered private practice first in Florida and then in upstate New York, those of us in the abortion industry were looking for a more efficient method of second trimester abortion. The Suction D&E procedure offered clear advantages over older installation methods. The procedure was much quicker and never ran the risk of a live birth. Understand that my partner and I were not running an abortion clinic. We practiced general obstetrics and gynecology but abortion was definitely part of that practice. Relatively few gynecologists in upstate NY would perform such a procedure and we saw an opportunity to expand our abortion practice. I performed first trimester suction D&C abortions in my office up to 10 weeks from last menstrual period and later procedures in an outpatient hospital setting. From 1981 through February 1985, I performed approximately 1200 abortions. Over 100 of them were second trimester Suction D&E procedures up to 24 weeks gestation.

Imagine if you can that you are a pro-choice obstetrician/gynecologist like I once was. Your patient today is 24 weeks pregnant. At twenty-four weeks from last menstrual period, her uterus is two finger-breadths above the umbilicus. If you could see her baby, which is quite easy on an ultrasound, she would be as long as your hand plus a half from the top of her head to the bottom of her rump not counting the legs. Your patient has been feeling her baby kick for the last

month or more but now she is asleep on an operating room table and you are there to help her with her problem pregnancy.

The first task is remove the laminaria that had earlier been placed in the cervix to dilate it sufficiently to allow the procedure you are about to perform. With that accomplished, direct your attention to the surgical instruments arranged on a small table to your right. The first instrument you reach for is a 14-French suction catheter. It is clear plastic and about nine inches long. It has a bore through the center approximately  $\frac{3}{4}$  of an inch in diameter. Picture yourself introducing this catheter through the cervix and instructing the circulating nurse to turn on the suction machine which is connected through clear plastic tubing to the catheter. What you will see is a pale yellow fluid that looks a lot like urine coming through the catheter into a glass bottle on the suction machine. This is the amniotic fluid that surrounded the baby to protect her.

With suction complete, look for your Sopher clamp. This instrument is about thirteen inches long and made of stainless steel. At the business end are located jaws about  $2\frac{1}{2}$  inches long and about  $\frac{3}{4}$  of an inch wide with rows of sharp ridges or teeth. This instrument is for grasping and crushing tissue. When it gets hold of something, it does not let go. A second trimester D&E abortion is a blind procedure. The baby can be in any orientation or position inside the uterus. Picture yourself reaching in with the Sopher clamp and grasping anything you can. At twenty-four weeks gestation, the uterus is thin and soft so be careful not to perforate or puncture the walls. Once you have grasped something inside, squeeze on the clamp to set the jaws and pull hard – really hard. You feel something let go and out pops a fully formed leg about six inches long. Reach in again and grasp whatever you can. Set the jaw and pull really hard once again and out pops an arm about the same length. Reach in again and again with that clamp and tear out the spine, intestines, heart and lungs.

The toughest part of a D&E abortion is extracting the baby's head. The head of a baby that age is about the size of a large plum and is now free floating inside the uterine cavity. You can be pretty sure you have hold of it if the Sopher clamp is spread about as far as your fingers will allow. You will know you have it right when you crush down on the clamp and see white gelatinous material coming through the cervix. That was the baby's brains. You can then extract the skull pieces. Many times a little face will come out and stare back at you. Congratulations! You have just successfully performed a second trimester Suction D&E abortion. You just affirmed her right to choose. If you refuse to believe that this procedure inflicts severe pain on that unborn child, please think again.

Before I close, I want to make a comment on the necessity and usefulness of utilizing second and third trimester abortion to save women's lives. I often hear the argument that we must keep abortion legal in order to save women's lives in cases of life threatening conditions that can and do arise in pregnancy. Albany Medical Center where I worked for over seven years is a tertiary referral center that accepts patients with life threatening conditions related to or caused by pregnancy. I personally treated hundreds of women with such conditions in my tenure there. There are several conditions that can arise or worsen typically during the late second or third trimester of pregnancy that require immediate care. In many of those cases, ending or "terminating" the pregnancy, if you prefer, can be life saving. But is abortion a viable treatment option in this setting? I maintain that it usually, if not always, is not.

Before a Suction D&E procedure can be performed, the cervix must first be sufficiently dilated. In my practice, this was accomplished with serial placement of laminaria. Laminaria is a type of sterilized seaweed that absorbs water over several hours and swells to several times its original diameter. Multiple placements of several laminaria at a time are absolutely required prior to attempting a suction D&E. In the mid second trimester, this requires approximately 36 hours to accomplish. When utilizing the D&X abortion procedure, popularly known as Partial-Birth Abortion, this process requires three days as explained by Dr. Martin Haskell in his 1992 paper that first described this type of abortion.

In cases where a mother's life is seriously threatened by her pregnancy, a doctor more often than not doesn't have 36 hours, much less 72 hours, to resolve the problem. Let me illustrate with a real-life case that I managed while at the Albany Medical Center. A patient arrived one night at 28 weeks gestation with severe pre-eclampsia or toxemia. Her blood pressure on admission was 220/160. As you are probably aware, a normal blood pressure is approximately 120/80. This patient's pregnancy was a threat to her life and the life of her unborn child. She could very well be minutes or hours away from a major stroke. This case was managed successfully by rapidly stabilizing the patient's blood pressure and "terminating" her pregnancy by Cesarean section. She and her baby did well. This is a typical case in the world of high-risk obstetrics. In most such cases, any attempt to perform an abortion "to save the mother's life" would entail undue and dangerous delay in providing appropriate, truly life-saving care. During my time at Albany Medical Center I managed hundreds of such cases by "terminating" pregnancies to save mother's lives. In all those hundreds of cases, the number of unborn children that I had to deliberately kill was zero.

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Mr. FRANKS. Thank you, Dr. Levatino.  
And Dr. Condic, I will now recognize you for 5 minutes.  
We have some audio/visual? Yes, ma'am. And would you turn  
your mike on and pull that close to you, please?

**TESTIMONY OF MAUREEN L. CONDIC, Ph.D., DEPARTMENT OF  
NEUROBIOLOGY AND ANATOMY, UNIVERSITY OF UTAH  
SCHOOL OF MEDICINE**

Ms. CONDIC. Yes. Okay, can you hear me?

Mr. FRANKS. Yes, ma'am.

Ms. CONDIC. Great. Chairman Franks, Congressman Nadler, distinguished Members of the Subcommittee, I'm Dr. Maureen Condic, associate professor of neurobiology and adjunct professor of pediatrics at the University of Utah School of Medicine.

I thank you for this opportunity to testify.

[Slides.]

Ms. CONDIC. So the experience of pain is obviously very complex. Here I have summarized the important events of brain development relevant to pain perception. The three points I'd like to emphasize are these.

First, brain development begins very early, by 4 weeks post fertilization. Second, the neural circuitry underlying the most basic response to pain is in place by 8 weeks. This is the earliest point at which a fetus can feel pain at any—in any capacity. And finally, the circuitry in the thalamus that's primarily responsible for both fetal and adult pain perception develops between 12 and 18 weeks post fertilization.

At this stage, a fetus is very well developed. All of the organs and structures are fully formed. She has a face, fingerprints, and based on my own experience with three pregnancies, a definite personality.

The debate over fetal pain is not whether pain is detected by a fetus at 20 weeks. There is essentially universal agreement on this point in the scientific community. Rather, the debate concerns how pain is experienced, whether a fetus has the same pain experience as a newborn or an adult.

Recently, the American College of Obstetricians and Gynecologists, or ACOG, the Royal College of Obstetricians and Gynecologists, and a review in the *Journal of the American Medical Association* have all addressed this point. Yet these reports have received serious scientific criticism.

And surprisingly, they all assumed without evidence that for a fetus to have a conscious experience of pain, certain late-developing cortical structures must exist. Yet many conclusive modern lines of evidence contradict this view, and I'm going to present just two of them.

First, it's clear that children born without cortical brain structures are capable of consciousness, including smiling when pleased, having preferences for particular kinds of music, and having adverse reactions to pain. Here is a picture of such a patient recognizing her physician.

This little girl was described in this case report as being a very happy child who particularly liked dancing to rock music. Yet, well over 80 percent of her brain is missing, and therefore, she does not possess the structures that ACOG and others erroneously insist are required for conscious recognition of her physician, for example.

This is a scan of the little girl's brain. The red star here indicates the limited area of the cortex that she possesses, and the yellow stars indicate empty space in the regions that ACOG and others

claim the parts of the brain that are required for conscious pain perception should exist.

The blue star indicates the position of the thalamus, which is the region of the brain that is, in fact, responsible for pain perception in this patient and in all human beings at all stages of life. And as I've noted, the pain perception circuitry in this region of the brain is in place by 18 weeks.

So a second line of evidence against the conclusions of ACOG and others is the large body of direct experimental data from adult humans that demonstrates that neither removing nor stimulating the cortex changes our experience of pain, whereas stimulating or removing lower brain structures, such as the thalamus, does.

So, for example, a recent study analyzed on videotape the behavioral responses of adult alert patients to 4,160 cortical stimulations, and the authors note that pain responses were very scarce, representing less than 1.5 percent of all the responses they observed. These authors then conclude that even for adult humans, in contrast to the JAMA report, the ACOG report, and the Royal Society reports that have been cited, the cortex is largely not involved in the conscious perception of pain. Pain perception is localized to the thalamus, and this circuitry is in place by 18 weeks post fertilization.

In addition to the neurobiological information I have just presented, what we directly observe about a fetus's response to pain is also very clear. Fetuses delivered prematurely exhibit pain-related behaviors, such as those shown here. Pain response observations are very precise, and they're based on objective criteria.

Strikingly, the earlier fetuses are delivered, the stronger their response to pain. And this is due to the absence of later-arising brain circuitry that actually inhibits a pain response in older infants and in adults.

Similarly, fetuses at 20 weeks post fertilization have an increase in stress hormones in response to painful stimuli that can be eliminated by appropriate anesthesia, just as for an adult. These and many other direct observations of fetal behavior and physiology have resulted in a clear consensus among professional anesthesiologists that the use of anesthesia is warranted in cases of fetal surgery, not based on pragmatic considerations like the suppression of fetal movement but, rather, based primarily on the fetus's experience of pain.

Finally, I'd like to conclude by saying we really must consider our own experience and ask what kind of a society we want to be. You know, we're all horrified by the pictures of the infants that were brutally killed by convicted murderer Kermit Gosnell, and yet we tolerate this same brutality and even worse for humans at 20 weeks of development.

Imposing pain on any pain-capable living creature is cruelty, and ignoring the pain experienced by another human for any reason is barbaric. We don't need to know if a fetus experiences pain precisely in the same way we do. We simply have to decide whether we're going to choose to ignore the pain of the fetus or not.

It is entirely uncontested in the scientific and medical literature that a fetus experiences pain in some capacity from as early as 8 weeks, and most modern neuroscientists conclude that the thalamic

circuitry that's in place by 18 weeks post fertilization is primarily responsible for human experience of pain at all stages of life.

Given that fetuses are members of the human species, human beings like us, they deserve the benefit of the doubt regarding their experience of pain and protection from cruelty under the law.

Thank you very much.

[The prepared statement of Ms. Condic follows:]

Testimony of  
 Maureen L. Condic, Ph.D.  
 University of Utah, School of Medicine, Department of Neurobiology and Anatomy  
 Before the Subcommittee on the Constitution and Civil Justice,  
 Committee on the Judiciary,  
 U.S. House of Representatives

May 23, 2013

Chairman Franks, Congressman Nadler, distinguished members of the subcommittee, I am Dr. Maureen Condic, Associate Professor of Neurobiology and Adjunct Professor of Pediatrics at the University of Utah School of Medicine. I am Director of Human Embryology instruction for the Medical School and of Human Neuroanatomy for the Dental School at my institution. Thank you for this opportunity to testify regarding certain aspects of the District of Columbia Pain-Capable Unborn Child Protection Act (H.R. 1797).

#### **What is Pain?**

The experience of pain is complex, with physical, psychological and mental elements. In the simplest sense, pain is an aversive response to a noxious (physically harmful or destructive) stimulus. The medical dictionary administered by the National Institutes of Health (NIH)<sup>1</sup> supports this view, defining pain as, "a basic bodily sensation that is induced by a noxious stimulus, is received by naked nerve endings, is characterized by physical discomfort (as pricking, throbbing, or aching), and typically leads to evasive action." As humans, we share this basic experience of pain with many other animals, from very simple creatures like reptiles and birds, up to mammals and primates.

Yet pain has more complex dimensions. The NIH dictionary also offers the following, more nuanced definition of pain: "a state of physical, emotional, or mental lack of well-being or physical, emotional, or mental uneasiness that ranges from mild discomfort or dull distress to acute often unbearable agony, may be generalized or localized, and is the consequence of being injured or hurt." This definition also defines pain as a response to a noxious stimulus or injury, but acknowledges that the response can have emotional or mental dimensions as well. And, like all mental experiences, it is difficult for any one of us to fully appreciate another person's psychological experience of pain. Every individual's reaction to pain is unique. Experiences one person might find extremely painful may seem insignificant to someone else. Moreover, even for a single individual, the perception of what is and what is not painful can change over time. Experiences a young woman might find painful (e.g. being snubbed at a social event) may seem trivial to a more experienced woman in middle age. And experiences a middle-aged woman might find painfully difficult (e.g. death of a colleague) may be far less painful to a young woman who has a less acute sense of her own mortality.

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<sup>1</sup> See definition "b" at: <http://www.merriam-webster.com/medlineplus/pain>.

### **How do we know if others are experiencing pain?**

While the psychological and mental aspects of pain are important to us, they are also fundamentally *personal*, and therefore not something that can be fully understood by anyone else. We can listen to someone's explanation of their painful experience. We can empathize. We can measure certain physical, neurological and endocrine responses to painful stimuli. But we cannot directly share another individual's experience of pain.

Importantly, our inability to fully understand someone else's experience of pain does not prevent us from making rational and prudent judgments about painful situations and how they obligate us to behave. We do not justify inflicting pain on another person by saying, "I can't possibly know how anyone else experiences me punching them in the face, therefore I am not obligated to restrain from this behavior." When considering the pain-experience of other humans, we are guided by three simple principles: what we know about pain, what we observe about another individual's reaction to a painful stimulus and what we can reasonably conclude from our own experience of pain.

*What we know.* When scientific data provides evidence that an experience causes harm or imposes significant risk of harm to another individual (i.e. it involves a "noxious" stimulus), this experience is reasonably viewed as "painful." Even if the individual's perception of this harmful stimulus is compromised in some manner (perhaps by a genetic condition that limits their ability to receive painful neural information or by drugs that have temporarily limited this ability), we are nonetheless obligated to avoid causing pain to another human individual, both out of compassion and out of justice.

*What we observe.* When observation, either casual or scientific, provides reasonable evidence that an individual perceives an experience as "painful," (the individual withdraws, cries out, grimaces, or shows elevated respiration, heart rate or stress hormones), we are obligated to avoid causing pain to that individual.

*What we experience ourselves.* When our own reaction to the experience another individual is having would be one of pain, we can reasonably conclude it is painful to them as well. Perhaps not in precisely the same manner or to the same degree, but things that hurt us tend to be hurtful to others as well.

### **Scientific data regarding fetal brain development and pain perception**

The ability to perceive noxious stimuli and react to them develops over a very long period of time in humans, continuing well after birth and (as noted above) changing significantly across any individual's lifespan.

The earliest "rudiment" of the human nervous system forms by 28 days (four weeks) after sperm-egg fusion. At this stage, the primitive brain is already "patterned"; i.e. cells in different regions are specified to produce structures appropriate to their location in the

nervous system as a whole.<sup>2</sup> Over the next several weeks, the brain will grow enormously and generate many complex connections, but the overall organization of the nervous system is established by four weeks. This is significant because it shows that even at this early stage, the brain is not anything like a mere collection of cells or a "blank slate" to be written upon by later developmental processes. Like all embryonic organs, the structure of the early brain "anticipates" the function of the mature system.

In the region of the brain responsible for thinking, memory and other "higher" functions (the neocortex), the earliest neurons are generated during the fourth week after sperm-egg fusion.<sup>3</sup> This tells us that at this early date, the brain is organizing the structures that will be required for distinctively human experiences, although these structures will not be fully mature for at least two decades.<sup>4</sup>

There is strong scientific evidence that communication between neurons of the brain is established in the seventh week. Synapses, which are the molecular structures required for brain cells to communicate with each other, are detected in the cortex at this time.<sup>5</sup> In animals, synapses are functional immediately and this is likely also true of humans. Thus, the earliest function of the neocortex as a network appears to commence in the seventh week.

The neural circuitry responsible for the most primitive response to pain, the spinal reflex, is in place by 8 weeks of development. This is the earliest point at which the fetus experiences pain in any capacity.<sup>6</sup> And a fetus responds just as humans at later stages of

<sup>2</sup> Langman's Medical Embryology, 11th Edition T.W. Sadler. (2009). Lippincott Williams and Wilkins. (ISBN-10: 0781790697) Chapters 5 and 6.

<sup>3</sup> Tangential networks of precocious neurons and early axonal outgrowth in the embryonic human forebrain. Bystron I, Molnár Z, Otellin V, Blakemore C. J Neurosci. 2005;25:2781-92.; ApoER2 and VLDLR in the developing human telencephalon. Cheng L, Tian Z, Sun R, Wang Z, Shen J, Shan Z, Jin L, Lei L. Eur J Paediatr Neurol. 2011;15:361-7.; The first neurons of the human cerebral cortex. Bystron I, Rakic P, Molnár Z, Blakemore C. Nat Neurosci. 2006;9:880-6. Epub 2006 Jun 18.; Development of the human cerebral cortex: Boulder Committee revisited. Bystron I, Blakemore C, Rakic P. Nat Rev Neurosci. 2008;9:110-22.

<sup>4</sup> Gogtay N et al (2004) Dynamic mapping of human cortical development during childhood through early adulthood. Proc Natl Acad Sci USA 101:8174; Sowell ER et al (2003) Mapping cortical change across the human life span. Nat Neurosci 6:309

<sup>5</sup> Synaptogenesis in layer I of the human cerebral cortex in the first half of gestation. Zecevic N. Cereb Cortex. 1998;8:245-52.

<sup>6</sup> Synaptogenesis in the cervical cord of the human embryo: sequence of synapse formation in a spinal reflex pathway. Okado N, Kakimi S, Kojima T. J Comp Neurol. 1979;184:491-518.; Onset of synapse formation in the human spinal cord. Okado N. J Comp Neurol. 1981;201:211-9.; The fine structure of the spinal cord in human embryos and early fetuses. Wozniak W, O'Rahilly R, Olszewska B. J Hirnforsch. 1980;21:101-24.; Early synaptogenesis in the spinal cord of human embryos. Milokhin AA. Acta Biol

development respond; by withdrawing from the painful stimulus. This simple response is tremendously important for humans at all ages because it rapidly protects the body from harmful events (heat, cold, chemical injury, crushing, cutting, etc.) without requiring the time it takes to reflect on the experience.

The earliest connections between neurons in the subcortico-frontal pathways (regions of the brain involved in motor control and a wide range of psychological phenomena, including pain perception) are detected by 37 days post sperm-egg fusion and are well established by 8-10 weeks.<sup>7</sup> This indicates that the brain is “wiring” itself in the first trimester, well before reaching the fetal stage of life. Early establishment of connections between neurons further indicates that brain formation is an active process of progressively building the structures and relationships required for mature brain function.

Connections between the spinal cord and the thalamus, the region of the brain that is largely responsible for pain perception in both the fetus and the adult, begin to form around 12 weeks and are completed by 18 weeks.<sup>8</sup>

The long-range connections within the cortex that some believe to be required for consciousness do not arise until much later, around 22-24 weeks.<sup>9</sup> And these connections continue to develop for an exceptionally long time. Indeed, recent studies indicate that the anatomy of the human brain, and therefore the pattern of brain activity underlying all higher functions (reason, memory, emotion, language, etc.) is not fully mature until approximately 25 years after birth.<sup>10</sup>

#### **What brain structures are necessary for a fetus to feel pain?**

To experience pain, a noxious stimulus must be detected. The neural structures necessary to detect noxious stimuli are in place by 8-10 weeks of human development.<sup>11</sup>

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Hung. 1983;34:231-45.; Development of pain mechanisms. Fitzgerald M. Br Med Bull. 1991;47:667-75.

<sup>7</sup> Development of axonal pathways in the human fetal fronto-limbic brain: histochemical characterization and diffusion tensor imaging. Vasung L, Huang H, Jovanov-Milošević N, Pletikos M, Mori S, Kostović I. J Anat. 2010;217:400-17.; Insights from in vitro fetal magnetic resonance imaging of cerebral development. Kostovic I, Vasung L. Semin Perinatol. 2009;33:220-33.

<sup>8</sup> Kostovic I, Goldman-Rakic PS: Transient cholinesterase staining in the mediodorsal nucleus of the thalamus and its connections in the developing human and monkey brain. J Comp Neurol 219:431-447, 1983.

<sup>9</sup> Functional maturation of neocortex: a base of viability. Gatti MG, Becucci E, Fagnoli F, Fagioli M, Ádén U, Buonocore G. J Matern Fetal Neonatal Med. 2012;25 Suppl 1:101-3; 3D global and regional patterns of human fetal subplate growth determined in utero. Corbett-Detig J, Habas PA, Scott JA, Kim K, Rajagopalan V, McQuillen PS, Barkovich AJ, Glenn OA, Studholme C. Brain Struct Funct. 2011;215:255-63.

<sup>10</sup> Ibid at 4.

<sup>11</sup> Ibid at 6.

There is universal agreement that pain is detected by the fetus in the first trimester. The debate concerns how pain is *experienced*; i.e., whether a fetus has the same pain experience a newborn or an adult would have. While every individual's experience of pain is personal, a number of scientific observations address what brain structures are necessary for a mental or psychological experience of pain.

First, it is clear that children born without higher brain structures ('decorticate' patients) are capable of experiencing pain and also other conscious behaviors, including smiling, recognizing and distinguishing between familiar/unfamiliar people and situations, having preferences for particular kinds of music and having aversive reactions to pain.<sup>12</sup> This indicates that the long-range connections that develop in the cortex only after 22 weeks (and are absent in these patients) are not obligatory for a psychological perception of pain. Similarly, experimental animals that have had the cortex removed also show a vigorous response to painful stimuli,<sup>13</sup> again indicating that late-developing cortical pathways are not required for pain perception and response.

The observations of human decorticate patients and experimentally decorticated animals noted above are consistent with what is known about the representation of consciousness and emotion in the brain. A recent review from the prestigious "Nature" series states, "Feelings constitute a crucial component of the mechanisms of life regulation, from simple to complex. Their neural substrates can be found at *all levels of the nervous system, from individual neurons to subcortical nuclei and cortical regions.*" (emphasis added).<sup>14</sup> Importantly, development of brainstem and thalamic nuclei (among the "subcortical nuclei" mentioned above) occurs quite early in humans, with the earliest spino-thalamic connections forming by 12-18 weeks post sperm-egg fusion.<sup>15</sup> Similarly, a second recent review concludes that consciousness persists in the absence of "vast

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<sup>12</sup> The presence of consciousness in the absence of the cerebral cortex. Beshkar M. *Synapse*. 2008;62:553-6.; Consciousness in congenitally decorticate children: developmental vegetative state as self-fulfilling prophecy. Shewmon DA, Holmes GL, Byrne PA. *Dev Med Child Neurol*. 1999;41:364-74.; The role of primordial emotions in the evolutionary origin of consciousness. Denton DA, McKinley MJ, Farrell M, Egan GF. *Conscious Cogn*. 2009;18:500-14.; Consciousness without a cerebral cortex: a challenge for neuroscience and medicine. Merker B. *Behav Brain Sci*. 2007;30(1):63-81.  
<sup>13</sup> Effects of partial decortication on opioid analgesia in the formalin test. Matthies BK, Franklin KB. *Behav Brain Res*. 1995;67:59-66.; Formalin pain is expressed in decerebrate rats but not attenuated by morphine. Matthies BK, Franklin KB. *Pain*. 1992; 51:199-206.

<sup>14</sup> The nature of feelings: evolutionary and neurobiological origins. Damasio A, Carvalho GB. *Nat Rev Neurosci*. 2013;14:143-52.

<sup>15</sup> Kostovic I, Goldman-Rakic PS: Transient cholinesterase staining in the mediodorsal nucleus of the thalamus and its connections in the developing human and monkey brain. *J Comp Neurol* 219:431-447, 1983.

regions of the cortex."<sup>16</sup>

Finally, direct experimental evidence from adult humans contradicts the assertion of ACOG,<sup>17</sup> JAMA<sup>18</sup> and Royal College of Obstetricians and Gynaecologists<sup>19</sup> that mature pain perception requires cortical circuitry. Ablation<sup>20</sup> or stimulation<sup>21</sup> of the cortex in humans does not affect pain perception, whereas ablation of lower centers, including the thalamus, does.<sup>22</sup> These neurological findings indicate that "mature" pain perception is largely localized to the thalamus. The spino-thalamic circuits required for pain perception are established between 12-18 weeks post sperm-egg fusion.

### **What we observe about fetal pain**

The preceding sections of this statement have dealt with only the first principle outlined above for how we can determine whether another individual experiences pain; i.e., what we know about the neuroanatomical structures underlying pain perception. In addition, what we directly *observe* about fetal pain is very clear and unambiguous. Fetuses at 20 weeks post sperm-egg fusion have an increase in stress hormones in response to painful

<sup>16</sup> Minimal neuroanatomy for a conscious brain: homing in on the networks constituting consciousness. Morsella E, Krieger SC, Bargh JA. *Neural Netw.* 2010;23:14-5.

<sup>17</sup> *Amicus Curiae Brief*, American College of Obstetricians and Gynecologists And American Congress of Obstetricians and Gynecologists. Paul A. Isaacson et al., v. Tom Horne No. 12-16670. United States Court of Appeals for the Ninth Circuit.

<sup>18</sup> Fetal pain: a systematic multidisciplinary review of the evidence. Lee SJ, Ralston HJ, Drey EA, Partridge JC, Rosen MA. *JAMA.* 2005;294:947-54.

<sup>19</sup> Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* (Mar. 2010)

<sup>20</sup> *Ibid* at 12 and 13.

<sup>21</sup> Motor cortex stimulation in patients with post-stroke pain: conscious somatosensory response and pain control. Fukaya C, Katayama Y, Yamamoto T, Kobayashi K, Kasai M, Oshima H. *Neurol Res.* 2003;25:153-6.; Stimulation of the human cortex and the experience of pain: Wilder Penfield's observations revisited. Mazzola L, Isnard J, Peyron R, Mauguière F. *Brain.* 2012;135:631-40.

<sup>22</sup> Brooks JC, Zambreau L, Godinez A, et al: Somatotopic organisation of the human insula to painful heat studied with high resolution functional imaging. *Neuroimage* 27:201-209, 2005; Nandi D, Aziz T, Carter H, et al: Thalamic field potentials in chronic central pain treated by periventricular gray stimulation: a series of eight cases. *Pain* 101:97-107, 2003; Nandi D, Liu X, Joint C, et al: Thalamic field potentials during deep brain stimulation of periventricular gray in chronic pain. *Pain* 97:47- 51, 2002.; Long-term outcomes of deep brain stimulation for neuropathic pain. Boccard SG, Pereira EA, Moir L, Aziz TZ, Green AL. *Neurosurgery.* 2013;72:221-30.; Regional cerebral perfusion differences between periventricular grey, thalamic and dual target deep brain stimulation for chronic neuropathic pain. Pereira EA, Green AL, Bradley KM, Soper N, Moir L, Stein JF, Aziz TZ. *Stereotact Funct Neurosurg.* 2007;85:175-83.; Penfield W, Jasper HH. *Epilepsy and the Functional Anatomy of the Human Brain.* Boston: Little, Brown & Co; 1954.

experiences that can be eliminated by appropriate anesthesia.<sup>23</sup> Multiple studies clearly indicate "the human fetus from 18–20 weeks elaborates pituitary-adrenal, sympatho-adrenal, and circulatory stress responses to physical insults."<sup>24</sup> All of these responses reflect a mature, body-wide response to pain.

Fetuses delivered prematurely, as early as 23 weeks, show clear pain-related behaviors<sup>25</sup> We know less about infants delivered prior to 23 weeks only because so few are available for study. Strikingly, the earlier infants are delivered, the stronger their response to pain.<sup>26</sup> These and many other direct observations of fetal behavior and physiology have resulted in a clear consensus among professional anesthesiologists (highly specialized physicians who are experts in pain management) that the use of medications to relieve pain is warranted in cases of fetal surgery.<sup>27</sup> Many of the advocates of fetal anesthesia make no claims regarding the *qualitative* nature of fetal pain, but based on both the scientific literature and on their own observations, they clearly conclude that pain *exists* for these fetuses and that as physicians they are obligated to address fetal pain medically, despite the many serious challenges and medical risks this procedure entails.<sup>28</sup>

#### **Our own experience; Why fetal pain matters**

As individuals and as a society we must choose the attitude we will embrace regarding fetal pain. Those who insist, "It is impossible to know what a fetus experiences," are denying the obvious fact that it is equally impossible to know what any other human individual experiences at any stage of life. This is not a legitimate argument for ignoring

<sup>23</sup> Effect of direct fetal opioid analgesia on fetal hormonal and hemodynamic stress response to intrauterine needling. Fisk NM, Gitau R, Teixeira JM, Giannakouloupoulos X, Cameron AD, Glover VA. *Anesthesiology*. 2001;95:828-35.

<sup>24</sup> Ibid at 22. See also; Human fetal and maternal noradrenaline responses to invasive procedures. Giannakouloupoulos X, Teixeira J, Fisk N, Glover V. *Pediatr Res*. 1999;45:494-9.; Fetal plasma cortisol and beta-endorphin response to intrauterine needling. Giannakouloupoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. *Lancet*. 1994;344:77-81.; Acute cerebral redistribution in response to invasive procedures in the human fetus. Teixeira JM, Glover V, Fisk NM. *Am J Obstet Gynecol*. 1999;181:1018-25.

<sup>25</sup> Pain behaviours in Extremely Low Gestational Age infants. Gibbins S, Stevens B, Beyene J, Chan PC, Bagg M, Asztalos E. *Early Hum Dev*. 2008;84:451-8.

<sup>26</sup> Determinants of premature infant pain responses to heel sticks. Badr LK, Abdallah B, Hawari M, Sidani S, Kassab M, Nakad P, Breidi J. *Pediatr Nurs*. 2010;36:129-36.

<sup>27</sup> Use of fetal analgesia during prenatal surgery. Bellieni CV, Tei M, Stazzoni G, Bertrando S, Cornacchione S, Buonocore G. *J Matern Fetal Neonatal Med*. 2013;26:90-5.; Towards state-of-the-art anesthesia for fetal surgery: obstacles and opportunities. Kuczkowski KM. *Rev Esp Anesthesiol Reanim*. 2013 Jan;60(1):3-6.; Fetal and maternal analgesia/anesthesia for fetal procedures. Van de Velde M, De Buck F. *Fetal Diagn Ther*. 2012;31:201-9.

<sup>28</sup> Anesthesia for fetal surgery. Lin EE, Tran KM. *Semin Pediatr Surg*. 2013;22:50-5.; Anesthesia for in utero repair of myelomeningocele. Ferschl M, Ball R, Lee H, Rollins MD. *Anesthesiology*. 2013;118:1211-23.

what we know from science and from our own observations. Similarly, those who insist, "Neuroscientists agree the cortex is required for pain perception," are denying the ample modern scientific evidence from credible, professional neuroscientists that contradicts this conclusion. The absence of a universal consensus regarding what anatomical structures are required for the complex (and personal) psychological experience of "conscious" pain perception does not excuse us from making a decision based on the best evidence available.

In the end, when considering pain in any other human individual we must choose, based on what we know and what we observe, whether we will give that individual the benefit of the doubt, out of compassion, empathy and justice, or whether we will ignore the pain they experience simply because the precise psychological quality of their pain cannot be known with certainty. And this choice is as much about the kind of society we want to be as it is about the experience of the fetus.

Imposing pain on any pain-capable living creature is *cruelty*. And ignoring the pain experienced by another human individual for any reason is *barbaric*. We don't need to know if a human fetus is self-reflective or even self-aware to afford it the same consideration we currently afford other pain-capable species. We simply have to decide whether we will choose to ignore the pain of the fetus or not.

From the perspective of neuroscience, it is unclear precisely what "psychological" aspects of a mature pain experience are in place at precisely what point in either human prenatal or *postnatal* development. It is impossible for me to know with certainty whether another adult, a teenager or a fetus experiences pain in precisely the same manner I do. Yet it is *entirely* uncontested that a fetus experiences pain in some capacity, from as early as 8 weeks of development. Moreover, most modern neuroscientists have concluded that the thalamic circuitry developed by 18 weeks post sperm-egg fusion is primarily responsible for human experience of pain at all stages of life.

Given that fetuses are members of the human species—*human beings like us*—they deserve the benefit of the doubt regarding their experience of pain and protection from cruelty under the law.

In light of the scientific facts, the observations of medical professionals, our own experience of pain, and our indirect experience of others' pain, we must conclude that there is indeed a "compelling governmental interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain." And this unambiguously requires a 20 week fetus to be protected from pain, as proposed under H.R. 1797.

Mr. FRANKS. Thank you, Dr. Condic.  
And Ms. Zink, we will now recognize you for 5 minutes. Thank you for being here.

**TESTIMONY OF CHRISTY ZINK, WASHINGTON, DC**

Ms. ZINK. Good morning, Mr. Chairman, Representative Nadler, and other Members of the Committee.

My name is Christy Zink. Late afternoons in May, my family is on the lookout for monarch butterflies. It's spring migration time, and the butterflies have winged their way from Mexico through Texas, moving now up through the country.

My daughter learns, as we all do, by sharing the stories of what she knows. Monarchs identify food with their feet, she tells me. They sip nectar through a proboscis, a word we work together to spell out on paper.

In our yard, as we spy out for the monarchs, her brother keeps his own watch. A toddler, he names what he sees in quick bursts. Grass. Truck. Tree.

For me, it's as if I'm learning along with him, trying out those words anew. My family teaches me every day, and I hold dear the privilege it is to raise my children and to be student to their wonder.

All families know this delight in their own way. There are families like mine who understand that joy in more complicated ways, earned through hard lessons and harder decisions. I'm here today to share my story with you so that you can understand why this bill that purports to prevent pain is instead harmful to families and to women in situations like the one I faced, and why all women in this country need access to safe, quality medical care.

In addition to the pregnancies with my two children, I was also pregnant in 2009. I wondered who my child might grow up to be. Would she inherit her father's love of the pitchers' duel in baseball? Would he make a habit of skipping to the last page of a book, peeking at the end as I do?

I looked forward to the ultrasound when we would get a chance to have a look at the baby in utero to learn a little bit more. I certainly hadn't imagined that we'd learn terrible news and that after the doctor's visit, my husband and I would have to make the most difficult decision of our lives.

I took extra special care of myself during that pregnancy. I received excellent prenatal attention from an award-winning obstetrician. Previous testing had shown a baby growing on target with the limbs and organs all in working order.

However, when I was 21 weeks pregnant, an MRI revealed that our baby was missing the central connecting structure of the two parts of his brain. A specialist diagnosed the baby with agenesis of the corpus callosum. What allows the brain to function as a whole was simply absent.

But that wasn't all. Part of the baby's brain had failed to develop. Where the typical human brain presents a lovely rounded symmetry, our baby had small globular splotches. In effect, our baby was also missing one side of his brain.

Living in a major city with one of the best children's hospitals in the country, my husband and I had access to some of the best

radiologists, neurologists, and geneticists not just in this city or in the country, but in the world. We asked every question we could. The answers were far from easy to hear, but they were clear.

There would be no miracle cure. His body had no capacity to repair this anomaly, and medical science could not solve this tragic situation. This condition could not have been detected earlier in my pregnancy. Only the brain scan could have found it.

The prognosis was unbearable. No one could look at those MRI images and not know instantly that something was terribly wrong. If the baby survived the pregnancy, which was not certain, his condition would require surgeries to remove more of what little brain matter he had, to diminish what would otherwise be a state of near constant seizures.

I am here today to speak out against the so-called Pain-Capable Unborn Child Protection Act. Its very premise that it prevents pain is a lie.

If this bill had been passed before my pregnancy, I would have had to carry to term and give birth to a baby whom the doctors concurred had no chance of a life and who would have experienced near constant pain. If he had survived the pregnancy, which was not certain, he might never have left the hospital. My daughter's life, too, would have been irrevocably hurt by an almost always absent parent.

The decision I made to have an abortion at almost 22 weeks was made out of love and to spare my son's pain and suffering. I'm horrified to think that the doctors who compassionately, but objectively explained to us the prognosis and our options for medical treatment and the doctor who helped us terminate the pregnancy would be prosecuted as criminals under this law for providing basic, safe medical care and expertise.

This bill does not represent the best interests of anyone, especially families like mine. What happened to me during pregnancy can happen to any woman regardless of her health, race, ethnicity, economic status, or where she lives. The proposed law is downright cruel, as it would inflict pain on the families, the women, and the babies it purports to protect.

It's in honor of my son that I'm here today speaking on his behalf. I'm also fighting for women like me to have the right to access safe, legal, high-quality abortion care when we need to beyond 20 weeks, especially for those women who could never imagine they'd have to make this choice.

Women across this country need to be able to make this very private decision with their partners, their doctors, and trusted counselors. I urge you not to pass this harmful legislation.

[The prepared statement of Ms. Zink follows:]

Testimony of Christy Zink before the House Judiciary Committee's Subcommittee on the  
Constitution and Civil Justice

May 23, 2013

Good morning, Mr. Chairman, Representative Nadler, and other members of the committee. My name is Christy Zink.

Late afternoons in May, my family is on the lookout for Monarch butterflies. It's spring migration time, and the butterflies have winged their way from Mexico, through Texas, moving now, up through the country. My daughter learns as we all do, by sharing the stories of what she knows. Monarchs identify food with their feet, she tells me; they sip nectar through proboscis, a word we work together to spell out on paper. In our yard, as we spy out for the Monarchs, her brother keeps his own watch. A toddler, he names what he sees in quick bursts: "Grass." "Truck." "Tree." For me, it's as if I'm learning along with him, trying out those words anew. My family teaches me every day, and I hold dear the privilege it is to raise my children and be student to their wonder.

All families know this delight in their own way. There are families, like mine, who understand that joy in more complicated ways, earned through hard lessons and harder decisions. I'm here today to share my story with you so that you can understand why this bill that purports to prevent pain is, instead, harmful to families and to women in situations like the one I faced, and why all women in this country need access to safe, quality medical care.

In addition to the pregnancies with my two children, I was also pregnant in 2009. I wondered who my child might grow up to be. Would she inherit her father's love of the pitcher's duel in baseball? Would he make a habit of skipping to the last page of a book, peeking at the end, as I do? I looked forward to the ultrasound when we would get a chance to have a look at the baby in utero, to learn a little bit more. I certainly hadn't imagined that we'd learn terrible news, and that, after that doctors' visit, my husband and I would have to make the most difficult decision of our lives.

I took extra special care of myself during that pregnancy. I received excellent prenatal attention from an award-winning obstetrician. Previous testing had shown a baby growing on target, with the limbs and organs all in working order. However, when I was 21 weeks pregnant, an MRI revealed that our baby was missing the central connecting structure of the two parts of his brain. A specialist diagnosed the baby with agenesis of the corpus callosum. What allows the brain to function as a whole was simply absent. But that wasn't all. Part of the baby's brain had failed to develop. Where the typical human brain presents a lovely, rounded symmetry, our baby had small, globular splotches. In effect, our baby was also missing one side of his brain.

Living in a major city with one of the best children's hospitals in the country, my husband and I had access to some of the best radiologists, neurologists, and geneticists not just in this city or in the country, but in the world. We asked every question we could. The answers were far from

easy to hear, but they were clear. There would be no miracle cure. His body had no capacity to repair this anomaly, and medical science could not solve this tragic situation.

This condition could not have been detected earlier in my pregnancy. Only the brain scan could have found it. The prognosis was unbearable. No one could look at those MRI images and not know, instantly, that something was terribly wrong. If the baby survived the pregnancy, which was not certain, his condition would require surgeries to remove more of what little brain matter he had, to diminish what would otherwise be a state of near-constant seizures.

I am here today to speak out against the so-called Pain-Capable Unborn Child Protection Act. Its very premise—that it prevents pain—is a lie. If this bill had been passed before my pregnancy, I would have had to carry to term and give birth to a baby whom the doctors concurred had no chance of a life and would have experienced near-constant pain. If he had survived the pregnancy—which was not certain—he might never have left the hospital. My daughter's life, too, would have been irrevocably hurt by an almost always-absent parent.

The decision I made to have an abortion at almost 22 weeks was made out of love and to *spare* my son's pain and suffering.

I am horrified to think that the doctors who compassionately but objectively explained to us the prognosis and our options for medical treatment, and the doctor who helped us terminate the pregnancy, would be prosecuted as criminals under this law for providing basic, safe medical care and expertise. This bill does not represent the best interests of anyone, especially families like mine. What happened to me during pregnancy can happen to any woman, regardless of her health, race, ethnicity, economic status, or where she lives. This proposed law is downright cruel, as it would inflict pain on the families, the women, and the babies it purports to protect.

It's in honor of my son that I'm here today, speaking on his behalf. I am also fighting for women like me, to have the right to access safe, legal, high-quality abortion care when we need to beyond 20 weeks—especially for those women who could never imagine they'd have to make this choice. Women across this country need to be able to make this very private decision with their partners, their doctors, and trusted counselors. I urge you not to pass this harmful legislation.

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Mr. FRANKS. Thank you, Ms. Zink.  
And I would now recognize Ms. Stanek, and Ms. Stanek, thank you for being here. Ms. Stanek?

**TESTIMONY OF JILL L. STANEK, RN, MOKENA, IL**

Ms. STANEK. Thank you. Thank you for having me.  
When I testified before this Committee in 2000 and 2001, it was to tell of my experience as a registered nurse in the labor and de-

livery department at Christ Hospital in Oak Lawn, Illinois, where I discovered babies were being aborted alive and shelved to die in the hospital's soiled utility room.

Among other familiar faces that I see here today is Congressman Nadler, who was a Member of the Committee at that time, as he indicated earlier, and he said that he was appalled by the incidents I described and found them heart wrenching. Indeed, I was traumatized and changed forever by my experience of holding a little abortion survivor for 45 minutes until he died, a 21- to 22-week-old baby who had been aborted because he had Down syndrome.

Since then, other appalling stories of abortion survivors either being abandoned or outright killed have been trickling out. The Kermit Gosnell case provides further evidence that the lines between illegal infanticide and legal feticide, both via abortion, have become blurred.

This abortionist was convicted only last week of three counts of first-degree murder in the deaths of three born babies whose spinal cords we all know were snipped, as he called them. Also last week came the revelation and photos from three former employees who allege that Houston abortionist Douglas Karpen routinely kills babies after they are born by puncturing the soft spot on their head or impaling the stomach with a sharp instrument, twisting the head off or puncturing the throat with his finger.

It is easy to be horrified by heart-wrenching stories such as this and to imagine the torture that abortion survivors endure as they are being killed. But it is somehow not so easy to envision preborn babies the same age being tortured as they are killed by similar methods.

Today, premature babies are routinely given pain relief, who are born at the same age as babies who are torn limb from limb or injected in the heart during abortions. The World Health Organization goes so far as to recommend pain relief for preemies getting a simple heel stick to draw a couple of drops of blood.

Likewise, prenatal surgery is becoming commonplace, and along with it, anesthesia for babies being operated on, even in "the middle of pregnancy" as the Cincinnati Children's Hospital says. Meanwhile, babies of an identical age are torn apart during abortions with no pain relief.

It must be that some people inexplicably think that the abortion provides a firewall against fetal pain or that babies marked for abortion are somehow numb while their wanted counterparts aren't. This thinking is better suited for the Middle Ages than for modern medicine.

Yet while NARAL Pro-Choice America eventually expressed neutrality on the Born-Alive Infants Protection Act, which provides legal protection for born babies no matter what gestational age and no matter if wanted or not, NARAL opposes legislation protecting babies of the same age from barbaric abortions after the point they are known to feel pain.

Abortion proponents attempt to say that abortionists who commit abortions past 20 weeks are rare. This is a myth. The National Right to Life Committee, perusing a report from Guttmacher Institute, which is a research arm of the abortion industry, in 2008 found that at least 300 abortion providers across the U.S. perform

abortions after 18 weeks post fertilization, and then at least 140 abortionists commit abortions on pain-capable children at 20 weeks post fertilization.

As for the number of late-term abortions committed in this country, nobody knows. There are no standardized mandatory Nationwide abortion reporting requirements, and some of the most liberal jurisdictions, such as California, Maryland, and D.C., don't report at all. And it is questionable that abortionists even comply with regulations and, as we know by Gosnell, that enforcement agencies enforce these reporting.

For instance, when the Elkton, Maryland, office of abortionist Steven Brigham was raided in 2010, investigators found 35 fetuses in his freezer. But there were no medical records documenting 33 of those abortions, much less reporting.

The Gosnell grand jury report said that between 2000 and 2010, Gosnell reported only 1 second trimester abortion when we know that he probably committed thousands of late-term abortions during that decade. No one knows how many abortions are committed after 20 weeks. So it is false for anyone to claim that they are rare.

It is also a myth that late abortions are mostly committed on babies with handicaps, although being handicapped is certainly no excuse for torture. Dr. Leroy Carhart, who commits abortions in Germantown, Maryland, just 30 miles from here, was caught on tape by Live Action stating he routinely commits elective abortions at 26 weeks.

"Saw four this week," Carhart quipped to the Live Action pregnant investigator, also joking that he uses a pickaxe and a drill bit to kill older babies.

Only two blocks from the White House, late-term abortionist Cesare Santangelo told a pregnant Live Action investigator he would kill her healthy 24-week-old preborn baby by snipping the umbilical cord, which is the equivalent of cutting the hose off of a scuba diver, causing death by slow asphyxiation. His Web site states that he will commit dilatation and evacuation abortions up to 26 weeks.

Having actually held a little abortion survivor, I cannot imagine standing there in the soiled utility room and tearing him apart to hurry up his killing. I expect that that thought horrifies everybody here. But this is what is done to others just like him on a daily basis, their excruciating fate determined simply by geography.

Our Nation makes progress when we put an end to senseless disparate treatment of anyone, and certainly the most vulnerable in our midst. It is time we apply this standard to preborn babies, such as what I have described.

Thank you.

[The prepared statement of Ms. Stanek follows:]

**Testimony of Jill L. Stanek, RN**  
**HR 1797, Pain-Capable Unborn Child Protection Act**  
**U.S. House Committee on the Judiciary**  
**Subcommittee on the Constitution and Civil Justice**  
**May 23, 2013**

When I testified before this committee in 2000 and 2001, it was to tell of my experience as a registered nurse in the Labor and Delivery Department at Christ Hospital in Oak Lawn, Illinois, where I discovered babies were being aborted alive and shelved to die in the department's soiled utility closet.

Among other familiar faces I see today is Congressman Nadler, who was a member of the committee then. He said he was "appalled" by the incidents I described and found them "heart-wrenching."

Indeed, I was traumatized and changed forever by my experience of holding a little abortion survivor for 45 minutes until he died, a 21/22-week-old baby who had been aborted because he had Down syndrome.

Since then, other appalling stories of abortion survivors being either abandoned or killed have trickled out.

In 2005, a mother delivered her 23-week-old baby in the toilet at EPOC Clinic in Orlando, Florida, and was shocked to see him move<sup>1</sup>. Abortion staff not only refused to help but turned away paramedics, who her friend had notified by calling 911<sup>2</sup>. Angele could do no more than helplessly sit on the floor rocking and singing to her baby for 11 minutes until he died.

In 2006, Sycoria Williams delivered her 23-week-old baby boy on a recliner at A Gyn Diagnostic Center in Hialeah, Florida. When he began breathing and moving, abortion clinic owner Belkis Gonzalez cut the umbilical cord and zipped him into a biohazard bag, still alive<sup>3</sup>.

The Kermit Gosnell case provides further evidence that the lines between illegal infanticide and legal feticide, both via abortion, have become blurred. This

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<sup>1</sup> "Rowan's story," *World Magazine*, May 7, 2005

([http://www.worldmag.com/2005/05/rowan\\_s\\_story](http://www.worldmag.com/2005/05/rowan_s_story))

<sup>2</sup> "Abortion clinic 911 calls - Baby Rowan," *YouTube*, July 11, 2008

(<http://www.youtube.com/watch?v=lfNzIzvT-k>)

<sup>3</sup> "Doctor investigated in badly botched abortion," *Associated Press*, February 5, 2009  
(<http://www.nbcnews.com/id/29037216/#.UZyw3YKOf9I>)

abortionist was convicted only last week of three counts of first-degree murder in the deaths of three born babies whose spinal cords were “snipped.”<sup>4</sup>

Also last week came the revelation and photos from three former employees who allege that abortionist Douglas Karpen in Houston, Texas, routinely kills babies after they are born by puncturing the fontanel (the soft spot at the top of the head), or impaling the stomach with a sharp instrument, twisting the head off, or puncturing the throat with his finger<sup>5</sup>.

It is easy to be horrified by heart-wrenching stories such as these, and to imagine the torture abortion survivors endure as they are being killed.

But it is somehow not so easy for some to envision preborn babies the same age being tortured as they are killed by similar methods.

Today, premature babies are routinely given pain relief who are born at the same age as babies who are torn limb from limb or injected in the heart during abortions. The World Health Organization goes so far as to recommend analgesia for preemies getting simple heel pricks for a couple drops of blood<sup>6</sup>.

Likewise, prenatal surgery is becoming commonplace, and along with it anesthesia for babies being operated on, even in the “middle of pregnancy”<sup>7</sup>. Meanwhile, babies of an identical age are torn apart during abortions with no pain relief.

It must be that some people inexplicably think the uterus provides a firewall against fetal pain, or that babies marked for abortion are somehow numb, while their wanted counterparts aren't.

This thinking is better suited for the Middle Ages than for modern medicine.

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<sup>4</sup> “Abortion doctor Kermit Gosnell convicted of first-degree murder,” NBC News, May 14, 2013 ([http://usnews.nbcnews.com/\\_news/2013/05/13/18232657-abortion-doctor-kermit-gosnell-convicted-of-first-degree-murder?lite](http://usnews.nbcnews.com/_news/2013/05/13/18232657-abortion-doctor-kermit-gosnell-convicted-of-first-degree-murder?lite))

<sup>5</sup> “Special Report: New stunning photos, testimony shows Texas abortionist kills babies born alive,” Operation Rescue, May 15, 2013 (<http://www.operationrescue.org/archives/special-report-new-stunning-photos-testimony-show-texas-abortionist-kills-babies-born-alive/>)

<sup>6</sup> “Sucrose for analgesia in newborn infants undergoing painful procedures,” WHO Reproductive Health Library, June 1, 2011 ([http://apps.who.int/rhl/newborn/cd001069\\_murkis\\_com/en/](http://apps.who.int/rhl/newborn/cd001069_murkis_com/en/))

<sup>7</sup> “Anesthesia for fetal surgery,” Cincinnati Children’s Hospital (<http://www.cincinnatichildrens.org/health/a/fetal-anesthesia/>)

Yet, while NARAL Pro-Choice America eventually expressed neutrality<sup>8</sup> on the Born-Alive Infants Protection Act, which provides legal protection to born babies no matter what their gestational age or circumstance of birth, NARAL opposes legislation protecting babies of the same age from barbaric abortions after the point they are known to feel pain.

Abortion proponents attempt to portray abortionists who commit abortions past 20 weeks as rare<sup>9</sup>. This is a myth. The National Right to Life Committee analyzed<sup>10</sup> data<sup>11</sup> published in 2008 by the Guttmacher Institute, which is an arm of the abortion industry, and found there were "at least 300 abortion providers who will perform abortions after 20 weeks LMP (last menstrual period)," and that of these, "at least 140 abortion providers willing to abort pain-capable unborn children at 22 weeks LMP (20 weeks post-fertilization)."

As for the number of late abortions committed in this country, no one knows. There are no standardized nationwide mandatory abortion-reporting requirements, and some of the most liberal jurisdictions, such as California, Maryland, and Washington, D.C., don't. Beyond that, it is questionable how many late abortionists comply with these requirements, and how much enforcement there is of these laws.

For instance, when the Elkton, Maryland, office of abortionist Stephen Brigham was raided in 2010, investigators found 35 fetuses in his freezer<sup>12</sup>, but there were no medical records documenting 33 of those abortions, much less state reporting.

The Gosnell Grand Jury Report<sup>13</sup> states that from 2000 to 2010 Gosnell reported a total of one second-trimester abortion to the state. Yet he may have performed thousands during that decade.

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<sup>8</sup> "Statement of NARAL on the Born Alive Infant Protection Act, June 13, 2001 (<http://www.jillstanek.com/NARAL%20-%20Born%20Alive%20001.pdf>)

<sup>9</sup> "'After Tiller' profiles last four U.S. doctors who do late-term abortions," *The Daily Beast*, January 22, 2013 (<http://www.thedailybeast.com/articles/2013/01/22/after-tiller-profiles-last-four-u-s-doctors-who-do-late-term-abortions.html>)

<sup>10</sup> "How many late term abortions and abortionists are there?", National Right to Life News, December 2, 2010 ([http://www.nrlc.org/News\\_and\\_Views/Dec10/nv120210part3.html](http://www.nrlc.org/News_and_Views/Dec10/nv120210part3.html))

<sup>11</sup> "Abortion in the United States: Incidence and access to services, 2005," *Perspectives on sexual and Reproductive Health*, March 2008 (<https://www.guttmacher.org/pubs/journals/4000608.pdf>)

<sup>12</sup> "Brigham behind secretive late-term abortion clinic," *Philadelphia Inquirer*, September 21, 2010 ([http://articles.philly.com/2010-09-21/news/24979408\\_1\\_late-term-abortion-steven-chase-brigham-elkton](http://articles.philly.com/2010-09-21/news/24979408_1_late-term-abortion-steven-chase-brigham-elkton))

<sup>13</sup> "Report of the Grand Jury," page 171, January 14, 2011 (<http://www.phila.gov/districtattorney/pdfs/grandjurywomensmedical.pdf>)

No one knows how many abortions are committed after 20 weeks, so it is false for anyone to assert they are "rare."

It is also a myth that late abortions are mostly committed on babies with handicaps, although being handicapped is certainly no excuse for torture.

Dr. LeRoy Carhart, who commits late abortions at Germantown Reproductive Health Services only 30 miles from here, was just caught on tape by Live Action stating he routinely commits elective abortions at 26 weeks: "Saw four this week," Carhart quipped to Live Action's pregnant investigator, also joking that he uses a "pickaxe" and "drill bit" to kill older babies<sup>14</sup>.

Only two blocks from the White House, late-term abortionist Cesare Santangelo told a pregnant Live Action investigator he would kill her healthy 24-week-old preborn baby by snipping the umbilical cord<sup>15</sup>, which is akin to cutting the hose of a scuba diver, causing death by slow asphyxiation. The website for his Washington Surgi-Clinic openly advertises dilatation and evacuation abortions up to 26 weeks<sup>16</sup>.

Having actually held a little abortion survivor, I cannot imagine standing there in the soiled utility room and tearing him apart to kill him. I expect the thought horrifies all of you as well.

But this is what is done to others like him on a daily basis, their excruciating fate determined simply by geography.

Our nation makes progress when we put an end to senselessly disparate treatment of anyone, and certainly of the most vulnerable in our midst. It is time we apply this standard to babies on the threshold of life as well.

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<sup>14</sup> "Investigation #4: Carhart," *Inhuman: Undercover in America's late-term abortion industry*, May 7, 2013 (<http://www.liveaction.org/inhuman/investigation-4-carhart/>)

<sup>15</sup> "Investigation #2: Washington, D.C.," *Inhuman: Undercover in America's late-term abortion industry*, April 29, 2013

(<http://www.liveaction.org/inhuman/investigation-2-washington-d-c/>)

<sup>16</sup> <http://www.washingtonsurgi-clinic.com/services.html>

Mr. FRANKS. Thank you, Ms. Stanek.

Thank you all for your testimony.

We will now proceed under the 5-minute rule with questions, and I will begin by recognizing Mr. Chabot from Ohio for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman. I appreciate you calling me out of order.

Before I ask a question, I would like to recognize Ms. Stanek. She has been in this fight for a long time. We met many years ago.

And as a result of your courage to come forward and be willing to take the criticism from some people that you revealed what was going on in these abortion chambers, babies that you knew that survived an abortion, and there were instances where they were found in a utility closet, in a garbage can, and a whole bunch of other types of things. Because of your willingness to come forward, there are at least two pieces of major legislation that were passed and are now the law of the land.

One is the Born-Alive Infant Protection Act to protect those babies that are born when an abortion was intended, but a live baby was the result. And then also the ban on partial-birth abortion. Both of those landmark pieces of legislation, you were absolutely responsible for those things taking place. So thank you for your work.

Now a question. If I could go to you, Dr. Levatino? Ms. Zink related her tragic story, and I think we certainly all sympathize with the situation that she faced. She made her choice.

Now you were an abortion doctor for a number of years and, I think you indicated, performed 1,200 abortions altogether. And some of those—those were the total number of abortions including late-term abortions, or were they just late-term abortions?

Dr. LEVATINO. Those were total number of abortions I performed in private practice. I performed several hundred more in training.

Mr. CHABOT. Okay. So my question is, of those—and I know you have changed your position 180 degrees since then, and I respect you greatly for doing that. But in those abortions that you performed, how many of those abortions would you estimate were cases where you had a baby which faced a severe health problem and maybe a matter of life and death versus babies which would have been born healthy, perhaps lived 70, 80 years, had children and grandchildren themselves, experienced the same experiences that all the people in this room have, that would have experienced the life that we have?

How many of those that faced the tragic things that Ms. Zink faced versus probably a healthy existence that we all have? What would be your estimate of that?

Dr. LEVATINO. I think I can estimate that very well, Congressman. My partners and I did very thorough histories on all of our patients who came in for abortions. We weren't running an abortion mill. This was a routine obstetrics and gynecology practice.

We did OB. We did GYN. We did abortions. We did deliveries. We had no financial incentive to push a patient one way or the other. If she wished to have an abortion, we could take care of her. If she wished to deliver her child, we could take care of her.

Of the 1,200 abortions that I performed, 2 were cases of rape or incest. Of the other 1,200, approximately a dozen were for fetal malformations. The rest were elective.

Mr. CHABOT. So the vast majority of the babies would have been healthy and probably led a productive life?

Dr. LEVATINO. The vast majority, yes, sir.

Mr. CHABOT. And had children themselves and grandchildren themselves someday?

Dr. LEVATINO. Probably so.

Mr. CHABOT. And I am not trying to make the pain that you went through any harsher here, but the reality is most of these babies—we talk about the exceptional cases here like Ms. Zink's, but in the vast majority of the cases, we are talking about ending the lives, the existence of human beings just like ourselves.

My next question. You had mentioned—well, let me ask you this, and I had asked you this question in a previous hearing. What was it that made you change your point of view on this?

Dr. LEVATINO. I was very pro choice through medical school and my training, and I guess I proved that by doing abortions in my private practice. In 1984, I lost a child of my own to an auto accident and through that experience looked very hard at what I was doing as an abortionist. And it became quite intolerable, and I stopped.

Mr. CHABOT. Thank you.

And finally, you mentioned what a brutal procedure this is and the nature of it, arms and legs, et cetera. But there has also been this idea that a war on women, which I think is repugnant that people would say that. But is there not a danger to the women themselves that are going through these procedures when you are reaching in?

I mean, you mentioned the uterus, for example. You have to be careful you don't perforate the uterus. So is there a danger to the woman that undergoes one of these procedures?

Dr. LEVATINO. There is always a risk. There is a risk with child birth. There is a risk with abortion. There is a risk with every medical procedure. There is a risk of infection. There is a risk of perforation of the uterus. There is a risk of death. There is a risk of hemorrhage.

In my career, I had the unpleasant experience during one of these abortions, as I said, when you're reaching in with—rather, a stainless steel instrument and reaching in, I had the experience of reaching in and pulling, and instead of getting a limb, I got the lady's intestines.

Just complications do occur.

Mr. CHABOT. Thank you, Doctor.

Dr. LEVATINO. Thank you.

Mr. CHABOT. Thank you. I yield back.

Mr. FRANKS. And I thank the gentleman.

And I recognize the Ranking Member, Mr. Nadler, for 5 minutes.

Mr. NADLER. Thank you, Mr. Chairman.

When Congress passed the Born-Alive Infants Protection Act, which I supported, which makes killing any infant born alive illegal—although it was illegal to start with, obviously—Congress was very clear that we were not imposing any new duty on

neonatologists to intervene, especially if the live birth was at a stage where survivability was seriously in doubt.

Given the testimony today, I am concerned that some members of this panel would want to impose such a duty even at a very early stage of development, say, 20 weeks. Do you take this position, and if so, what should be the dimensions of that duty, Dr. Levatino?

Dr. LEVATINO. If a child is born alive, that child is a person under the law and has rights. One of those rights is to proper medical care, period.

Mr. NADLER. But that is a preexisting medical—I am sorry. It is a preexisting legal obligation. So you would not agree that the born-alive bill established new neonatology requirements that didn't already exist in law?

Dr. LEVATINO. I would agree that it didn't establish anything that wasn't already present in law. Unfortunately, it seems that too many physicians, Dr. Gosnell among them, would choose to ignore that.

Mr. NADLER. Well, Dr. Gosnell was convicted of murder.

Dr. LEVATINO. Too many children, in fact, are being born outside of facilities where they can't even get the care that they are entitled to as citizens.

Mr. NADLER. Okay. Ms. Zink, first of all, I want to thank you for agreeing to testify today. As a parent, your story was very difficult to listen to, and I can't even begin to imagine how difficult it must have been to live through it, much less to come here and describe your experience to people.

So I want to thank you for your willingness to put a human face on this question and for your courage in being here.

One of the really harmful consequences of this bill, in my opinion, is that there are some fetal conditions that cannot be diagnosed before the 20th week of pregnancy. In those situations, the tragedy of learning that there is, for example, a fetal anomaly that is incompatible with life is compounded by the fact that this bill would make it impossible to receive abortion care if that is the medically indicated treatment.

In fact, isn't it correct that the diagnosis in your case could not have been made before the 20th week?

Ms. ZINK. That's correct.

Mr. NADLER. If this bill had been law when you had to face your ordeal, your doctors would have had to risk jail and a lawsuit if they provided you with the medical services you required. Could you comment on that?

Ms. ZINK. I think that one of the things that I want to say is that through all of the presentations about experience, my experience is not reflected in any of that. We got excellent medical care. It was connected. All of the doctors were speaking to each other. We got care before and during and after, and excellent medical, safe care.

And I think that that sort of notion of not having access to that and to know that doctors who are looking at their medical knowledge, looking at each individual case, talking to women, talking to families in the way that doctors and patients should be talking to each other about what the prognosis is, what the steps are, what the range of options are, to cut that off I think is horrible.

Mr. NADLER. So you think that your liberty, along with your husband, in consultation with your doctor to do what was best for your family would have been precluded by this bill?

Ms. ZINK. Absolutely.

Mr. NADLER. Thank you. Thank you, Ms. Zink.

We received a letter today, which I ask be placed in the record at this point, from the American Congress of Obstetricians and Gynecologists, the American Medical Women's Association, the American Nurses Association, the American Society for Reproductive Medicine, the Association of Reproductive Health Professionals, Medical Students for Choice, the National Association of Nurse Practitioners in Women's Health, the National Family Planning and Reproductive Health Association, Physicians Reproductive Health, and Planned Parenthood of America.

[The information referred to follows:]

May 23, 2013

Dear Member of the House of Representatives,

We, the undersigned medical organizations, stand in strong opposition to H.R. 1797, the District of Columbia Pain-Capable Unborn Child Protection Act, sponsored by Representative Trent Franks (R-AZ). This bill would deny women residing in the District of Columbia of safe and legal medical care through governmental interference with the doctor-patient relationship. We oppose this bill and any attempt to apply this ban nationwide.

If enacted, H.R. 1797 would ban most abortions in the District of Columbia at 20 weeks after fertilization. The bill expands medical liability by granting relatives the ability to sue and threatens providers with fines and/or imprisonment, all clearly intended to intimidate and discourage doctors from providing abortion care.

This legislation endangers women by criminalizing safe, legal abortion. With only a narrow and inadequate exception for the life and health of a woman, H.R. 1797 would place doctors in the untenable position of denying abortions to women in need, including women carrying a pregnancy with severe and lethal anomalies, which are sometimes not diagnosed until 20 weeks or later. These include:

- Anencephaly, a "lethal defect characterized by absence of the brain and cranium above the base of the skull and orbits;"<sup>21</sup>
- Renal agenesis, the failure of kidneys to materialize;
- Limb-body wall complex, in which the organs are often outside the body cavity;
- Severe heart defects; and
- Neural tube defects such as encephalocele (the protrusion of brain tissue through an opening in the skull) and severe hydrocephaly (severe accumulation of excessive fluid within the brain).

These and other pregnancy complications often result in fetal death before or soon after birth.

The bill attempts to dictate how physicians should care for their patients, based on inaccurate and unscientific claims:

- Gestational Age

Obstetrician-gynecologists use last menstrual period (LMP) to date pregnancies. This bill seeks to take the determination of gestational age away from medical doctors who are trained to make this determination.

- Fetal Pain

A rigorous 2005 scientific review of evidence on fetal pain in *Journal of the American Medical Association (JAMA)*<sup>ii</sup> concluded that fetal perception of pain is unlikely before the third trimester. No new studies since then have changed this dominant view of the medical profession. While bill supporters present studies which support the claim of fetal pain prior to the third trimester, when weighed with the JAMA study and other available information, the supporters' conclusion does not stand.

- Fetal Viability

Most ob-gyns understand fetal viability occurs near 24 weeks gestation using LMP dating. The bill relies on misleading evidence about fetal viability, using post-fertilization age instead of LMP dating in a normal (or healthy) pregnancy, falsely implying high survival rates among neonates.

We strongly oppose governmental interference in the doctor-patient relationship. H.R. 1797 jeopardizes the health of DC women by denying access to safe and legal abortion, and replaces personal decision-making by women and their doctors with politicians' personal ideology.

Our organizations oppose this interference and threat to women's health and urge you to oppose passage of H.R. 1797.

Sincerely,

American Congress of Obstetricians and Gynecologists  
 American Medical Women's Association  
 American Nurses Association  
 American Society for Reproductive Medicine  
 Association of Reproductive Health Professionals  
 Medical Students for Choice  
 National Association of Nurse Practitioners in Women's Health  
 National Family Planning & Reproductive Health Association  
 Physicians for Reproductive Health  
 Planned Parenthood Federation of America

<sup>i</sup> Cunningham et al. eds. *Williams Obstetrics*. 22d ed. 2005, 394.

<sup>ii</sup> Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal pain: A systematic multidisciplinary review of the evidence. *JAMA* 2005; 294: 947-954.

Mr. NADLER. The letter makes several points. One, that fetal viability is generally regarded as occurring at 24 weeks gestation using LMP, last menstrual period, and that this bill, by counting from fertilization, falsely implies high survival rates among neonates.

Two, that the generally held view in the profession is that fetal pain does not occur prior to the third trimester, a view found in a widely cited *Journal of the American Medical Association* study

and a review by the Royal College of Obstetricians and Gynecologists.

Three, that severe and lethal anomalies, such as the absence of the brain and cranium above the base of the skull, the failure of the kidneys to form, organs growing outside the body cavity, severe heart defects, and neural tube defects, often are not diagnosed before 20 weeks.

In light of this, let me ask Dr. Levatino, do you believe it should be a crime to perform an abortion post 20 weeks in these cases of severe and lethal fetal anomalies? And what would you say to Ms. Zink about her tragic situation?

Dr. LEVATINO. Ms. Zink lost a child, just as I do. And as I told her a year ago, I'm sorry for your loss.

As far as the vast, vast, vast majority of those anomalies are diagnosed prior to this time. Twenty weeks from post fertilization is 22 weeks from last menstrual period. The vast majority, and I would point out even Ms. Zink's baby, was diagnosed prior to that time.

It's rare at this point—there are a few cases where they will get diagnosed after that time. But the vast majority, you have mentioned a few in that letter, like anencephaly, easily seen on an ultrasound at 16 weeks, which is almost routinely performed.

Mr. NADLER. Excuse me. But the letter that we have from all these journals or organizations says that many of these things are not—are often not diagnosed before 20 weeks. You are saying they are incorrect?

Dr. LEVATINO. Rare, Congressman. Rare.

Mr. NADLER. It says often.

Dr. LEVATINO. That's what they say. In my experience, rare. And I dealt with preemies all the time.

Mr. NADLER. And what about those rare cases?

Dr. LEVATINO. Rare cases you take on a case-by-case basis.

Mr. NADLER. No, but should we make it illegal to perform an abortion after 20 weeks in those rare cases of anencephaly, failure of kidneys to form, severe heart defects, neural tube defects, and so forth, if they are discovered, let us say, in the 21st week?

Dr. LEVATINO. Yes.

Mr. NADLER. And that is a moral judgment on your part, obviously—

Dr. LEVATINO. Yes.

Mr. NADLER [continuing]. Which others may disagree with?

Dr. LEVATINO. Yes.

Mr. NADLER. Thank you.

I see my time is expired.

Mr. FRANKS. I thank the gentleman.

And I will now recognize myself for 5 minutes.

You know, over the years, if one has worked in this area a long time, you become used to people saying, well, you know you are just focused on the wrong thing or somehow you should be focusing on more important things. But Dr. Martin Luther King said something that occurs to me in a very profound way. He said our lives begin to end the day we become silent about things that really matter.

And I would just suggest to those in the audience, those here on the panel that there are some of us that believe this really matters because whatever else happens during a late-term abortion, whatever else happens, a child dies a lonely and often painful death. The mother is never the same and is often, no matter the circumstances, left with great loss and emotional heartache. And whatever gifts that child might have brought to humanity are, of course, lost forever.

And it just occurs to me that if we don't have the courage or the will to protect the most innocent among us, then I wonder if we will ever have the will or the courage as a people to protect any kind of liberty for anyone. I wonder where we go as a human family.

And with that, Dr. Levatino, I heard a lot of witnesses, and I find your testimony to be so incredibly compelling. And I find myself always wanting to just express a sense of condolence for your loss. But I think your little girl would be very, very proud of you.

Recently, three former clinic employees have come forward with allegations against an abortionist in Houston, Texas. One former employee, speaking out about late abortions, reportedly alleged that, "Most of the time, the fetus would come all the way out before he either cut the spinal cord or introduced one of the instruments into the soft spot of the fetus in order to kill the fetus."

She said, "Either that or twisting the head off the neck with his own bare hands." She alleged that most of the time, "We would see the fetus come all the way out, and of course, the fetus was still alive." And allegedly, according to the news report, "The abortionist also suffocated babies by putting his finger down the windpipes."

Now I'm going to ask for a couple of photos to be shown, reluctantly. To be put on the plasma screens. And they are exceedingly gruesome. So I would want to give fair warning to those who might want to look away, and we would give you a few moments to do that.

All right. Now, Dr. Levatino, directing your attention to the two photos on the screen that were allegedly taken at the abortionist's clinic I spoke of in Houston, Texas, in your estimation, how old would you say that this baby—there is two pictures there. How old would you say that this baby is?

Dr. LEVATINO. It's always difficult to estimate gestational age just based on a photograph, but comparing to an adult's hand, I would estimate that child between 24 and 28 weeks of gestation from last menstrual period.

Mr. FRANKS. Now if a healthy baby, otherwise healthy, were born alive at that age, what would be his or her chances of long-term survival?

Dr. LEVATINO. The majority would survive.

Mr. FRANKS. Now looking at the second paragraph—excuse me, the second photograph.

[Pause.]

Mr. FRANKS. They may be looking at the wrong one, but there is a thumb that is inserted in the gash in the baby's neck, and it was the previous one. What might cause a gash like that?

Dr. LEVATINO. A gash in the base of a baby's neck is not a birth injury. There is no condition or no condition of delivery that I am

aware of that could possibly cause such an injury. I have seen those photographs.

Mr. FRANKS. And the nature of this would tell you—

Dr. LEVATINO. The injury would have to be traumatic and induced and performed on this child after that child was born.

Mr. FRANKS. And so, it would be made outside the womb rather than inside the womb?

Dr. LEVATINO. Correct.

Mr. FRANKS. Now whether the baby was inside or outside, would it have been painful to the baby, assuming the baby was born alive?

Dr. LEVATINO. Yes.

Mr. FRANKS. Thank you, Dr. Levatino.

Dr. CONDIC, I know it is difficult, but do you have any observations?

Ms. CONDIC. No, I am not a physician. I'm a scientist. That's why I really can't comment on those photographs in a professional capacity. But certainly, as a woman and as a mother, it's horrifying that a child would be treated in this manner.

Mr. FRANKS. Dr. Levatino, did you have a further point?

Dr. LEVATINO. No, sir.

Mr. FRANKS. Okay, all right. When we look at these things, I know they are hard. But one thing they do do is they put out of reach any claim that we didn't know. And now that we have seen those, the question occurs as to whether or not we will come to the rescue of these children and find our humanity and hope for better days for America, or we will allow ourselves to slide into that Sumerian darkness where the light of compassion has gone out and the survival of the fittest is prevailed over humanity.

And it is an important question. And so, with that, I would now yield to Mr. Conyers for 5 minutes for questions.

Mr. CONYERS. Thank you very much, Mr. Chairman.

This has been a painful and uncomfortable discussion here today for me personally, and I know that Ms. Zink has probably been as well. And I wanted to ask you, Ms. Zink, is there anything that you would like to add to this discussion, since not an awful lot of questions have been directed to you, about the issues that bring us here today in the Judiciary Subcommittee?

If you do, I would welcome hearing from you at this time.

Ms. ZINK. I just think it's worth it to add that this is not a hypothetical situation. This is not a philosophical discussion. This affects real women, real families, real lives, and even if our—if my situation is rare, there are many women that it has affected already and who have gone through this.

And there are many women, unfortunately, it's a community that grows every day of people who face these really awful decisions. But it's something that has to be a private decision to trust the doctors and their knowledge, to work with their counsel, to talk to our families, and to talk to our counselors.

And that that's the reality of how all of this works at a very human level.

Mr. CONYERS. Thank you for giving us this viewpoint. It is important for the record.

Dr. Levatino, might I ask you, sir, if you believe children are entitled to healthcare once they are born? I presume that you do.

Dr. LEVATINO. Yes, sir.

Mr. CONYERS. We all know that the Affordable Care Act protects women and children to ensure that they have the kind of care that you alluded to. Do you have any feelings or viewpoint about the Affordable Healthcare Act?

Dr. LEVATINO. The Affordable Healthcare Act, with respect, I don't think is actually all that relevant to today's discussion. Like most physicians in this country, I guess I have a lot of feelings about the Affordable Healthcare Act, sir.

Mr. CONYERS. Sure. You are not in support of it?

Dr. LEVATINO. I'm not sure. It's such a broad topic. Are you asking about something specifically?

Mr. CONYERS. Well, yes. Specifically, since we have voted on it 37 times in the Congress, I am interested in your view. Not anything in specific. There are probably a lot of things we could go into, but not in 5 minutes.

Can you just—well, let me put it like this, Doctor, and I want to be fair to you. Could you just say you don't like it?

Dr. LEVATINO. No, I couldn't say that at all.

Mr. CONYERS. Could you say that you do like it?

Dr. LEVATINO. No, I couldn't say that either.

Mr. CONYERS. Well, what—

Dr. LEVATINO. The Affordable Care Act, I think, is an effort to try to correct a lot of the problems we have with medical care in our country. There are a lot of things about the Affordable Care Act that I think are just fine. We're going to provide insurance for people who had difficulty getting insurance. We're going to—

Mr. CONYERS. So you like parts of it, and you don't like other parts.

Dr. LEVATINO. We're going to take away the horrible situation where—or the difficult situation—

Mr. CONYERS. Okay.

Dr. LEVATINO [continuing]. Where people change jobs and lose their insurance.

Mr. CONYERS. All right.

Dr. LEVATINO. On the other hand, we are depending on young people—

Mr. CONYERS. Pardon me, sir.

Dr. LEVATINO [continuing]. To float the system and are just not going to do it.

Mr. CONYERS. I see you are a pretty professional witness, but just let me—I got the yellow light, and I don't want to cut you off. But how do you think we should pay for the kind of care necessary for expectant mothers at 20 weeks or 24 weeks?

Dr. LEVATINO. I'm not sure I understand your question, Congressman.

Mr. CONYERS. If a fetus is born at 20 weeks, do we have an obligation to provide the necessary medical care to that mother?

Dr. LEVATINO. Yes.

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

Mr. CONYERS. Well, that is some progress, and I thank you, Doctor, for your responses.

Dr. LEVATINO. Thank you, Congressman.

Mr. CONYERS. And thank you, Mr. Chairman.

Mr. FRANKS. The Chair now recognizes Mr. King for 5 minutes.

Mr. KING. Thank you, Mr. Chairman.

I thank the witnesses for your testimony today. As I listen I can't help but reflect upon stepping into the office of one of my district employees who happens to also be a State senator. As I sat down and borrowed his telephone, I looked up at the shelf, and there was a framed picture of the 4-D ultrasound of my godson.

And I would ask—I think I would ask Dr. Condic do you have any—what is your opinion as to the availability of that technology and how it might have moved hearts and minds?

Ms. CONDIC. I think the 4-D ultrasound is a very powerful way of looking inside a situation that has been a black box in the past, and I think we are very visual creatures. Humans react to things they can see.

And a lot of the emotional disposition of people in the abortion debate has centered on the fact that we can't really see that baby, and everything that's happening, as Dr. Levatino so graphically described, is happening in the dark. So being able to open the womb, to a picture of a baby that's moving, that you can recognize as a baby I think has a strong emotional effect because it allows people to see what's really there. Not—not some mass of tissue or blob of cells, but—

Mr. KING. It is curious that we call it a 4-D ultrasound, but yet we can't hear the sound of the baby.

Ms. CONDIC. By four dimensions, they mean you see three dimensionally. So you see the baby as not as a flat image, but as a projection in space. And then the fourth dimension is time. So you can see the baby moving.

Mr. KING. Well, let us explore that other dimension of sound, and it occurs to me that people are emotionally sensitive to sound. And I just was thinking this through. I know people that don't eat any red meat, and part of the reason is they can hear in their mind's ear the sound of that animal that is being harvested for our consumption.

So they don't eat beef. They don't eat pork. They say I don't eat red meat. But they might eat chicken or duck probably because the sound of a chicken or duck doesn't trouble them as much. I have heard them say that. And then some will not eat poultry, but they will eat fish because fish can't scream for their own mercy.

And so, I go on down the line to the vegan side of it, no animal products and only vegetables, and it occurs to me that those that have a dietary preference, that is fine. Those that have a political position, I guess that is fine. But some of them, they can't abide the sound of the processing of that animal in their mind's ear.

And I recall sitting in this Committee during the partial-birth abortion debates that we had, and the description of the partial-birth abortion about babies being delivered to just right an inch before they could fill their lungs with free air and scream for their own mercy.

And it strikes me that that sound is in the mind's ear of the jury of Dr. Gosnell, and it is now in the mind's ear of the people in this

country that are deliberating on this. And I would wonder, Doctor, if you would comment on that?

Ms. CONDIC. I think anything that allows people to more realistically understand what a fetus really is and what it's really capable of—its experiences, its reactions, its emotions—is a movement toward honesty. And I would fully support it.

Mr. KING. Thank you.

Ms. Stanek, you said that the excruciating fate of the child is determined simply by geography, and I didn't hear your testimony expand on that. Could you expand on that thought a little for us, please?

Ms. STANEK. Yes, the baby that I held who was between 21 and 22 weeks old was about the size of my hand, and he didn't move very much because he was just attempting to survive by breathing. And after he was pronounced dead, you know, took him to the morgue, where we take all our other dead patients.

And that same age baby, who I held, an abortion survivor, is aborted today, going on right now, limb from limb, drawn and quartered, as Dr. Levatino described. And whereas, we give pain relief to born babies that same age, it is well known, in utero when they are being operated on and after they are born, we don't seem to give any care or regard to these same babies if they are not wanted, if the moms want to terminate their pregnancies.

Mr. KING. So that is determined by the prospect of their survival, as well as their geography?

Ms. STANEK. It's—I'm sorry. What was that?

Mr. KING. By the prospect of their survival? If the child is receiving surgery in order to save this child—

Ms. STANEK. Right.

Mr. KING [continuing]. As opposed to an operation to kill the child?

Ms. STANEK. Right, right.

Mr. KING. So the prospects of survival.

And then if I could just quickly turn to Dr. Levatino, and I would ask this opinion. I heard the gentleman from Michigan, Mr. Conyers, say that this was a painful and uncomfortable experience here. Could you compare that painful and uncomfortable experience here to the one that a child goes through?

Dr. LEVATINO. I have done this my entire professional life. I've dealt with preemies down to this size and even smaller. Well, certainly down to this size. And I've done the abortions firsthand.

I am dismayed sometimes at particularly the American College of Obstetricians and Gynecologists. I was a fellow in that organization for over 20 years. I held a leadership post at one point. And I withdrew my membership several years ago because of some of—despite all the good things that the organization does, and there are many, the frankly what I saw as the obvious political stance they took on this issue.

And it bothers me when they talk about, oh, fetuses don't feel any pain at all until they're viable. Isn't that amazing? It just suddenly switches on when they're viable.

And if anybody thinks that ripping off arms and legs and crushing these children the way we do during these procedures isn't

painful, they are just kidding themselves. They are badly kidding themselves.

And when you look at those pictures of that, this abortionist now in Houston, I hope he will be properly investigated and possibly prosecuted. These children almost had their heads torn off. And if you don't think that's painful.

I have been sitting here ruminating a little bit about the letter that was read. Very interesting, you know? Children with renal agenesis are not entitled to a chance at life? Children with Down syndrome are not entitled to a chance to life? Children with different types of brain injuries are not even entitled to a chance to live? Is that what we're championing here?

Mr. KING. Thank you, Doctor.

I thank all the witnesses, and I yield back the balance of my time, Mr. Chairman.

Mr. FRANKS. Thank you, Mr. King.

I am reminded that I had a brother who had Down syndrome that was given the chance to live for almost 40 years, and we are very grateful.

The gentleman from Texas, Mr. Gohmert, is recognized for 5 minutes.

Mr. GOHMERT. Thank you, Mr. Chairman.

I have a first cousin whose mother and our whole family is glad that he was—that she carried him and has taken care of him. And anyway, it raises difficult issues, and having had a preemie for our first child, we weren't sure what we were getting. We felt like, apparently, it was going to be a girl. But she came so early, this was a very difficult time in our lives.

And Ms. Zink, you have my great sympathy. But having had a child who was premature and having sat there, we had an incredible neonatologist in Shreveport, Dr. Tsing, T-s-i-n-g, and I haven't seen him since then. But he had such a love for the children, and when we were told we could go either to Dallas or Shreveport, I asked about the survivability, and he said we seem to have more children live in Shreveport, for whatever reason.

My wife and I had talked about it. Well, let us go to Shreveport, anything we could do for our child, because they were losing her.

And as you know, among preemies, blindness can be an issue if you expose to 100 percent oxygen or too much oxygen too quickly because of the blood vessels. The dilation causes the separation or the little fingers that come out that separate it from the retina. And I knew when they went from 20 to 40 to 60 to 80 percent oxygen very quickly that they were—they knew our baby was in big trouble.

But Dr. Tsing said it is so important that the baby hear your voice. Please talk to your baby. Here is a stool beside the isolette, and caress her, talk to her. She—her eyes don't work very well. She won't recognize you, but she will know your voice because she has heard you in utero.

And as you would know, the lungs are about the last to develop. They have trouble breathing. Breathing is so shallow and so rapid, and the heart rate so erratic.

But I would, as my wife had said, go do anything you can for our baby. They said you can sit for 2 hours, and so I sat. And he said

caress her, talk to her, and as I did, the little bitty fingers grasped around the end of my finger, and I sat there for an hour or so.

Dr. Tsing came by and said, "Have you noticed the monitors?" Breathing still very shallow, heartbeat fast, but they had stabilized and not become so erratic. And Dr. Tsing said, "She is drawing strength, she is drawing life from you."

Well, with that, I couldn't leave. And after 8 hours, they told me I had to take a break. I couldn't keep sitting there. But I'm helping my child. How could I leave?

But when I read and hear of your account, Doctor, of how a child like mine would have the Sopher clamp placed on a leg and then ripped from the body, grab an arm and ripped from the body, and I think about our little Katie, hanging on to my finger for dear life, it is pretty difficult as well.

Being there in an advanced neonatal ICU, I did see there was one child that was born that was missing parts, including a spine. And the parents ended up—when it was very clear there was no brain activity whatsoever, there was nothing—there were decisions that they had to make at that point.

Ms. Zink, having my great sympathy and empathy both, I still come back wondering, shouldn't we wait like that couple did and see if the child can survive before we decide to rip them apart? So these are ethical issues. They are moral issues. They are difficult issues.

And the parents should certainly be consulted. But it just seems like it is a more educated decision if the child is in front of you to make those decisions. So I appreciate all that each of you bring.

Ms. Stanek, I have known and loved you before I ever saw your picture, and I just read the account of what I knew you endured. But thank each of you for being here. Thank you for the input that each of you bring to this difficult issue.

Thank you, Mr. Chairman.

Mr. FRANKS. "This is our first task, caring for our children. It is our first job. If we don't get that right, we don't get anything right. That is how as a society we will be judged.

"Are we really prepared to say that we are powerless in the face of such carnage, that the politics are too hard? Are we prepared to say that such violence visited on our children year after year after year is somehow the price of freedom?"

I pray that we would all heed the words of our President, and with that, this meeting is adjourned.

[Whereupon, at 12:11 p.m., the Subcommittee was adjourned.]