

PARTIAL-BIRTH ABORTION BAN ACT OF 2002

HEARING
BEFORE THE
SUBCOMMITTEE ON THE CONSTITUTION
OF THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTH CONGRESS
SECOND SESSION

ON

H.R. 4965

JULY 9, 2002

Serial No. 93

Printed for the use of the Committee on the Judiciary



Available via the World Wide Web: <http://www.house.gov/judiciary>

U.S. GOVERNMENT PRINTING OFFICE

80-553PDF

WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

COMMITTEE ON THE JUDICIARY

F. JAMES SENSENBRENNER, JR., WISCONSIN, *Chairman*

HENRY J. HYDE, Illinois	JOHN CONYERS, JR., Michigan
GEORGE W. GEKAS, Pennsylvania	BARNEY FRANK, Massachusetts
HOWARD COBLE, North Carolina	HOWARD L. BERMAN, California
LAMAR SMITH, Texas	RICK BOUCHER, Virginia
ELTON GALLEGLY, California	JERROLD NADLER, New York
BOB GOODLATTE, Virginia	ROBERT C. SCOTT, Virginia
STEVE CHABOT, Ohio	MELVIN L. WATT, North Carolina
BOB BARR, Georgia	ZOE LOFGREN, California
WILLIAM L. JENKINS, Tennessee	SHEILA JACKSON LEE, Texas
CHRIS CANNON, Utah	MAXINE WATERS, California
LINDSEY O. GRAHAM, South Carolina	MARTIN T. MEEHAN, Massachusetts
SPENCER BACHUS, Alabama	WILLIAM D. DELAHUNT, Massachusetts
JOHN N. HOSTETTLER, Indiana	ROBERT WEXLER, Florida
MARK GREEN, Wisconsin	TAMMY BALDWIN, Wisconsin
RIC KELLER, Florida	ANTHONY D. WEINER, New York
DARRELL E. ISSA, California	ADAM B. SCHIFF, California
MELISSA A. HART, Pennsylvania	
JEFF FLAKE, Arizona	
MIKE PENCE, Indiana	
J. RANDY FORBES, Virginia	

PHILIP G. KIKO, *Chief of Staff-General Counsel*
PERRY H. APELBAUM, *Minority Chief Counsel*

SUBCOMMITTEE ON THE CONSTITUTION

STEVE CHABOT, Ohio, *Chairman*

WILLIAM L. JENKINS, Tennessee	JERROLD NADLER, New York
LINDSEY O. GRAHAM, South Carolina	BARNEY FRANK, Massachusetts
SPENCER BACHUS, Alabama	JOHN CONYERS, JR., Michigan
JOHN N. HOSTETTLER, Indiana	ROBERT C. SCOTT, Virginia
MELISSA A. HART, Pennsylvania,	MELVIN L. WATT, North Carolina
<i>Vice Chair</i>	
LAMAR SMITH, Texas	
J. RANDY FORBES, Virginia	

BRADLEY S. CLANTON, *Chief Counsel*
PAUL B. TAYLOR, *Counsel*
CRYSTAL M. ROBERTS, *Counsel*
KRISTEN SCHULTZ, *Full Committee Counsel*
DAVID LACHMANN, *Minority Professional Staff Member*

CONTENTS

JULY 9, 2002

OPENING STATEMENT

	Page
The Honorable Steve Chabot, a Representative in Congress From the State of Ohio, and Chairman, Subcommittee on the Constitution	1
The Honorable Jerrold Nadler, a Representative in Congress From the State of New York, and Ranking Member, Subcommittee on the Constitution	3

WITNESSES

Ms. Kathi Aultman, M.D.	
Oral Testimony	6
Prepared Statement	9
Mr. Simon Heller, Consulting Attorney, Center for Reproductive Law and Policy	
Oral Testimony	15
Prepared Statement	16
Mr. Robert A. Destro, Professor of Law, Columbus School of Law, Catholic University of America	
Oral Testimony	20
Prepared Statement	21
Mr. Curtis Cook, M.D.	
Oral Testimony	25
Prepared Statement	27

APPENDIX

STATEMENTS SUBMITTED FOR THE HEARING RECORD

The Honorable Steve Chabot, a Representative in Congress From the State of Ohio, and Chairman, Subcommittee on the Constitution	47
The Honorable Jerrold Nadler, a Representative in Congress From the State of New York, and Ranking Member, Subcommittee on the Constitution	48
The Honorable Randy Forbes, a Representative in Congress From the State of Virginia	49

MATERIAL SUBMITTED FOR THE HEARING RECORD

Material Submitted by the Honorable Steve Chabot, a Representative in Congress From the State of Ohio, and Chairman, Subcommittee on the Constitution	50
Letter from Simon Heller, Consulting Attorney, Center for Reproductive Law and Policy	170
Material Submitted by Dr. Kathi Aultman	182
<i>Issues in Law and Medicine</i> Article, Submitted by Dr. Curtis Cook	262

PARTIAL-BIRTH ABORTION BAN ACT OF 2002

TUESDAY, JULY 9, 2002

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

The Subcommittee met, pursuant to call, at 2:09 p.m., in Room 2237, Rayburn House Office Building, Hon. Steve Chabot [Chairman of the Subcommittee] presiding.

Mr. CHABOT. The Committee will come to order. I'm Steve Chabot, the Chairman of the Subcommittee on the Constitution of the Judiciary Committee. We're convening this afternoon to receive testimony on H.R. 4965, the Partial-Birth Abortion Ban Act of 2002.

Partial birth abortion is the termination of the life of a living baby just seconds before it takes its first breath outside the womb. The procedure is violent. It's gruesome. It's infanticide.

On June 19, on behalf of a bipartisan coalition, I introduced H.R. 4965, the Partial-Birth Abortion Ban Act of 2002. H.R. 4965 will ban this dangerous and inhumane procedure during which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant.

An abortionist who violates this ban would be subject to fines or a maximum of 2 years' imprisonment or both. H.R. 4965 also establishes a civil cause of action for damages against an abortionist who violates the ban and includes an exception for those situations in which a partial-birth abortion is necessary to save the life of the mother.

A moral, medical, and ethical consensus exists that partial-birth abortion is an inhumane procedure that is never medically necessary and should be prohibited. Contrary to the claims of those who proclaim the medical necessity of this barbaric procedure, partial-birth abortion is in fact a dangerous medical procedure that poses serious risks to the long-term health of women.

In fact, 10 years after Dr. Martin Haskell presented this procedure to the mainstream abortion community, partial-birth abortions have failed to become the standard of medical practice for any circumstance under which a woman might seek an abortion. As a result, the United States Congress voted to ban partial-birth abortions during the 104th, 105th, and 106th Congresses, and at least 27 States enacted bans on this procedure. Unfortunately, the two

Federal bans that reached President Clinton's desk were promptly vetoed.

Two years ago, in *Stenberg v. Carhart*, the United States Supreme Court struck down Nebraska's partial-birth abortion ban, which was similar but not identical to the previous bans passed by Congress.

To address the concerns raised by the majority in *Stenberg*, H.R. 4965 differs from previous proposals in two areas. First, the bill contains a new more precise definition of the prohibited procedure to address the Court's concerns that Nebraska's definition of the prohibited procedure might be interpreted to encompass a more commonly performed second trimester abortion procedure. The second difference addresses the majority's opinion that the Nebraska ban placed an undue burden on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the health of the mother.

The *Stenberg* Court based its conclusion on the trial court's factual findings regarding the relative health and safety benefits of partial-birth abortions, findings which were highly disputed. The *Stenberg* Court, however, was required to accept these trial court findings because of the highly deferential clearly erroneous standard that is applied to lower court factual findings.

Those factual findings, however, are inconsistent with the overwhelming weight of authority regarding the safety and medical necessity of the partial-birth abortion procedure, including evidence received during extensive legislative hearings during the 104th and 105th Congresses which indicates that a partial-birth abortion is never medically necessary to preserve the health of a woman, that it poses serious risks to a woman's health and lies outside the standard of medical care. In fact, the American Medical Association has concluded that partial-birth abortion is, "not an accepted medical practice," and that it has, "never been subject to even a minimal amount of the normal medical practice development.

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

To conclude otherwise would forever bind Congress to the factual findings of one Federal district court, no matter how questionable those findings may have been or how much those facts may be altered by time. This simply cannot be the case.

Thus, the first section of H.R. 4965 contains Congress's factual findings that, based upon extensive medical evidence compiled during congressional hearings, a partial-birth abortion is never necessary to preserve the health of a woman.

Despite overwhelming support from the public, past efforts to ban partial-birth abortion were blocked by President Clinton. Now we have a President who is equally committed to the sanctity of life, a President who has promised to stand with Congress in its

efforts to ban this barbaric and dangerous procedure. It is time for Congress to end the national tragedy of partial-birth abortion and protect the lives of these helpless, defenseless little babies.

I'll now yield to the gentleman from New York, Mr. Nadler, the Ranking Member of the Committee, for his opening statement.

Mr. NADLER. Thank you, Mr. Chairman.

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

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

This bill as written fails every test the Supreme Court has laid down for what may or may not be a constitutional regulation on abortion. It reads almost as if the authors went through the Supreme Court recent decision in *Stenberg v. Carhart* and went out of their way to thumb their noses at the Supreme Court—and we know that Congress in recent days has a habit of very deliberately thumbing its nose at courts, but that has no effect—and especially at Justice Sandra Day O'Connor, who is generally viewed as a swing vote on such matters and who wrote a concurring opinion stating specifically what would be needed to uphold a statute.

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

First and foremost, it does not contain a health as well as life exception to the ban which the bill imposes. And of course, the Court has repeatedly said a health and life exception is necessary throughout pregnancy, even post-viability. I know that some of my colleagues do not like this rule, but it is the law of the land, and it is not in this bill. Even the Ashcroft Justice Department, in its brief defending a similar Ohio statute, has acknowledged that a health exception is required by law if a statute is to be found constitutional. While I may disagree with the department's restrictive views on whether the Ohio statute adequately protects women's health, there is at least an acknowledgement that the law requires the protection of women's health, if it is to be found constitutional.

This bill consists mostly of congressional findings. If there is one thing the current very activist Supreme Court has made clear, it is that it does not care about congressional findings of fact. While Congress is entitled to declare anything it wants—Congress can declare that it is not necessary to have a health exception in such a bill to make it constitutional with the same effect that Congress can declare that moon is made of green cheese. It can declare anything it wants, but the courts are not duty-bound to accept everything we say at face value simply because it appears in a footnote in the United States Code.

While I realize that many of the proponents of this bill view all abortion as tantamount to infanticide, this is not a mainstream

view. This bill attempts to foist the marginal view on the general public by portraying it as something more extreme, as having to do only with healthy, full-term fetuses. If the proponents of this bill want to deal with post-viability abortions, where a woman's life and health are not in jeopardy, then let them write a bill dealing with that issue. But we should not play these kinds of games.

As one of the lead sponsors of the Religious Freedom Restoration Act, passed in 1993 unanimously, or with one dissenting vote—I forget—by this Congress, signed into law by the President, and declared unconstitutional in 1997 by the Supreme Court, I know, as does Professor Destro, one of the witnesses before us, what comes of Congress ignoring the will of the Supreme Court. Whatever power Congress thought it had under section 5 of the 14th amendment, as a result of *Katzenbach v. Morgan*, repeatedly cited in the findings in this bill, which is copiously cited in the bill's findings, the more recent Boerne decision vastly undercut these powers, vastly undercut the power of Congress to enforce the 14th amendment.

Even if *Katzenbach* were still fully enforced, as I personally wish it were, that case only stands for the proposition that Congress may expand the rights conferred under the 14th amendment. It does not stand for the proposition that Congress may curtail rights guaranteed to people under the 14th amendment, which this bill does. This bill aims to do exactly the opposite of what was found constitutional in *Katzenbach*.

It is, of course, an election year, and that means it is once again the silly season in Washington. This, Mr. Chairman, is about as silly as it gets. I would say that we know that there are dire consequences for American women if this legislation passes, but of course we know this legislation will not pass. The other body is too intelligent to consider it. They've read the Supreme Court decisions. They know you can't repeal Supreme Court decisions by statute. They know you can't set aside Supreme Court decisions by findings of fact. They're not going to waste their time with this bill. So the damage will be limited to the damage to the reputation of this house, which is unfortunate, but thank God it's not going to go any further than that.

Thank you, Mr. Chairman.

Mr. CHABOT. Thank you.

Other Members of the Committee who would like to make opening statements may have the opportunity to do so at this time.

Mr. Hostettler of Indiana? Okay.

Mr. Scott of Virginia?

Any of the three Members down here? Mr. Forbes?

Mr. FORBES. Not at this time.

Mr. CHABOT. Okay, thank you very much.

We will at this point introduce the panel of witnesses here this afternoon, and we do have a very distinguished panel.

Our first witness will be Dr. Kathi A. Aultman. Dr. Aultman is certified by the American Board of Obstetrics and Gynecology and has been in private practice since 1981. She currently practices with the North Florida Ob-Gyn Associates of Jacksonville, Florida, and is currently chairman of the governing board of Orange Park Surgery Center. Previously, she served as chairman of the Ob-Gyn

department of Columbia-Orange Park Medical Center in Orange Park, Florida, and was medical director of Planned Parenthood of Jacksonville, Florida, from 1981 to 1983.

Dr. Aultman has testified before hearings in State Legislatures and in courts, as an expert witness, on partial-birth abortion legislation. She also testified at the American Medical Association meeting concerning the AMA's position on partial-birth abortion. Dr. Aultman received her doctorate of medicine from the University of Florida College of Medicine in 1977 and completed her Ob-Gyn residency in 1981 with the University of Florida Health Education Program.

We welcome you here this afternoon, Doctor.

Our second witness will be Simon Heller. Mr. Heller, who was most recently director of the domestic program of the Center for Reproductive Law and Policy, is a constitutional expert who has been an abortion advocate for over 10 years. Most recently, Mr. Heller argued on behalf of Dr. LeRoy Carhart in *Stenberg v. Carhart*. In addition, he has litigated a number of other abortion-related cases throughout the country, including challenges to Medicaid funding restrictions, laws that limit the performance of an abortion to a physician, parental involvement laws, and the partial-birth abortion bans of Wisconsin and Virginia.

Prior to helping found the CRLP, Mr. Heller was a staff attorney at the Reproductive Freedom Project at the American Civil Liberties Union. He also served as an assistant district attorney in Manhattan. He is now a consulting attorney at CRLP. Mr. Heller received his juris doctorate from Yale Law School in 1986 and his master's and bachelor's from the State University of New York at Stony Brook.

We welcome you here this afternoon, Mr. Heller.

Mr. HELLER. Thank you.

Mr. CHABOT. Our third witness will be Professor Bob Destro. Professor Destro is the professor of law at Columbus School of Law at Catholic University of America in Washington, D.C., where he has been a member of the faculty since 1982. He is creator and co-director of Catholic University's Law and Religion Program. Professor Destro has served as commissioner on the U.S. Commission on Civil Rights, where he led the commission's discussions in the areas of discrimination on the basis of disability, national origin, and religion. He has served as general counsel to the Catholic League for Religious and Civil Rights and is adjunct associate professor of law at Marquette University. He has also practiced private law with the firm of Squire, Sanders & Dempsey in Cleveland, Ohio. Professor Destro's areas of specialization, scholarship, and litigation include freedom of speech and religion; discrimination on the basis of race, disability, origin, and religion; legal ethics and bioethics; and is co-author of "Religious Liberty in a Pluralistic Society," the leading law school textbook in the United States on the subject of religious liberty.

Professor Destro received his undergraduate degree from Miami University in Oxford, Ohio, and his law degree from the University of California at Berkeley.

We welcome you here this afternoon, Professor.

Mr. DESTRO. Thank you.

Mr. CHABOT. And our final witness will be Dr. Curtis Cook. Dr. Cook, who has been practicing medicine since 1990, is an Ob-Gyn who specializes in perinatology, or high-risk pregnancies. He currently practices in Grand Rapids, Michigan, with Spectrum Health, the Metropolitan Hospital, St. Mary's Hospital, and Mercy General Health Partners in Muskegon, Michigan. He is currently assistant clinical professor at the Michigan State University College of Human Medicine and serves as both the associate director of the maternal-fetal medicine assistant residency program and the associate director of the downtown department of obstetrics and gynecology with Spectrum Health.

Previously, he was an instructor with the Department of Obstetrics and Gynecology at the University of Louisville's School of Medicine. He was certified by the American Board of Obstetricians and Gynecologists in 1996 and the Maternal-Fetal Medicine Board in 1998. Dr. Cook is a member of the Association of Professors of Gynecology and Obstetrics, the American College of Obstetricians and Gynecologists, the Society of Maternal-Fetal Medicine, and the American Medical Association.

His honors include receiving the CREOG National Faculty Award for Excellence in Resident Education, and the Michigan State University College of Human Medicine Outstanding Clinical Faculty Resident Teaching Award.

In addition to his professional accomplishments, Dr. Cook testified on this very subject during a joint hearing held before this Subcommittee and the Senate Judiciary Committee in March 1997.

Dr. Cook received his undergraduate degree from Wabash College in Crawfordsville, Indiana; his medical degree from the Indiana University School of Medicine in Indianapolis, Indiana; and served his residency at Butterworth Hospital in Grand Rapids, Michigan.

We welcome you here this afternoon, Doctor.

Dr. COOK. Thank you.

Mr. CHABOT. And we'll begin with Dr. Aultman.

And I would ask the witnesses, if possible, to confine their testimony to 5 minutes. And we have a light system here, where the green light is on for 4 minutes; the yellow light will be on the last minute; and when the red light is on, if you could please wrap it up. We'll give you maybe a little bit of flexibility, but try to stay within that, if possible. Thank you.

STATEMENT OF KATHI AULTMAN, M.D.

Dr. AULTMAN. Thank you, Chairman Chabot and distinguished Committee Members. I want to thank you for asking me here today.

I've spent most of my adult life taking care of women, and their health issues are extremely important to me. I'm also experienced with D&C with suction and D&E, dilation and evacuation, which is the second trimester dismemberment procedure. I had to go get extra training in that outside of my residency program. And I did it because of my interest in women's health.

Although I don't currently perform abortions, I have continued to dialogue with abortion providers regarding current practices and have studied the medical literature on abortion. I continue to per-

form D&C with suction, D&E and inductions in cases of incomplete abortion and fetal demise. I continue to treat women with complications from abortion. And I also aborted my first child, so I come at this from all angles.

I'm familiar with the partial-birth abortion issue, having testified, as the Chairman has already stated.

I support H.R. 4965 for the following reasons: One, this bill clearly distinguishes partial-birth abortion from other abortion procedures. Two, the ban will not in any way endanger women's health. Three, it actually protects women from a dangerous experimental procedure. Four, partial-birth abortion has blurred the line between abortion and infanticide. And this act bans a procedure that is abhorrent to the vast majority of Americans.

Partial birth abortion is a legal term that covers a set of circumstances that culminate in the physician intentionally killing the fetus after it's been partially born. We use the term "partially born" to mean the position of the fetus as defined under the act at the point it's killed.

Partial birth abortion includes but is not limited to D&X, or dilation and extraction, or intact D&E when it's performed on a live fetus. It would also ban a procedure used in China where formaldehyde is injected into a baby's brain after the head had been delivered in order to kill it prior to birth. It does not prohibit chemical abortions, D&C with suction, D&E inductions, or cephalocentesis, which is a procedure used to remove fluid from the brain of a hydrocephalic baby. It would not cover a D&X on a dead fetus, nor would it cover the accidental death of a baby during the normal birth process.

This act eliminates the concern that D&E is prohibited by more precisely defining what is meant by a partial-birth abortion. The Supreme Court noted that if the definition were more narrowly defined to clearly exclude D&E, a ban might be constitutional.

Both the American Medical Association and the American College of Obstetricians and Gynecologists clearly distinguish D&X and D&E. The difference between D&E, or dilation and evacuation, and D&X, dilation and extraction, is that, in the D&E, the cervix is dilated just enough to allow passage of the forceps and the removal of fetal parts. By grasping an extremity and pulling, the part can be detached because the rest of the body can't pass through the cervix. Once the smaller parts have been removed, the physician can crush the thorax and head and remove them.

In the D&E, the fetus dies in the uterus as it is dismembered or crushed. In D&X, the cervix is dilated to a much larger degree so that everything but the head can pass through. The head is then decompressed and the fetus is delivered.

In D&X, the fetus is still alive when everything but the head is delivered into the vagina, but then dies when the head is crushed or the brains are suctioned.

D&E can be performed from about 13 to 22 weeks and, rarely, until 24 weeks' gestation, early to mid second trimester. Past that point, the tissues become too tough to break apart easily. D&X is generally performed from about 20 to 22 weeks' gestation and beyond and has been done as late as 40 weeks, full term.

The ban on partial-birth abortion would not endanger a woman's health because it isn't medically necessary and there are standard alternative methods available at every gestational age. There's also an exception if her life is truly threatened.

Obstetricians regularly handle medical complications of pregnancy that may threaten a woman's health or life without having to resort to partial-birth abortion. In an emergency situation, when immediate delivery is necessary, D&X would not be used because it would take too long. In its report on late-term pregnancy termination techniques, the AMA stated: Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

They also stated that according to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion and ethical concerns have been raised by intact D&X.

In my opinion, the health exception required under current case law is so broad that it basically allows elective abortion through term. When I reviewed Mr. McMahan's testimony given in 1995, I found that the maternal indications he listed for D&Xs he had preformed were generally not serious and the majority were done for fetal indications, which were actually very mild.

I think most of them were for Down's Syndrome and in a good number of the women for depression.

Dr. Haskell admitted that he did the vast majority of his D&Xs on normal fetuses and pregnancies.

During the course of this debate, I received a letter from an abortionist in Orlando, for example, offering termination of pregnancy up to 28 weeks for fetal indications, if they had a letter from their personal physician indicating that to continue her pregnancy would threaten her health.

As the Court currently defines "health," even continuing a normal pregnancy may threaten her health.

H.R. 4965 will protect women from being subjected to a dangerous experimental procedure. There have not been any peer-reviewed, controlled studies that have looked at the benefits and risks of D&X as compared to other abortion or delivery methods, nor do we have adequate data on its mortality or morbidity. The complications of D&X include hemorrhage; infection; DIC; embolus; retained tissue; injury to pelvic organs, including the bowel and bladder; and cervical incompetence. These are similar to those with D&E; however, these risks are increased with D&X because it can be done at much later gestational ages.

Partial birth abortion has blurred the line between abortion and infanticide. What if, after the baby's head was delivered, a woman demanded her doctor terminate the pregnancy because she didn't think she could handle the emotional trauma of bearing a baby with a cleft lip? We already have had circumstances where an infant was not treated with the same standard of care after delivery because the mother had intended to abort it.

We were horrified when teens killed their babies. Had they been smart enough to leave a foot in the vagina prior to killing baby,

they could have only been charged with practicing medicine without a license.

The majority of Americans have also found partial-birth abortion abhorrent and have supported legislation in numerous States banning its use. We also know that the fetus feels pain, which makes this procedure even more ghastly.

This bill safeguards women and does not unduly interfere with their ability to obtain an abortion. It clearly does not cover D&E or other commonly performed abortion techniques so that women have alternatives at every gestational age. It reestablishes a bright line between abortion and infanticide. And it bans a procedure that is abhorrent to most Americans.

As a moral people, there are some things that should not be allowed. And the killing of a baby during the process or birth is one of them.

I urge you to pass H.R. 4965, the Partial-Birth Abortion Act of 2002, and I would like you to remember that, once in this country, slavery was also codified into law.

Thank you.

[The prepared statement of Dr. Aultman follows:]

PREPARED STATEMENT OF KATHI A. AULTMAN, MD

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

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

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

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

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

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

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

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

5) It bans a procedure that is abhorrent to the vast majority of Americans.

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

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

“the term “partial-birth abortion” means an abortion in which (A) the person performing the abortion deliberately and intentional vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus;”

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

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

The “Partial-Birth Abortion Ban Act of 2002” eliminates the concern that D&E is prohibited under the act by more precisely defining what is meant by a Partial Birth Abortion. According to the Supreme Court in Stenberg v Carhart, the Nebraska statute banning Partial-Birth Abortion was unconstitutional because it applied to dilation and evacuation (D&E) as well as to dilation and extraction (D&X). The court held that the statute was unconstitutional because it imposed an undue burden on a woman’s ability to choose D&E (the most common 2nd trimester abortion procedure), thereby unduly burdening her right to choose abortion itself. The Court commented, however, that if the definition were more narrowly defined to clearly differentiate D&E, a ban might be constitutional.

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

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

D&E (dilation and evacuation) is generally used from about 13–15 weeks up until 20–22 weeks and occasionally 24 weeks gestation (early to mid second trimester) and is not prohibited under HR 4965 because the fetus is removed in pieces. In D&E the cervix is dilated usually using Laminaria over the course of 1–2 days. It is dilated just enough to allow the forceps to be inserted into the uterine cavity and for body parts to be removed. The membranes are ruptured and the fluid is generally suctioned. The forceps are inserted into the uterine cavity with or without

ultrasound guidance. Usually an extremity is grasped first and brought down into the vagina. The rest of the body cannot pass through the cervix so the abortionist is able to detach it by continuing to pull on it. After the smaller parts have been removed, the thorax and head would be crushed and removed from the uterine cavity. The ability to dismember the fetus is based on not over-dilating the cervix. Prostaglandins and/or oxytocin may be used to help "ripen" the cervix and/or help the uterus contract. D&E is not prohibited under the act because fetus dies as a result of being dismembered or crushed while the majority of the body is still within the uterus and not after it has been "partially born".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) The line between abortion and infanticide was blurred,
- (2) The State's ability to regulate abortion at any gestation even in the case of a procedure as repugnant as PBA was effectively blocked and
- (3) The State's ability to promote any interest in the potentiality of human life, even post viability, was lost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Mr. CHABOT. Thank you very much, Dr. Aultman.

Mr. Heller.

**STATEMENT OF SIMON HELLER, CONSULTING ATTORNEY,
CENTER FOR REPRODUCTIVE LAW AND POLICY**

Mr. HELLER. Mr. Chairman and distinguished Members of the Committee, I am honored to be given the opportunity to speak to you today in opposition to this abortion ban.

As the lawyer who conducted the trial in *Stenberg v. Carhart* and the appeals that followed, I am in a unique position to respond to some of the distortions that have been made about the trial record in that case. And I also have significant expertise in United States abortion jurisdiction.

The bill as written is clearly unconstitutional. It jeopardizes women's health and is cloaked in a web of deceptive so-called findings.

Instead, engaging in this attempt to end-run around the Supreme Court will only undermine the ability of Congress to make legitimate findings in the future.

All of this is actually being done with the purpose of establishing a new legal theory that extends legal protection to the fetus and that can be used to criminalize all abortions. It's also being done in an attempt to shift public opinion about abortion at the expense of women's health.

Since at least 1803 when the Supreme Court decided *Marbury v. Madison*, it has been established that the United States Supreme Court is the final arbiter of the meaning of our Constitution. This is a very basic principle of our system of Government, part of our separation of powers. Thus, when the Supreme Court renders a legal ruling on the scope of constitutional rights, neither Congress nor the President is empowered to alter that ruling by statute.

This bill violates this basic principle of our system of Government because it seeks to supplant the Supreme Court's role with a new congressional role in determining the scope of constitutional rights through this device of so-called congressional findings.

The Supreme Court's holdings relevant to the bill under consideration are crystal clear. They derive from the basic and consistent holding of the Court over the last 30 years that when Government seeks to regulate abortion, to regulate the woman's choice between abortion and child birth, it must always permit the woman to pursue the course that is safest for her.

As summarized this past February in a brief written by Attorney General Ashcroft's assistant, the *Stenberg v. Carhart* ruling says, and I quote, "There are two constitutional requirements for State restrictions on the partial-birth method of abortion. The Supreme Court held that a ban on the partial-birth method of abortion cannot extend to the D&E method prior to fetal viability and must contain an exception allowing the partial-birth procedure where necessary to preserve a woman's life or health."

This bill doesn't even pass Attorney General Ashcroft's test for constitutionality. In fact, it has precisely these same two flaws. It proposes a new, broad definition of partial-birth abortion yet persists in encompassing more than one technique that the Chairman described at the beginning of his opening statement. And it lacks any exception for the woman's health whatsoever.

It applies at any stage of pregnancy, intentionally blurring the line between pre-viability and post-viability. And it ranges much more broadly than any one specific abortion technique. In fact, when you read the findings and prohibitory sections of the bill, they describe several different techniques, internally within the bill.

Second, whatever set of abortion methods the bill does ban, it lacks an exception allowing the physician to use the banned methods when it is safest and medically most appropriate for the woman's health. And in order to circumvent the Supreme Court's holding, the sponsors have invented a set of facts based on skewed information. They simply ignore, in Orwellian fashion, any evidence or information contrary to their own findings, including evidence presented at congressional hearings that they simply don't like.

The judiciary will ultimately not be taken in by this effort. Indeed, the Supreme Court has recently viewed congressional findings with extreme skepticism, even when those findings had much more than a veneer of basis in evidence. The Court has never accorded congressional findings greater weight than the properly made findings of a Federal Court.

I want to give, briefly, two examples of the distortions in this bill. The bill essentially claims that the Supreme Court was duped by the findings of one Federal district judge in Nebraska. But in fact, those very same findings were reached by many, many judges across the country—in Arkansas, in Arizona, in Illinois, in New Jersey, in Ohio. The one judge who reached contrary findings, one lone Federal judge in Wisconsin, was reversed on that by the eminent conservative judge, Richard Posner of the 7th Circuit.

And in fact, these courts heard many of the same witnesses that this Committee is hearing today. Dr. Aultman testified in several of these cases, and her testimony was rejected.

I want to summarize briefly by just saying that the bill is clearly unconstitutional, and its effect will be to jeopardize women's health. It has the further vice that it seeks to overturn Supreme Court precedent by a kind of slight of hand that should be rejected.

Thank you.

[The prepared statement of Mr. Heller follows:]

PREPARED STATEMENT OF SIMON HELLER

Mr. Chairman:

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

I. INTRODUCTION

H.R. 4965 is not a ban on one clearly defined, late-term abortion method, as its proponents deceptively claim. Instead, it is an extreme measure that sacrifices women's health to further the ideological agenda of the anti-choice movement. It is therefore unconstitutional under controlling Supreme Court precedent. Since *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court has consistently held that the right to privacy under our Constitution gives primacy to the pregnant woman's health: she has the right to end a pregnancy that threatens her health, *Roe*, 410 U.S. at 164, and she has the right to the safest method of ending the pregnancy. See *Thornburgh v. ACOG*, 476 U.S. 747, 768–69 (1986). H.R. 4965, captioned as a ban on “partial-birth abortion,” is unconstitutional in that it suffers from precisely the two flaws identified by the United States Supreme Court in its recent decision strik-

ing down Nebraska's ban on "partial-birth abortion." *Stenberg v. Carhart*, 530 U.S. 914 (2000). In *Carhart*, the Court invalidated the Nebraska law for "at least two independent reasons":

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

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

II. H.R. 4965 IMPOSES AN UNDUE BURDEN ON THE RIGHT TO CHOOSE ABORTION

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

The sponsors of H.R. 4965 have altered the definition of "partial-birth abortion," which is not a medical term, but instead a propaganda term designed to inflame public opinion against all abortions. Yet this alteration still does not result in a prohibition on a narrowly circumscribed category of abortion techniques. Instead, just like the language of Nebraska's statute, it could still prohibit many pre-viability abortions using the D&E method, of which the specific technique described in the first paragraph of the bill's findings is simply one type. In fact, the prohibitory language of the bill is quite plainly broader than the abortion technique described in paragraph one of the bill's "findings." Compare H.R. 4965 §2, ¶1 (describing breech presentation technique) with §3, ch. 74 §1531(b)(1)(A) (prohibiting both breech and cephalic presentation techniques). The bill perpetuates the problem of Nebraska's law: it uses language which sweeps more broadly than the single technique described in the "findings" by the sponsors.

III. H.R. 4965 WILL HARM WOMEN'S HEALTH

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

We know of no support . . . for the proposition that if the constitutionality of a statute depends in part on the existence of certain facts, a court may not review [Congress's] judgment that the facts exist. If [Congress] could make a statute constitutional simply by "finding" that black is white or freedom, slavery, judicial review would be an elaborate farce. At least since *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 2 L.Ed. 60 (1803), that has not been the law.

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

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

But the Supreme Court has removed this medical determination from the political arena. As the Court stated in *Carhart*, “[we have] made clear that a State may promote but not endanger a woman’s health when it regulates the methods of abortion.” 530 U.S. at 931 (citing *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768–69 (1986); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 76–79 (1976); *Doe v. Bolton*, 410 U.S. 179, 197 (1973)). The sponsors of H.R. 4965 assert in their findings that the abortion techniques they are prohibiting are not only “unnecessary to preserve the health of the mother, but in fact pose[] serious risks to the long-term health of women and in some circumstances, their lives.” § 2 (“Findings”), ¶ 2. As is very clear from the factual record not only in the *Carhart* case itself, but in many other cases challenging partial-birth abortion bans, there is, at a minimum, significant evidence that no technique banned by H.R. 4965 is harmful to women.

Instead, there is significant evidence that one technique banned by H.R. 4965, called dilation and extraction (D&X) by the Supreme Court, see *Carhart*, 530 U.S. at 927, is in fact the safest and best abortion technique in some cases. Thus, though acknowledging the lack of statistical studies comparing the safety of the D&X technique with other abortion methods, federal judges reviewing statutes from the following states made the following factual determinations about the D&X technique based on testimony both favoring and disfavoring the D&X technique:

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

Illinois: “[D&X] reduces the risk of retained tissue and reduces the risk of uterine perforation and cervical laceration because the procedure requires less instrumentation in the uterus. [It] may also result in less blood loss and less trauma for some patients and may take less operating time.” *Hope Clinic v. Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998) (Korcoras, J., appointed by President Carter).

New Jersey: “The intact dilatation and extraction, or intact D&X, has not been the subject of clinical trials or peer-reviewed studies and, as a result, there are no valid statistics on its safety. As its ‘elements are part of established obstetric techniques,’ the procedure may be presumed to pose similar risks of cervical laceration and uterine perforation. However, because the procedure requires less instrumentation, it may pose a lesser risk. Moreover, the intact D&X may be particularly helpful where an intact fetus is desirable for diagnostic purposes.” *Planned Parenthood of Central New Jersey v. Verneiro*, 41 F. Supp. 2d 478, 484–85 (D.N.J. 1998) (Thompson, C.J., appointed by President Carter) (citation to ACOG Statement on Intact D&X omitted).

Ohio: “[T]his Court finds that use of the D&X procedure in the late second trimester appears to pose less of a risk to maternal health than does the D&E procedure, because it is less invasive—that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent—and does not pose the same degree of risk of uterine and cervical lacerations . . . [T]he D&X procedure appears to have the potential of being a safer procedure than all other available abortion procedures . . .” *Women’s Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995) (Rice, J., appointed by President Carter).

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

Virginia: “When the relative safety of the D&E is compared to the D&X, there is evidence that the D&X (which is but a type of D&E . . .) has many advantages from a safety perspective. . . . For some women, then, the D&X may be the safest procedure.” *Richmond Medical Center for Women v. Gilmore*, 55 F. Supp. 2d 441, 491 (E.D. Va. 1999) (Payne, J., appointed by President Bush) (citations to the trial record omitted).

Wisconsin: “The D&X procedure is a variant of D&E designed to avoid both labor and the occasional failures of induction as a method of aborting the fetus, while also avoiding the potential complications of a D&E. For some women, it may be the safest procedure. So at least the plaintiff physicians believe, and these beliefs are detailed in affidavits submitted in the district court. This is also the opinion of the most reputable medical authorities in the United States to have addressed the issue: the American Medical Association and the American College of Obstetricians and Gynecologists.” *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463, 467–468 (7th Cir. 1998) (per Posner, C.J., appointed by President Reagan, joined by Rovner, J., appointed by President Bush) (emphasis added).

Perhaps most importantly, the Supreme Court held that the absence of medical consensus about the safety or benefits of a particular abortion technique does not

authorize the government to ban the technique: “Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view,” 530 U.S. at 937, neither Congress nor the States may ban the procedure. H.R. 4965 directly contravenes this legal holding by choosing one side in the medical debate about abortion methods via the device of Congressional findings. Yet this is a debate the Supreme Court has required the government to stay out of.

IV. The Bill Threatens the Separation of Powers

The bill also presents a greater threat to our constitutional system of government. Where constitutional rights are at stake, the Judiciary conducts its own independent review of the facts. *See, e.g., Landmark Communications, Inc. v. Virginia*, 435 U.S. 829, 843–44 (1978). Even where constitutional rights are not at stake, the Court has recently viewed with skepticism Congressional findings purportedly supporting its exercise of powers under Article I or Section 5 of the Fourteenth Amendment. *See, e.g., United States v. Morrison*, 529 U.S. 598, 614 (2000). Here, the sponsors assert that factual findings made by the Judiciary can be, in essence, set aside by contrary Congressional findings. Under this novel regime, Congress could have overturned *Brown v. Board of Education* by “finding” that racially separate schools were, in fact “equal,” or could, in line with this bill’s approach, ban all D&E abortions by “finding” that all D&E procedures were unsafe and that, contrary to actual fact, D&E’s were rarely performed. Ultimately, Congressional findings that seek to defy the Supreme Court and the function of the federal courts as triers of facts will not only threaten the independence of the Judiciary, but undermine the value of Congressional findings in other contexts where such findings may, unlike in this bill, actually be a legitimate and appropriate exercise of Congressional power.

Congressional attempts to overturn Supreme Court precedents have always failed. For example, Congress passed the Religious Freedom Restoration Act (RFRA) in response to an earlier Supreme Court decision. *Employment Div., Dept. of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990) (holding that neutral, generally applicable laws may be applied to religious practices even when not supported by a compelling state interest). Congress held separate hearings to assess the issues and made independent findings, prior to enacting the law. In striking down RFRA, the Supreme Court held that Congress “has been given the power ‘to enforce,’ not the power to determine what constitutes a constitutional violation.” *City of Boerne v. Flores*, 521 U.S. 507, 519 (1997). The Court further held that “The power to interpret the Constitution in a case or controversy remains in the Judiciary,” *id.* at 524, and “RFRA contradicts vital principles necessary to maintain separation of powers and the federal balance.” *Id.* at 536.

Similarly, Congress attempted to overturn the Supreme Court’s *Miranda* requirements by enacting a new “voluntariness” standard in their place. In *Dickerson v. United States*, 530 U.S. 428, 435–36 (2000), the Supreme Court reviewed the law, and in striking it down held that “*Miranda*, being a constitutional decision of this Court, may not be in effect overruled by an Act of Congress,” *id.* at 432, and “Congress may not legislatively supersede our decisions interpreting and applying the Constitution.” *Id.* at 437.

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

V. Conclusion

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

Mr. CHABOT. Thank you, Mr. Heller.
Professor Destro.

**STATEMENT OF ROBERT A. DESTRO, PROFESSOR OF LAW, CO-
LUMBUS SCHOOL OF LAW, CATHOLIC UNIVERSITY OF AMER-
ICA**

Mr. DESTRO. Thank you, Mr. Chairman. It's an honor to be here, and I thank you for the invitation. And I thank the rest of the Members of the Committee for their attention this afternoon.

Like Mr. Heller, I have been involved in quite a bit of constitutional litigation, and probably in the last 10 years or so I have spent a lot of time and a lot of effort in research on looking at how constitutional litigation develops and why constitutional cases come out the way they do.

And one of the things I've learned over these years is that constitutional law is not a static set of rules. It develops over time, case by case, controversy by controversy, and that every significant area of constitutional law has developed in that fashion, whether it was the lead-up to *Brown v. Board of Education*, which started as a set of controversies over whether or not black students could use the library or get into specific schools, to the point where the Court finally said, separate is inherently unequal. If we approached race discrimination as a static set of rules, we would be stuck, basically, with *Plessy v. Ferguson*.

What I'm suggesting to you today is that in order to determine whether or not this particular statutory proposal is constitutional, we have to look at the words of the statute and have to see whether or not they are defensible in a court of law. And it's not really the findings of fact which are going to be litigated; it's the actual operation of the statute within the scope of the rules that the Court laid down in *Carhart*.

So I begin basically with the observation that Mr. Heller and his litigation team did a superb job in *Carhart*. They did a much better job, I think, and I don't mean to cast aspersions at the State of Nebraska—but when you litigate abortion cases, the presupposition is as Mr. Nadler put it, that any kind of law that you try and pass is by definition a bad-faith effort to impinge on the rights of women.

It seems to me that quite the contrary is true in this case, that this case or this statute takes as its starting point Justice O'Connor's opinion in *Carhart*, and that opinion suggests—in fact, it invites—Congress to legislate. It invites Congress and the States to legislate, to see where that dividing line between the powers of Congress and the powers of the courts resides.

So in order to figure out where that resides, you have to start with the words of the statute itself. It draws a distinction between terminating the pregnancy, ending the pregnancy, and, quote, “an overt act that the person knows will kill a partially delivered living fetus whose body has cleared the birth canal to a certain point.” That makes this is a new—this is a new case or controversy. This is not relitigating *Carhart*. It is this act, not D&X abortions in general, that H.R. 4965 prohibits.

Justice O'Connor's opinion in *Carhart* invites this legislation. The legislative process presupposes legislative findings of fact. That's what legislatures do. The legislature's findings are generally to be given great deference, the findings of Congress are entitled to special deference because Congress and the Court share the duty

to protect the rights and liberties protected by the 14th amendment.

That's what section 5 is all about, and that's what I suggested in my testimony on the Religious Freedom Restoration Act. I was actually the one who questioned whether or not Congress could get away with such broad findings, not narrow findings like this one.

So you have to draw a distinction between the factual findings in the case or controversy which is before the Court, known as *Stenberg*, and the case and controversy that this statute or this proposed statute suggests. Justice O'Connor's recent opinions make it very clear that she's interested in the facts, not the facts that Congress found, those are helpful, but how the law actually operates in practice. Is this overt act, that which is prohibited by H.R. 4965, other than the completion of delivery, is that overt act of killing the fetus necessary to preserve the life and health of the mother? That's why this case, that's why this statute, is seen—is viewed as being such a threat, because it does in fact ask Justice O'Connor to consider very specifically where is the dividing line between the power of Congress to legislate on behalf of the life of the fetus and the ending point of the woman's right to terminate a pregnancy. Does it necessarily suggest—does *Roe v. Wade* suggest necessarily that she has a right to a dead fetus?

No case—well, one case, actually. One district court case suggests that she does. But I don't think—the Supreme Court has never inherently addressed that.

So in conclusion, let me say that all constitutional litigation, as we found out in the most recent voucher case, is inherently fact sensitive. Justice O'Connor wants to hear what the facts are. She has the controlling vote on this, and I would suggest to you that in a properly litigated, thoroughly litigated case, this one could be won.

Thank you.

[The prepared statement of Mr. Destro follows:]

PREPARED STATEMENT OF PROFESSOR ROBERT A. DESTRO

Mr. Chairman:

Thank you for giving me the opportunity to testify before the Committee this afternoon, and to submit these written comments for the record. It is an honor and a privilege to contribute to the legislative process.

My oral testimony emphasizes three main points.

1. Although I believe H.R. 4965 is a constitutional exercise of Congress' law-making authority under Article I §8 judicial affirmation of its constitutionality will depend upon the Court's willingness to hold, *as a matter of constitutional fact*, that banning partial-birth abortions does not impose an "undue burden" on the right of a woman "to terminate her pregnancy." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) reaffirming the "central holding of *Roe v. Wade*, 410 U.S. 113 (1973).
2. The Supreme Court of the United States is closely divided (5–4) on which "burdens" are reasonable, and therefore constitutional, and which should be classified as "undue," and thus unconstitutional. Based on the Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the ultimate decision concerning the constitutionality of H.R. 4965 appears to turn on how Justice Sandra Day O'Connor will read the factual record, both before the Congress and in the trial court. Concurring in *Stenberg*, she wrote that "a ban on partial birth abortion that only proscribed the D & X method of abortion and that included an exception to preserve the life and health of the mother would be constitutional in my view." *Stenberg*, 530 U.S. at 951 (O'Connor,

J. concurring). As a result, her vote is likely to rest on the answers to four questions of fact:

- a. Is H.R. 4965 a good faith effort by Congress to strike a reasonable and narrowly-tailored balance between the government’s interest in preserving the health of women seeking to terminate late-term pregnancies, its legitimate interest in protecting unborn children from cruel and painful procedures for the termination of pregnancy, and its equally significant interest in ensuring that each member of the medical profession understand that the lives of unborn children are protected by law once the birth process has progressed to the point where killing the child is not necessary to effectuate the termination of the woman’s pregnancy?
- b. Is the “the overt act, other than completion of delivery, *that kills the partially delivered living fetus*,” § 1531(B)(1)(b) (emphasis added), necessary to the preservation of the health of women seeking the termination of their pregnancies?
- c. Are there equally effective alternatives to the partial-birth abortion (D&X) procedure that will permit the termination of a pregnancy without adverse effects on the health of the woman?
- d. Is there sufficient evidence to support Congressional findings that the lack of an open-ended health exception would not “amount in practical terms to a substantial obstacle to a woman seeking an abortion,” *Stenberg*, 530 U.S. at 951, because “partial-birth abortion poses serious risks to the health of a woman undergoing the procedure,” and because of its primary and secondary effects on the woman, the attending physician and staff, and on society as a whole.

I. H.R. 4965 IS A GOOD FAITH EFFORT BY CONGRESS TO PROTECT WOMEN, THEIR UNBORN CHILDREN, THE MEDICAL PROFESSION, AND SOCIETY AS A WHOLE FROM AN INHUMANE, MEDICALLY UNNECESSARY, AND ETHICALLY UNACCEPTABLE PROCEDURE.

A majority of the Supreme Court has long been skeptical of State and federal attempts to eliminate or restrict abortion. In *Stenberg v. Carhart*, 530 U.S. 914, 920 (2000), the Court reaffirmed its view that a law that has “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus” is unconstitutional.

The Congressional Findings of Fact that introduce H.R. 4965 make it clear that the Congressional purpose is not to place a “substantial obstacle in the path of a woman seeking an abortion” of either a nonviable or a viable fetus, but rather to legislate to the full extent of its authority under the Constitution—and only that far. Unlike the Nebraska law involved in *Stenberg*, H.R. 4965 is limited in its scope. It does not even cover all partial-birth abortions, but only those in which the child has emerged from his or her mother’s body to the point where an overt act killing it becomes an obvious offense against the life of a specific child, and to the interests of society as a whole.

Under *Roe v. Wade* and its progeny, the legislatures are not to place “undue burdens” on the right of a woman to choose to “terminate her pregnancy.” Under H.R. 4965, that right is unburdened unless and until the *physician* decides to deliver the child to the point to the point where the head or the lower trunk “past the navel” is completely delivered. At that point, it is not only reasonable—but ethically imperative—that the physician bear the burden of proving that killing the child is necessary to preserve the life or physical health of the mother.

It is my opinion that Congress has ample power to pass this legislation. U.S. Const. art. I § 8. The fact that the power is exercised at the “boundary” of what is permissible under *Roe v. Wade* does not make it any less legitimate. In *Youngstown Sheet & Tube v. Sawyer*, 343 U.S. 579, 635 (1952), the late Justice Robert Jackson noted that the “actual art of governing under our Constitution does not and cannot conform to judicial definitions of the power of any of its branches based on isolated clauses or even single Articles torn from context.” Accordingly, he noted, that there is a “zone of twilight” between the branches where “concurrent authority [may exist], or in which its distribution is uncertain” and that “[i]n this area, any actual test of power is likely to depend on the imperatives of events and contemporary imponderables rather than on abstract theories of law.” *Id.*, 343 U.S. at 637 (Jackson, J. concurring). The cases listed in the Findings of Fact also bear witness to the Court’s willingness to recognize the legitimacy of Congressional authority in cases where “events and contemporary imponderables” make it legitimate to defer to the superior fact-finding ability and political good sense of the People’s elected representatives.

Partial-birth abortion—as defined by H.R. 4965—is defined very narrowly. I will now turn to the question: “Does H.R. 4965 strike a reasonable balance between the right of a woman to terminate her pregnancy and other important individual and social interests?”

II. JUSTICE O’CONNOR HOLDS THE BALANCE OF POWER

The Supreme Court of the United States is closely divided (5–4) on which “burdens” are reasonable, and therefore constitutional, and which should be classified as “undue,” and thus unconstitutional. Based on the Court’s decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the ultimate decision concerning the constitutionality of H.R. 4965 appears to turn on how Justice Sandra Day O’Connor will read the factual record, both before the Congress and in the trial court.

A Justice O’Connor

Concurring in *Stenberg*, Justice O’Connor has written that “a ban on partial birth abortion that only proscribed the D & X method of abortion and that included an exception to preserve the life and health of the mother would be constitutional in my view.” *Stenberg*, 530 U.S. at 951 (O’Connor, J. concurring). As a result, her vote is likely to rest on the answers to four questions of fact:

1. Is H.R. 4965 a good faith effort by Congress to enact a narrowly-tailored law designed to strike a reasonable balance between the government’s interest in preserving the health of women seeking to terminate late-term pregnancies, its legitimate interest in protecting unborn children from cruel and painful procedures for the termination of pregnancy, and its equally significant interest in ensuring that each member of the medical profession understand that the lives of unborn children are protected by law once the birth process has progressed to the point where killing the child is not necessary to effectuate the termination of the woman’s pregnancy?
2. Is the “*the overt act, other than completion of delivery, that kills the partially delivered living fetus,*” § 1531(B)(1)(b) (emphasis added), necessary to the preservation of the health of women seeking the termination of their pregnancies?
3. Are there equally effective alternatives to the partial-birth abortion (D&X) procedure that will permit the termination of a pregnancy without adverse effects on the health of the woman?gq02
4. Is there sufficient evidence to support Congressional findings that the lack of an open-ended health exception would not “amount in practical terms to a substantial obstacle to a woman seeking an abortion,” *Stenberg*, 530 U.S. at 951, because “partial-birth abortion poses serious risks to the health of a woman undergoing the procedure,” and because of its primary and secondary effects on the woman, the attending physician and staff, and on society as a whole.

Justice O’Connor’s opinions make it clear that reference to factual context and the actual operation of the statute is relevant in every context where laws are challenged on the basis of the Bill of Rights or the Fourteenth Amendment. See, e.g., *Palazzolo v. Rhode Island*, 121 S. Ct. 2448, 2467 (2001) (O’Connor J., concurring) (“careful examination and weighing of all the relevant circumstances”). A thorough understanding of the immediate facts and social context is critical in Equal Protection cases, see *Yick Wo v. Hopkins*, 118 U.S. 356 (1886); in cases involving free speech, see *Rosenberger v. Rector & Visitors of the Univ. of Va.*, 515 U.S. 819 (1995), *Capitol Square Review & Advisory Bd. v. Pinette*, 515 U.S. 753 (1995); in cases raising free exercise claims, *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520 (1993), in Establishment Clause cases, *Zelman v. Simmons-Harris*, 536 U.S.—(2002); *Lynch v. Donnelly*, 465 U.S. 668, 693–94 (1984) (“communicat[ion] of an endorsement of religion” is “in large part a legal question to be answered on the basis of judicial interpretation of social facts.”) (O’Connor, J., concurring).

If abortion providers are to challenge H.R. 4965 utilizing the “undue burden” test, they must prove, by a preponderance of the evidence:

1. That the statute—taken as a whole and viewed in context—either has no legitimate purpose, or that the alleged purpose of the statutory scheme at issue is a pretext for an otherwise unconstitutional attempt to limit a woman’s right under *Roe v. Wade* to terminate a pregnancy; or
2. That the statute would have the “purpose or effect of placing a *substantial* obstacle in the path of a woman seeking an abortion”

Under H.R. 4965, the nature of the judicial task is thus inherently different than that which faced the Court in *Stenberg*. A ban on partial-birth abortion—as defined by H.R. 4965—does not implicate “a woman’s right of privacy or bodily integrity” unless and until the physicians desiring to perform them can make the case that *killing the fetus* is “necessary to preserve the health of the mother” at or after the point that it has largely emerged from its mother’s body. Based on the facts adduced by Congress to date, that task will be nearly impossible.

B Justices Stevens & Ginsburg

Justices Stevens & Ginsburg are of the view that that *any* law “that ‘has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus’ violates the Constitution.” In their view, “[s]uch an obstacle exists if the State stops a woman from choosing the procedure her doctor ‘reasonably believes will best protect the woman in [the] exercise of [her] constitutional liberty.’” *Stenberg v. Carhart*, 530 U.S. at 951 (Ginsburg & Stevens, JJ. concurring), quoting Stevens, J. in *Carhart* and *Casey*, 505 U.S., at 877 (“means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it”).

Unless the Department of Justice mounts an extraordinary effort at trial to defend the Congressional findings of fact, it will be virtually impossible to prove to these two Justices that the Partial-Birth Abortion Act of 2002 is a “good faith effort” designed in part to protect women choosing to terminate their pregnancies. It is fairly safe to predict that they will view Congress’ efforts in much the same way Judge Posner viewed Wisconsin’s in *Hope Clinic v. Ryan*, 195 F.3d 857, 881 (C.A.7 1999): “if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue.” *quoted in Carhart*, 530 U.S. at 951 (Ginsburg & Stevens, JJ. concurring).

C The Chief Justice, and Justices Scalia and Thomas

The Chief Justice, and Justices Scalia and Thomas are of the view that *Roe v. Wade* and *Planned Parenthood v. Casey* are wrongly decided as a matter of constitutional principle. In *Stenberg* they wrote that striking the Nebraska statute was both wrong in principle, and also as an application of the rules elaborated by the Court in *Roe v. Wade* and *Casey*. Unless there were some indication that the Act was an attack on the power of judicial review itself, it is likely that they would vote to uphold H.R. 4965.

D Justices Breyer, Souter & Kennedy

Along with Justice O’Connor, the remaining three members of the Court—Justices Breyer, Souter, and Kennedy—will rest their opinions on the weight of the evidence brought to bear at trial in defense of the Act.

1) Justices Souter & Breyer

Justice Souter joined the majority opinion in *Stenberg* without qualification, and Justice Breyer wrote it. The degree to which they parsed the medical evidence available to them in the trial record indicates that, in their view, *all* abortion procedures are permissible if there is a reasonable difference of medical opinion concerning their utility.

Although it is possible that a strong trial record supporting the Congressional findings of fact might convince them that Congress’ conclusions are correct, and that a partial-birth abortion is “never medically necessary to preserve the health of a woman,” Findings of Fact ¶ 14(E), the more likely response is that the lack of any evidence tending to show that the procedure should be available *as an option is* “beside the point” because “[t]he word ‘necessary’ . . . cannot refer to an absolute necessity or to absolute proof.” *Stenberg*, 530 U.S. at 934–937.

In their view, a statute, like this one, that does not contain a health exception will fail because “the health exception question is whether protecting women’s health requires an exception for those infrequent occasions [when it might be useful under the circumstances].” *Id.*, 530 U.S. at 934.

2) Justice Kennedy

Justice Kennedy, by contrast, concluded on the facts that the Nebraska law at issue in *Stenberg* was one that “denie[d] no woman the right to choose an abortion and place[d] no undue burden upon the right.” Because the Act is very tightly drawn, and prohibits *only* partial-birth abortions that occur after complete expulsion from the body of the mother of the head, or the lower trunk “past the navel,” it is likely that he would vote to uphold the it.

III. DEVELOPMENTS IN MEDICAL TECHNOLOGY MAKE IT IMPERATIVE THAT CONGRESS BEGIN TO DRAW A DISTINCTION BETWEEN THE "TERMINATION OF PREGNANCY" AND THE DISPOSITION OF THE UNBORN CHILD

It is no longer true—as the majority in both *Roe v. Wade* and *Stenberg v. Carhart* seem to assume—that "termination of pregnancy" and "abortion" are synonymous with the demise of the fetus. Partial-birth abortion—like cloning and fetal experimentation—are controversial because both the public and their elected representatives know that it is not only possible to protect the interests of the unborn in these circumstances, it is possible to do so without harming to the woman's right to "to terminate her pregnancy before viability."

Congress can accomplish this goal in part by passing H.R. 4965, which permits the termination of pregnancy to continue as planned, but criminalizes an overt act intended to kill the infant once it has reached the point where "birth" is either imminent, or has taken place, depending upon one's reading of relevant state and federal law.

If anything is clear from the cases and commentary, it is that "birth" is the point at which the child acquires rights of its own. The statutory and case law is also clear that the state's interest in protecting the child exists before birth. The law of homicide, for example, requires certainty "beyond a reasonable doubt" that the child was actually "born alive," whereas the law of inheritance requires less certainty. In tort, the fact of birth is now irrelevant—as long as causation can be proved.

Developments in microsurgery and reproductive technology make it plain that the law is struggling to keep up with science, and that Congress needs to act to protect its ability to prevent human life from becoming a commercial or industrial commodity. If a pregnant woman permits *ex utero* surgery on a child, and has it returned to her womb, when does its "birth" take place? When it is outside the woman's body, after it becomes "viable," or when the pregnancy "terminates" by natural or induced labor or C-section? *Roe v. Wade* does not even speculate on questions such as these. Nor does it resolve the legal and moral status of frozen or cloned embryos. The Thirteenth and Fourteenth Amendments leave those questions to Congress.

In *Kass v. Kass*, 91 N.Y.2d 554, 564, 696 N.E.2d 174, 673 N.Y.S.2d 350 (1998), a dispute between divorcing spouses over the disposition of frozen embryos, the New York Court of Appeals held that the disposition of pre-zygotes "does not implicate a woman's right of privacy or bodily integrity in the area of reproductive choice; nor are the pre-zygotes recognized as "persons" for constitutional purposes" (emphasis added).

The point is a simple one: science will one day make it possible for a woman to terminate her pregnancy and preserve the life of her unborn offspring. H.R. 4965 recognizes that where the medical profession has the ability to terminate a pregnancy without taking any overt steps to kill the child, it must do so. It is a modest step toward preserving not only the spirit of the Thirteenth Amendment, but also Congressional power to protect human life. I urge you to pass it.

Mr. CHABOT. Thank you very much, Professor.

And our final witness this afternoon will be Dr. Cook. Dr. Cook.

STATEMENT OF CURTIS COOK, M.D.

Dr. COOK. Good afternoon, Mr. Chairman and Members of the Committee. I thank you again for the opportunity to share my testimony with you today.

Again, my name is Dr. Curtis Cook, and I am a board-certified maternal-fetal medicine specialist, as well as an obstetrician-gynecologist. And I practice and teach obstetrics in the State of Michigan.

In my practice, I care exclusively for women that are experiencing complicated pregnancies. This includes women that have preexisting medical conditions, like high blood pressure, diabetes, even cardiac disease and cancer. This group of complicated pregnancies also includes babies with suspected fetal abnormalities, even lethal fetal anomalies like anencephaly or renal agenesis.

Additionally, this group includes those pregnancies that develop complications during the course of their pregnancy, various dif-

ferent obstetrical complications like early labor, early rupture of the membranes, or the water breaking prematurely.

Never in the more than 10 years that I have been providing perinatal care to women with complicated pregnancies have I ever experienced a single clinical situation where the late-term abortion procedure being considered before this Committee has ever been required or even considered a superior option clinically to other well-known and readily available medical and surgical options. This includes clinical situations where this technique has actually in fact been used before by certain care providers and even the theoretical situations that have been proposed to me and other witnesses by zealous advocates of this rogue procedure.

Additionally, I have asked and queried many of my colleagues with decades of clinical experience in caring for women with complicated pregnancies and have yet to find a single individual who has experienced a clinical situation that would require this procedure. This in fact has been admitted to by practitioners of this procedure and even by the American College of Obstetrics and Gynecology, which is a well-known supporter of all abortion techniques.

This procedure has been discussed publicly now for more than 5 years. In fact, I testified in front of this very Committee more than 5 years ago. And yet we have still not seen it embraced by the medical community simply for its lack of merit in modern obstetrics.

Additionally, as part of my professional responsibilities, I also teach medical students and residents the clinical management of pregnant women. And this includes various medical and surgical options for effecting a delivery of a woman and her fetus and eventual infant, as well as emptying the uterus in all three trimesters of pregnancy. I have never encountered any teaching materials for this particular abortion technique other than the information that was presented by Dr. Haskell at a National Abortion Federation seminar. I am a fellow of the American College of Obstetricians and Gynecology, also of the Society of Maternal-Fetal Medicine, as well as a member of the Association of Professors of Gynecology and Obstetrics. I am not aware of any educational materials from any of these groups discussing the specific technique of partial-birth abortion. And I think that is the term that is clearly the best term to use, because it's invariably termed "D&X,"

"intact D&E," "intact D&X." I think "partial-birth abortion" best describes the procedure both medically and legally.

The appropriate clinical use of this procedure has not been described by any of these groups, nor even clinical reports of its use. This leads me to believe that this is a rogue procedure with no role in modern obstetrics.

Frankly, I am appalled that any physician would consider providing such services, given the gruesome nature of this inhumane procedure. By their own admission, these procedures are performed predominantly on healthy mothers carrying health fetuses, generally between 20 and 26 weeks' gestation, mostly, again, on healthy mothers with healthy babies.

And if we look at our current survivability data, this is quite concerning. Infants at 23 weeks' gestation have a survival in excess of 30 percent; at 24 weeks' gestation, in excess of 70 percent; by 28 weeks, their survival rate exceeds 95 percent.

These infants are literally inches away from enjoying the full rights afforded any other American citizen, including the rights to life, liberty, and the pursuit of happiness. This is what separates it from other abortion techniques. This is taking place outside the womb, and this is taking place on an infant who is literally just about to born. That's why we talk about blurring the line between abortion and infanticide.

Every erroneous argument brought forth by zealous advocates of this procedure has been summarily dismissed in the light of the medical facts. This even prompted us to perform organizations to provide accurate medical information. This includes even early arguments that the procedure existed at all. Other arguments then followed that it was rarely performed or only on babies that had severe abnormalities, or mothers with severe medical conditions.

This was actually discounted even by practitioners of the procedure. They themselves admitted they were mostly done in elective situations, mostly on healthy mothers and healthy babies, and then independently supported by other investigative bodies as well.

Then we went through the whole issue of the anesthesia, where there was a discussion about the anesthesia killing the fetus before the delivery. And that again was just summarily discounted by every organization and medical body as just pure falsehoods. And the fact that the physicians that would provide these sort of procedures would put forth such medical nonsense, or that people that advocate for this procedure would support such medical nonsense, shows us, I think, the importance of the need to regulate procedures like this, because I would not want women depending upon these people's medical opinions for what is safest for them.

I think, in summary, we feel that this procedure is unnecessary, it's unsavory, it's potentially unsafe for women, and it certainly doesn't benefit the infant. Unfortunately, it is still being perpetrated upon thousands of innocent partially born children in this country every year. As I did before this Committee 5 years ago, I again urge you to act quickly to prohibit this perversion of American medicine.

And I thank you again for this opportunity to share my deep concern for the women and children of this country.

[The prepared statement of Dr. Cook follows:]

PREPARED STATEMENT OF CURTIS COOK, M.D.

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

Never in the ten years I have been providing perinatal care to women with complicated pregnancies have I ever experienced a clinical situation where the late-term abortion procedure being considered before this committee (partial-birth abortion) has ever been required or even considered as a clinically superior procedure to other well-known and readily available medical and surgical options. This includes the clinical situations where this technique has been used by some physicians, and even the theoretical situations proposed by zealous advocates of this rogue procedure. Additionally, I have queried many colleagues with decades of clinical experience and

have yet to find one individual who has experienced a clinical situation that would require this procedure. This procedure has been discussed very publicly for more than five years and yet we have not seen it embraced by the medical community simply for its lack of merit in modern obstetrics.

As part of my professional responsibilities, I also teach medical students and residents the clinical management of pregnant women. This includes the various medical and surgical options for facilitating a birth or emptying a uterus in all three trimesters of pregnancy. I have never encountered teaching materials on this technique (PBA) except for the information presented by Dr. Haskell at a National Abortion Federation seminar. I am also a fellow of both the American College of Obstetricians and Gynecologists and the Society of Maternal-Fetal Medicine as well as a member of the Association of Professors of Gynecology and Obstetrics. I am not aware of any educational materials from any one of these groups discussing the specific technique of partial-birth abortion (or D&X/intact D&E), the appropriate clinical use of this procedure or even clinical reports of its use. This also leads me to believe this is a rogue procedure with no role in modern obstetrics.

Frankly, I am appalled that any physician is providing such "services" given the gruesome nature of this inhumane procedure. By their own admission these procedures are being performed primarily between 20–28 weeks gestation and sometimes beyond on mostly healthy mothers carrying healthy babies. The current survivability of infants born at 23 weeks is greater than 30% and at 24 weeks it is almost 70%. By 28 weeks the survival rate exceeds 95%! Many of these infants are literally inches away from enjoying the full rights afforded any American citizen including the rights to life, liberty and the pursuit of happiness.

Every argument brought forth by the zealous advocates of this procedure has been summarily dismissed in the light of the medical facts. This includes even early arguments that this procedure was never being performed. Later the argument proposed was that this procedure was rarely performed and when it was performed it was provided only to mothers or infants with severe medical problems. We know now by the independent investigations of the Washington Post, the New Jersey Bergen Record, the American Medical Association News and others that these procedures are being performed by the thousands on mostly healthy mothers carrying healthy babies as admitted to by high profile providers of this technique. It was even preposterously proclaimed that the anesthesia provided the mother during the procedure was responsible for killing the fetus rather than the act of puncturing the base of the skull and suctioning out the brain contents. This was roundly criticized by all legitimate medical bodies putting to rest the concerns of thousands of other women undergoing indicated surgical procedures during the course of their pregnancy. Indeed several pediatric pain specialists and obstetrical anesthesiologists have stated that there is good evidence to support that this procedure would generate excruciating pain for the partially born infant. In fact, this technique would not even be allowed for the purpose of euthanizing research laboratory animals.

Again I speak from the experience of providing medical and surgical care to infants at the same point in pregnancy at which these abortions are being performed. I also regularly care for women with same diagnoses as those undergoing partial-birth abortion and have been able to safely deliver these women without having to resort to these brutal techniques. This procedure does not protect the life nor preserve the health of pregnant women. It also does not enhance the ability of women to have successful pregnancies in the future and may even hinder such efforts. I am at a loss to think of any benefit of this procedure other than the guarantee of a dead baby at the time of the completed delivery.

In summary, I feel this procedure (PBA) is unnecessary, unsavory and potentially unsafe for women. Unfortunately it is still being perpetuated upon thousands of innocent partially-born children in this country every year. As I did before this committee five years ago, again I urge you to act quickly to prohibit this abomination of American medicine.

I thank you again for the opportunity to share my testimony and my deep concern for the women and children of this country.

Mr. CHABOT. Thank you very much, Doctor.

We've now reached the point where Members of the panel here will be able to ask questions of the witnesses for 5 minutes. And I'll begin with myself for 5 minutes.

The Supreme Court struck down the Nebraska partial-birth abortion statute based upon two principle things. One was the lack of a health exception. The other was the definition of partial-birth

abortion that might include other types of abortions, that sort of thing. The language in this legislation has been tightened up. The definition is more precise than it was in previous congressionally passed legislation or in the Nebraska partial-birth abortion ban.

And relative to the health exception, the Supreme Court's decision was based upon the factual findings of the lower court. And our findings are based upon extensive congressional hearings, testimony that we've had from experts, like those before us today. And among those findings are three that are probably the most significant.

One being that, according to the American Medical Association and others, the partial-birth abortion procedure is never medically indicated. It's never medically necessary that the partial-birth abortion procedure, or whatever one wants to term this type—I have people that have said that we should call it killing the baby during birth, which is probably an accurate definition as well. But in any event, that this procedure can pose serious medical health risks to the woman herself.

And the third item is that this particular procedure is outside the standard medical care. As you had indicated, Dr. Cook, it's not something that's taught or you find medical documentation out there promoting this procedure.

I'd like to ask either Dr. Cook or Professor Destro, or perhaps both at this time, after hearing the testimony, after looking at what we have done in changing this from the previous legislation, is it your opinion that the definition is, at this point, as concise as it ought to be, and that the factual findings in there are appropriate? I'd ask either one.

Dr. COOK. I know that the concerns in the previous language had to do with this issue of "partially vaginally delivers" and also the perceived vagueness about the overtness of the act of the killing procedure. I think from a medical standpoint, as far as looking for guidance in what things are allowed and what things aren't allowed, the two things that clarify it from a medical perspective are giving clear anatomic landmarks as far as what is a partially vaginally delivered or a majority of a partially vaginally delivered infant, by identifying the infant being delivered in a feet-first position up to the point of the umbilicus and in a head-first position being delivered up to the point of the head. So there are clear anatomic landmarks.

The other thing that I think is helpful is the fact that it requires an overt act, other than completion of the delivery, as a killing process.

Those two things, from a medical standpoint, clearly distinguish this procedure from other procedures.

Mr. CHABOT. Thank you.

Professor Destro, anything you want to add on that?

Mr. DESTRO. The only thing I want to add about that is that the prosecutors—or, the defense attorneys in Nebraska had a much harder case than you would here, because the definition is so clear.

Mr. CHABOT. Okay.

Mr. DESTRO. And it only limits a purposeful delivery of this sort.

Mr. CHABOT. Thank you.

Mr. Heller, you've continued to assert that the Supreme Court is the ultimate and final authority on what is and is not constitutional. Yet the Court has consistently held that Congress's factual conclusions are entitled to judicial deference when they represent reasonable inferences based upon substantial evidence.

Are you saying that we should ignore these cases? Is Congress the final authority only when we agree with the conclusions of the Supreme Court?

Mr. HELLER. Well, as you yourself just said, the courts will defer to congressional findings when they represent reasonable inferences from substantial evidence. Otherwise, they won't defer to those findings.

And clearly, I know of no case, and maybe Professor Destro does, where a district court has concluded, based on testimony and other evidence, that something is a fact, and that the Supreme Court has said, "Well, we're going to set that aside because Congress found something else." There is no such case.

Mr. CHABOT. Thank you.

And, Dr. Aultman, again, I'm running out of time, so I'll make my question quick. The American Medical Association has said that partial-birth abortion is, "not good medicine" and is, "not medically indicated in any situation." Do you agree with that statement?

Dr. AULTMAN. Yes, I do. And I think there's one thing to remember here, that if—I can't imagine—I cannot imagine an instance where this would occur, but if there ever was an instance where it was critical for someone's health, the one easy thing that can be done is that fetus can be given an intracardiac injection or intrafetal injection of potassium chloride or digoxin, or the cord can be cut before the beginning of the procedure and D&X can be done.

Mr. CHABOT. Thank you very much, Doctor. My time has expired.

The gentleman from New York, Mr. Nadler, is recognized for 5 minutes.

Mr. NADLER. Thank you, Mr. Chairman.

Professor Destro, in its brief in the Ohio case in support of the Ohio statute recently, the Justice Department, headed by Attorney General Ashcroft, acknowledges that a health exception to a partial-birth abortion ban is constitutionally required.

Do you agree with the Attorney General that a health exception is constitutionally required for such a bill? Or do you think that Attorney General Ashcroft is taking much too restrictive a view?

Mr. DESTRO. I think that what is—I think that putting it that way is too restrictive. And the reason I say that is that these cases are fact sensitive, and the ultimate constitutional fact in these cases is whether or not the law, as passed, imposes an undue burden on the right of a woman to terminate a pregnancy.

If Congress were to pass a statute—and I'll just hypothesize one—that says you can't use a machine gun to terminate a pregnancy, there's obviously not going to be a health exception to that, because we know that the procedure itself is inherently dangerous.

If the case—

Mr. NADLER. I hear you, but let me ask you this, then. A quote from Justice O'Connor's decision in the *Stenberg* case, she said, "If there were adequate alternative methods"—adequate alternative

methods—“for a woman to safely obtain an abortion before viability, it is unlikely that prohibiting the D&X procedure alone would amount in practical terms to a substantial obstacle to a woman seeking an abortion.’ Thus, a ban on partial-birth abortion that only proscribed the D&X method of abortion and that included an exception to preserve the life and health of the mother would be constitutional in my view.”

So she seems to be saying very clearly, if you limit your definition to a D&X and you have an exception for life and you have an exception for health, then it’s okay. How do you get around that exception for health?

Mr. DESTRO. The way you get around it is if you can point to the procedure as being difficult for women or unhealthy for women. I mean, Justice O’Connor clearly is concerned about the health of women. So, too, is this bill.

Mr. NADLER. You think that Congress can make that medical determination and outweigh the woman’s doctor’s determination as to which is the better for her health? We can pass that here and import that into every operating room?

Mr. DESTRO. I think that the case can be made that, as a matter of fact, you can do it, if you find that the procedure is dangerous.

Mr. NADLER. Well, under that reasoning, if Congress, controlled by people who don’t control it now—let’s say, in 1954, it passed legislation re-imposing segregation prefaced by copious findings that separate can in fact be equal, never mind the finding in *Brown v. Board of Education of Topeka* that separate is inherently unequal. “We know, and here are our findings that separate can be equal.” Do you have any belief that the *Brown* Court or the current Court would defer to these findings?

Mr. DESTRO. They’re totally different—they’re not the same. Of course, the Court wouldn’t defer to them. But the question in *Brown* isn’t whether or not separate is a due or an undue burden on the rights of black children. It’s whether or not it’s equal or not.

Mr. NADLER. Mr. Heller, we’ve heard representations here that this bill as drafted is significantly different from the bill that the Supreme Court held unconstitutional in *Stenberg*. Is it really different in any constitutional sense?

Mr. HELLER. It is, from a constitutional perspective, identical. It does not adhere to the viability line that the Supreme Court has repeatedly said marks the time in which States or Congress can begin to regulate abortion methods. It has no health exception. And it doesn’t even define the one procedure—and, by the way, Justice O’Connor mentioned three State statutes with specific language that she thought were reasonably good, based on her view.

The sponsors of this have rejected Justice O’Connor’s proposal and substitute their own vague, amorphous language that, even as Dr. Aultman said, excludes some partial-birth abortion, maybe there are others it doesn’t prohibit, doesn’t prohibit all of D&X’s, only the ones—only certain ones. She said that herself in her written testimony.

So it’s another vague, overbroad bill and suffers from exactly the same—

Mr. NADLER. Thank you.

My last question is to Dr. Aultman. Dr. Aultman, you've been before this Committee before as an expert witness, have you not?

Dr. AULTMAN. No.

Mr. NADLER. You have not? But you have testified in court?

Dr. AULTMAN. Yes.

Mr. NADLER. And am I right that two Federal judges, one in Virginia and one in Iowa, concluded that you are not current on abortion procedures, and that a Federal magistrate in Arkansas refused to certify you as an expert in obstetrics or abortion but instead considered you an expert only in gynecology?

Dr. AULTMAN. Well, it's somewhat true and somewhat incorrect.

Mr. NADLER. Somewhat true? Wrong State?

Dr. AULTMAN. I did not testify in Iowa. I testified in Arkansas. And the—that was the very first time I had ever testified. And the judge qualified me as an expert in gynecology. He did not qualify me as an expert in abortion.

In Arkansas, he did qualify me as an expert.

Mr. NADLER. So in this 1998 case, where it says that "plaintiffs have offered unrefuted evidence that Dr. Kathi Aultman, one of the defendant's affiants, has not performed an abortion since 1982 and is not current on the medical aspects of abortion," that's correct?

Dr. AULTMAN. No.

Mr. CHABOT. The gentleman's time has expired. The witness can answer the question.

Mr. NADLER. Is the court incorrect in saying that?

Dr. AULTMAN. What you just said was incorrect.

Mr. NADLER. I just read from the court decision.

Dr. AULTMAN. I know, but—

Mr. NADLER. This is *Planned Parenthood of Greater Iowa v. Miller*, Southern District of Iowa, 1998, footnote 9. It says, "Plaintiffs have offered unrefuted evidence that Dr. Kathi Aultman, one of the defendant's affiants, has not performed an abortion since 1982 and is not current on the medical aspects of abortion." That was correct in 1998?

Dr. AULTMAN. Okay, I—what I would say is, I don't know what that finding was. It's true that I had not performed an abortion since that time.

Mr. NADLER. More important is the second half, "is not current on the medical aspects."

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

Mr. NADLER. That was the finding of the court.

Mr. CHABOT. The gentleman's time has expired. She has an opportunity to explain her answer. Go ahead.

Dr. AULTMAN. I would just say that I have kept current on abortion techniques. That particular court may have decided that I wasn't for some reason, but I have.

Mr. CHABOT. Okay. The gentleman from Tennessee is recognized for 5 minutes.

Mr. JENKINS. Thank you, Mr. Chairman.

I'd be interested in knowing the relative amount of knowledge that this lady has compared to the Members of the panel here. [Laughter.]

Mr. JENKINS. I don't have any questions at this time. And I'm willing to yield to the Chairman, if the Chairman has additional questions.

Mr. CHABOT. Thank you. I have a few, and I appreciate the gentleman yielding.

Dr. Aultman, let me ask you this, when asked about the pain experience involved in one of these, and I think you had mentioned before that there is certainly pain involved in a partial-birth abortion, Professor Robert White, the director of the Division of Neurosurgery and Brain Research Laboratory of Case Western Reserve School of Medicine stated that, quote, "The fetus within this time of gestation, 20 weeks and beyond, is fully capable of experiencing pain," unquote. And in referring to partial-birth abortion, he concluded, and again I quote, "Without question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure."

Would you agree with that? And is there anything that you'd like to comment on, relative to it?

Dr. AULTMAN. Yes. That's not my area of expertise, but actually I had planned to submit some articles written by experts on the mechanisms of pain in fetuses.

Mr. CHABOT. Okay, thank you.

Dr. Cook, did you—I saw you looking over there. I've got another question for you, but I'll—

Dr. COOK. Just briefly, clearly, on the fetal pain issue, I do fetal surgeries on fetuses that are in utero at the exact same gestational ages. We do anesthetize those babies. They do withdraw from needles and other instruments. They do show pain and grimace responses. And we observe the same thing in infants of the same gestational ages in our neonatal unit where we also work with those infants.

Mr. CHABOT. Thank you very much.

And, Dr. Aultman, I'd like to get back to you, if I can. What are some of the health risks for women undergoing partial-birth abortion? What are some of the problems that one could have or could result from partial-birth abortion?

Dr. AULTMAN. These would include hemorrhage; infection from retained products; DIC, which is a condition where a woman can just start bleeding and can't stop because of her clotting factors being used up; embolus, where fluid or tissue can enter the mother's circulation. I think that one of the biggest things that we see or that there's a concern of is incompetent cervix, because the cervix is dilated so much more in this procedure than it is in the D&E. And there's some suggestion that, as you dilate the cervix larger, that there's more chance of incompetence. And I think Dr. Cook has actually seen that in his practice, where he's had women come in with cervical incompetence.

Mr. CHABOT. Thank you very much, Doctor.

Dr. Cook, let me get back to you, if I can. In your testimony, at least in the written testimony, you had stated that you queried many colleagues with decades of clinical experience and have yet to find one individual who has experienced a clinical situation that would require this procedure, and of course "this procedure" being

partial-birth abortion. Could you expand on this? Were most of those whom you queried experts in your field as well?

Dr. COOK. When the procedure first came to the attention of the more general medical public in the mid 1990's, we all began to ask ourselves, "Are people really doing this procedure? This sounds crazy. Why are they doing this procedure? What benefit is there to this procedure?" And none of us ever found any answers. And then we all look at the actual cases where these were performed. And, again, these are performed predominantly by general practitioners.

Dr. Carhart, for instance, has no hospital privileges, is not certified by any board of medicine. A lot of these practitioners are in those similar situations.

And we reviewed those cases that were submitted to Congress—Dr. McMahon's series, Dr. Haskell's cases—and could not find a medical indication for why they were doing these procedures, because we care for the exact same women with the exact same diagnoses, and we never have to resort to these barbaric procedures.

So we started asking ourselves why are people doing these things, and we never really came up with any good reason why anyone would be doing this. And I think that's why people like the AMA say this is bad medicine. There is no indication to do this.

And there are, in fact, health risks of doing this procedure. The ones that I see are the more prolonged health risks, the concerns about this massive, over-dilation of the cervix, with up to 15 to 25 dilators during this 3-day process to effect this partial-birth abortion. These women then have cervical weakness, inability to carry pregnancies with subsequent pregnancies.

So we're concerned that this is going to endanger the health of women. It's not only not necessary to protect the women's health, but it may be endangering their health.

Mr. CHABOT. Thank you, Doctor. And the gentleman from Tennessee's time has expired. And I thank him for yielding.

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

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Heller, it was pointed out that several States have passed similar laws. Are any of them presently being enforced?

Mr. HELLER. Well, all that were challenged have been held unconstitutional. The remaining ones that were never challenged in court are generally viewed as unenforceable in those States, so none of them stand as an enforceable statute.

Mr. SCOTT. And who gets to decide these procedures? The doctor, the patient, the judge, and I guess we're doing congressional findings—if you had a trial, Mr. Heller, how would—would the congressional findings even be admissible?

Mr. HELLER. They might be admissible as a statement of what Congress enacted. But I will say that the people who determine what is the most appropriate procedure to use in any medical area, abortion and otherwise, are typically the physician and the patient, or perhaps a group of physicians. What the Supreme Court has long said is that especially in the area of abortion, you don't have people like Dr. Aultman and Dr. Cook who oppose all abortion telling doctors who actually provide this needed service to women how they should go about doing their medical treatment.

Mr. SCOTT. Dr. Aultman, are you familiar with the position of medical organizations and where they are on this issue?

Dr. AULTMAN. You mean as far as the American Medical Association and ACOG?

Mr. SCOTT. Yes, those would be two.

Dr. AULTMAN. Yes.

Mr. SCOTT. What is their position?

Dr. AULTMAN. Well, ACOG, although they stated that they could find no reason for this procedure, they don't feel the Government should be regulating the practice of medicine.

Mr. SCOTT. Did you say they support or oppose the bill?

Dr. AULTMAN. ACOG opposes the bill.

Mr. SCOTT. Okay. AMA?

Dr. AULTMAN. The AMA I think basically supported—are you—well, the original—I don't know how they support this bill.

Mr. SCOTT. Do you have any communication from the AMA subsequent to May 14th, 1997?

Dr. AULTMAN. I'd have to look.

Mr. SCOTT. I have a letter from them that says that they have a report: Other than in extraordinary circumstances where severe fetal abnormalities inconsistent with life exist, because sacrificing the fetus and/or destruction of the fetus is rarely necessary, even when ending the pregnancy to preserve the life or health of the mother.

They suggest it's rarely needed or only in extraordinary circumstances, suggested there are some circumstances where it would be needed for the health or life of the mother. Is that right?

Dr. AULTMAN. Well, I think that they probably put that language in there because no one knows anything for certain.

Mr. SCOTT. But the AMA does not support the legislation. Is that what you've informed us of?

Dr. AULTMAN. I think they don't support the intervention of Government in medicine.

Mr. SCOTT. Which means that they do not support. Do you know of any health groups that support the legislation?

Dr. AULTMAN. PHACT, Physicians' Ad Hoc Coalition for Truth, which is a group of physicians. I know that APLOG, which is the American College of Pro-Life Obstetricians and Gynecologists supports this bill.

Mr. SCOTT. Okay, those are organized for a specific purpose of opposing abortion. Do any general medical organizations support the legislation, that you're aware of?

Dr. AULTMAN. Actually, PHACT does not support abortion—legislation. It only was created regarding this issue.

Mr. SCOTT. Can you have legislation without a health exception? Mr. Heller, do you want to answer that? Is there anyway that you can pass legislation without a health exception? Or has the Supreme Court told us each and every time they've dealt with it that you have to have a health exception?

Mr. HELLER. It's consistent through the last 30 years of Supreme Court jurisprudence that there must be a health exception. Attorney General Ashcroft believes there must be a health exception. Every court that has considered every one of these statutes has struck it down in part because it lacked a health exception.

Mr. SCOTT. Does this legislation include a health exception?

Mr. HELLER. No, none.

Mr. SCOTT. Thank you.

Mr. NADLER. Would you yield to me?

Mr. SCOTT. I would yield to the gentleman from New York.

Mr. CHABOT. The gentleman's time has expired, but if he wants to yield for a quick question.

Mr. NADLER. Yes, thank you.

I was intrigued—it's been repeatedly said here that there's never a proper necessity—there's never a necessity for a partial-birth abortion or for a D&X procedure. And I'm reading a quote here from the American College of Obstetricians and Gynecologists that says, "Depending on the physician's skill and experience, the D&X procedure can be the most appropriate abortion procedure for some women in some circumstances. D&X presents a variety of potential safety advantages over other abortion procedures used during the same gestational period. Compared to D&Es involving dismemberment, D&X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments and reduces the presence of sharp fetal bone fragments that can injure the uterus and cervix. There's also considerable evidence that the D&X reduces the risk of retained fetal tissue, a serious abortion complication that can cause maternal death, and that D&X reduces the incidence of a free-floating fetal head that can be difficult for a physician to grasp and remove and can thus cause maternal injury. That D&X procedures usually take less time than other abortion procedures used at a comparable stage of pregnancy can also have health advantages."

In view of this finding of ACOG, Dr. Aultman, can you justify your statement that ACOG and others have—that no one has ever cited—that there are never circumstances where a D&X procedure is the indicated best and safe procedure?

Mr. CHABOT. And since the gentleman is out of time, I'd like to add something to that question: Isn't it also accurate that this same organization has also said just the opposite of what they said there?

Dr. AULTMAN. I think that's true. They've said both things.

And I have to say that I totally disagree with—

Mr. NADLER. I didn't ask you if you disagree. I asked if—how, given the fact that ACOG, which is the American College of Obstetricians and Gynecologists, has cited all these different reasons why in some cases D&X is the safest and best procedure, you can sit there and say that it is clear that no one ever said that it's the safest and best procedure under any circumstances. It's simply untrue.

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

Mr. NADLER. Because you don't want her to answer the question.

Mr. CHABOT. The doctor has an opportunity to answer the question, all those questions, if the doctor would like to.

Mr. NADLER. It was one question.

Mr. CHABOT. Although, at this time, it's a little bit difficult to know exactly what the question is.

Mr. NADLER. Shall I restate it? [Laughter.]

Mr. CHABOT. No.

Dr. AULTMAN. I—I——

Mr. NADLER. I think I better restate it in one sentence.

Mr. CHABOT. The point is, they've been on both sides of the issue, as has the AMA.

Mr. NADLER. No, no. The question was, in one sentence, given that quote from the American College of Obstetricians and Gynecologists, how can it be truthful to say that no respectable body of medical professionals involved in the field believes that D&X procedures are ever the best, safest procedure in any circumstance?

Dr. AULTMAN. I guess I had not seen that particular——

Mr. NADLER. Thank you.

Mr. CHABOT. But the doctor has seen the statement that indicates that they're never medically necessary by the same organization?

Dr. AULTMAN. That's right.

Mr. CHABOT. Okay.

Mr. NADLER. Do you have that citation?

Mr. CHABOT. I'll yield at this time—the gentleman's time has expired—to the gentleman from Alabama. Mr. Bachus is recognized for 5 minutes.

Mr. BACHUS. I thank the Chairman.

Mr. NADLER. Do you have the citation for that other statement?

Mr. CHABOT. We'll get it to you.

Mr. BACHUS. And I've not attended the whole hearing, so I would ask the Chairman or someone else, if I'm asking a repetitive question, just to stop me and I'll go on to another.

Mr. CHABOT. Repetitiveness has never stopped us in this Committee before, so—— [Laughter.]

Mr. CHABOT. Or any other Committee, I might add.

Mr. BACHUS. This question is for Dr. Cook. Dr. Cook, I was reading your testimony, and you say you have questioned many colleagues with decades of clinical experience and have yet to find one individual who has experienced a clinical situation that would require this procedure. Would you expand on that?

Has he been asked to expand on that before?

Mr. CHABOT. He's been asked, but I think it's an appropriate question.

Dr. COOK. I can just answer briefly. Again, this came as new information to most of us that practice medicine of complicated pregnancies, and we began to ask ourselves—many of us would talk amongst ourselves, you know, "Who's doing this procedure?" "Where have you seen this procedure?" "Why is it being done?" No one could come up with a reason why it would be a preferable procedure, and no one had any data to show that it was a preferable procedure.

The expert in the Carhart decision, for instance—Dr. Stubblefield himself hasn't even performed the procedure. So this is not a procedure that is ever relied upon by anybody who is practicing legitimate medicine to perform a procedure to empty the uterus. Most medical physicians have to answer to someone, usually either your institution, where you have an institutional review board, or your board of medicine. But if you bypass those situations by not having hospital privileges anywhere, and not being board certified by any-

one, maybe you can bypass that system. Most of us don't have that opportunity.

Mr. BACHUS. In your testimony, you state that the procedure in the legislation would ban, quote—or the procedure it bans “does not protect the life nor preserve the health of pregnant women. It also does not enhance the ability of women to have successful pregnancies in the future and may even hinder such efforts.”

Now, Mr. Heller, on the other hand, he has—there's a statement in the legislation that says that a partial-birth abortion is never medically necessary and may in fact be harmful to a woman's health. He calls that part of the legislation, that statement in the legislation, false. Are those statements in the legislation false or are they true? Are his assertions groundless?

Dr. COOK. Those statements are true. When I testified before this Committee in '97, there were no physicians willing to come forward to testify in support of the procedure. This procedure still has not become a mainstream medical procedure. It's still not endorsed. And nobody still has come forward with any credible evidence showing the indication for the procedure, why it should be used, why it would be preferable. It's just not the case.

So it is not a situation where it would endanger a woman's health to eliminate the procedure. And in fact, we feel it would protect women's health.

We have been approached by women who have had the procedure done, who have had subsequent pregnancy complications. I'm not there at the time the procedure is being performed, so I don't know about the immediate complications. But I have been contacted by women about long-term complications from the procedure.

Mr. BACHUS. Okay. So his assertions are basically groundless?

Dr. COOK. I don't know upon what he bases those assertions.

Mr. BACHUS. But you don't—okay.

Professor, I'd like to ask you a question. In your opinion, does Congress have the authority to legislate based upon factual conclusions that contradict the findings of fact issued by a district court judge who has reviewed the same evidence?

Mr. DESTRO. Well, first of all, Congressman, I think the answer is, if it's purely the same evidence, probably not. But it's not the same evidence. I mean, there's more evidence here.

And what I would like you to think about, and it's a way of rehabilitating one of our witnesses here, Mr. Nadler made the point that there was unrefuted testimony that Dr. Aultman wasn't qualified. Okay, whose fault was that, that it was unrefuted? It was the defense counsel's fault. It wasn't her fault. He didn't come in—the defense counsel didn't do his job.

In this case, defending this is going to be the job of the Justice Department. They're going to have to come forward and they're going to have to show that Congress had a reason for passing this law.

And in point of fact, and I'd ask you to engage in a bit of a thought experiment here, the fact of the matter is that the American College of Obstetricians and Gynecologists is no more happy if the woman undergoing one of these procedures were to turn around later and sue the doctor for malpractice. If she wins, that's a regulation of the practice of abortion. And there's no doctor—no

doctor is going to be able to come in later and say, "Oh, but the jury had to have a health exception in mind. I did it for her."

So what Justice O'Connor wants to know about is: Is this procedure healthy for women? If the answer is no, then it doesn't need a health exception.

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

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

Mr. HOSTETTLER. Thank you, Mr. Chairman. Mr. Chairman, I'm going to take a little bit different tack, in that this Subcommittee is the Subcommittee on the Constitution in the House of Representatives, and so, therefore, we are much more concerned with the constitutional authority of the House of Representatives to legislate in these areas. And as we all take an oath to uphold the Constitution—and not necessarily as the Supreme Court sees the Constitution.

But, Mr. Heller, you suggested in your testimony that it was stated in *Marbury v. Madison* that the Court has the final word on constitutionality. You're not suggesting that Chief Justice John Marshall actually said that in *Marbury v. Madison*, are you?

Mr. HELLER. Not in those exact words.

Mr. HOSTETTLER. Right.

Mr. HELLER. But it's certainly what the case stands for.

Mr. HOSTETTLER. Well, because as Walter Murphy in his work, why *Marbury v. Madison*, said this, "For his part, Marshall in *Marbury* never claimed judicial monopoly on constitutional interpretation, nor did he allege judicial supremacy, only authority to interpret the Constitution in cases before the Court."

So with regard to individual cases, he talked about constitutionality. And you would say that laws made in pursuance of the United States—made in pursuance of the Constitution are supreme laws of the land, would you not?

Mr. HELLER. A statute passed by Congress is not supreme above the Constitution.

Mr. HOSTETTLER. Are you familiar with article VI of the Constitution?

Mr. HELLER. Yes.

Mr. HOSTETTLER. Article VI of the Constitution says that the Constitution and the laws of the United States which shall be made in pursuance thereof, and all treaties made or which shall be made, under the authority of the United States, shall be the supreme law of the land, correct?

Mr. HELLER. That's what it says, but the Supreme Court for over 200 years—well, 199 years, and I think Congress probably has said this as well, that the Constitution is supreme over statutes and treaties.

Mr. HOSTETTLER. But the Constitution doesn't say that? You'll give me that?

Mr. HELLER. Well, you know, I think this is such a basic principle of our Government that you'd have to have a revolution in this country to change it.

Mr. HOSTETTLER. Well, that's what the Constitution was the result of, revolution.

Mr. HELLER. That's right. You'd need another one to supplant the Supreme Court.

Mr. HOSTETTLER. Is that right? You think so? Well, that's not what Chief Justice John Marshall said. As you probably know, after *Marbury v. Madison*, they impeached Samuel Chase, they were so impressed by that opinion.

Mr. HELLER. But he wasn't John Marshall; he was Samuel Chase. [Laughter.]

Mr. HOSTETTLER. And I'd like to read you—according to Louis Fisher, a specialist on separation of powers for the Library of Congress, he said, "If that move succeeded," meaning the impeachment and removal of John Marshall, "Marshall had reason to believe he was next in line."

In a letter that was written between Marshall and Samuel Chase, Marshall suggested this—and the Court is very desirous of using letters from high U.S. Government officials to other individuals. So this is what he said, "I think the modern doctrine of impeachment should yield to an appellate jurisdiction in the Legislature. A reversal of those legal opinions deemed unsound by the Legislature would certainly better comport with the mildness of our character than would a removal of the judge who has rendered them unknowing of his fault." So Marshall suggested to Chase that an opinion that was not within the desired realm of the Court should yield to an appellate jurisdiction, that appellate jurisdiction being the Legislature.

You would agree with Marshall on that, would you not?

Mr. HELLER. No, but I would actually I think defer to Professor Destro, who I think will agree with me that the Constitution is the supreme law of the land and that the Supreme Court is the final arbiter of what the Constitution means.

Mr. HOSTETTLER. Don't get me wrong, I'm not an attorney, so I just read the Constitution.

Mr. HELLER. Yes. You're misreading it. [Laughter.]

Mr. HOSTETTLER. I am?

Mr. HELLER. Yes.

Mr. HOSTETTLER. Is that right? So to say—so I'm misreading it when I say—so article VI, that's not article VI of the Constitution?

Mr. HELLER. Again, I would defer to Professor Destro. Maybe he can agree with you about some of that.

Mr. HOSTETTLER. I can defer to all the law school professors there are. They'll probably say the same thing. And if the Court in fact changes its mind next month, they'll have to put out new textbooks to teach the next set of law students the same thing—the new thing.

So as you both suggested, and Professor Destro said, that's ongoing, that in fact later the Supreme Court and subsequently law schools will say that partial-birth abortion is in fact—the ban of it is constitutional. Is that not right?

Mr. HELLER. Well, what is true, and I agree with Professor Destro that *Plessy v. Ferguson* over 50 years later was reversed by *Brown v. Board of Education*. I daresay, during those 50 years, the composition of the Supreme Court completely changed. Here we have—

Mr. HOSTETTLER. And so if it completely changes, if it completely changes between now and, say, the election in 2008, partial-birth abortion may be in fact constitutional? Is that not right? I mean, may be unconstitutional, the protection of it.

Mr. HELLER. Also during those 50 years, there were significant changes in American society. Here we have Congress 2 years after a Supreme Court decision directly defying a Supreme Court precedent where there has been not only no change in the composition of the Supreme Court but no suggestion of a change in the composition of the Supreme Court.

Mr. HOSTETTLER. Are you suggesting that the Federal judiciary—

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

Mr. HOSTETTLER. One more question.

Mr. CHABOT. Okay.

Mr. HOSTETTLER. Are you suggesting that the Federal judiciary is somehow immune from popular influence with regard to its decisions?

Mr. HELLER. No.

Mr. HOSTETTLER. Thank you.

Mr. CHABOT. Thank you.

The gentlelady from Pennsylvania is recognized.

Would the gentlelady yield for just a moment?

I appreciate the gentlelady yielding.

I would disagree with Mr. Heller's point that the Congress is directly refuting the Supreme Court here. I think we have very carefully crafted a bill which takes the two principle concerns that the Supreme Court had in the lower court case into consideration, one being the definition of partial-birth abortion, one being the factual findings that the lower court found. We are a separate constitutional branch of the Government. After extensive congressional hearings and expert witnesses, both this afternoon and in previous Congresses, we have entered into the findings of fact in this legislation, those findings.

So I think this is a different partial-birth abortion bill than the Nebraska case and the two previous congressional cases.

And I thank the lady for yielding, and I now give her her time back, which is 4 minutes and 8 seconds, to be exact.

Ms. HART. Thank you, Mr. Chairman.

Well, I hope this is not taken as browbeating, but, Mr. Heller, I have a question for you regarding *Stenberg*. And I want to know, first of all, if you would agree that regardless of the final findings of the district court, that the factual record was highly disputed. It appears as though today we have witnesses who would dispute those factual findings. Obviously, the Congress disputes those factual findings. I would like to know if you agree with me that they are disputed, as well.

Mr. HELLER. Well, I guess anyone can get up and dispute anything they want. These people are certainly—

Ms. HART. With some very fair, factual findings. My question to you is yes or no.

Mr. HELLER. I'm sorry, with what factual findings?

Ms. HART. Do you agree that those are reasonably disputed factual findings, that the medical professionals—

Mr. HELLER. I don't believe they're reasonable.

Ms. HART. Okay, then I don't choose to ask you any more questions. [Laughter.]

Ms. HART. My next question I guess is for Dr. Aultman. And I'm sorry about the browbeating that you received earlier. It appears to me that you have quite a bit of experience, having participated in a number of different angles of this issue.

The question I have for you is regarding any clinical studies of the D&X procedure. Are you aware of any? Have any been done that you're aware of that would provide us with a little more facts regarding its necessity?

Dr. AULTMAN. When I was first asked to testify, one of the questions to me was, has there been any change? Have there been any studies? And I did an extensive literature search and had other people doing searches for me, and we could not find anything new since—well, we couldn't find anything at all.

And one of the problems in general is that D&X's aren't a separate category. Reporting is voluntary. Four States don't even report to the CDC, so it's—and there have been no studies that I know of, looking at complications, looking at when its indicated, or anything like that.

Ms. HART. Okay, so I would I guess ask Dr. Cook, are you aware of those type of studies, clinical studies that were done of that procedure that would give us any more clear light on that issue?

Dr. COOK. I am not. And, again, it's the same sort of situation. These are voluntary reporting situations. They're frequently performed in clinics outside of supervision of hospitals and other regulatory bodies, so they're seemingly done, to me, intentionally to sidestep such supervision.

Ms. HART. Thank you.

And I just want to also, Mr. Chairman, if I may, further discuss the issue of the AMA and its support or nonsupport of this procedure. I know that this Congress and our staffs have done some pretty extensive research and found that there are no articles published in any peer-review journals that establish that partial-birth abortions are superior in any way to other established abortion procedures. And I think that's an important issue for us to consider. Obviously, as we look at this, and we look at findings and modern medicine, it does progress as the years go by, and I think it's important for the Congress to look at new findings and facts as we consider how to handle this issue.

Thank you, Mr. Chairman. I yield back.

Mr. CHABOT. I thank the gentlelady from Pennsylvania.

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

Mr. NADLER. Mr. Chairman, before that, I think I must comment on an aspersion thrown by the previous witness, and I request permission to do so.

Ms. HART. No.

Mr. CHABOT. Which witness are we talking about?

Mr. NADLER. Dr. Cook.

Mr. CHABOT. I didn't hear any aspersion.

Mr. NADLER. I did, and I'll identify—

Ms. HART. Mr. Chairman—

Mr. HOSTETTLER. Regular order.

Mr. NADLER. Regular order? I—

Mr. CHABOT. If it's a point of personal privilege, I'll let—it was an aspersion toward whom?

Mr. NADLER. Towards all abortion clinics and all doctors who perform abortions.

Mr. CHABOT. I could give you lots of aspersions toward abortion clinics, but that's— [Laughter.]

Mr. NADLER. I'd like to comment on it, if I may, for a moment.

Mr. CHABOT. I'll give the gentleman 1 minute to make his comments.

Mr. NADLER. Thank you. It'll only take a minute. The gentleman, Dr. Cook, casually commented that people perform abortion in clinics in order to escape supervision. I would point out that the reason these procedures and other abortion procedures are done in clinics are because, for various reasons—perhaps political power, perhaps certain organizations involved physical coercion and terrorism—lots of hospitals won't do abortion procedures of any type. And that's why they're done in clinics, not to escape certain kinds of medical supervision. And I'd also point out, they're all subjected to State licensing boards.

Thank you.

Dr. COOK. With all due respect to the Congressman, it does concern me when physicians who perform these type of rogue procedures who are not even board certified by any board of medicine, performing these procedures without any hospital privileges in outside clinics with no regulation or supervision. That concerns me.

Mr. NADLER. Then perhaps we ought to require these procedures to be performed in every hospital and only in hospitals.

Mr. CHABOT. The gentleman is saying that he would require partial-birth abortions—

Mr. NADLER. No, I would—

Mr. CHABOT [continuing]. Be performed in hospitals?

Mr. NADLER. No. I don't think we ought to comment on partial-birth abortions. But I do think that since there's a constitutional right to have abortions performed, one of the real problems is that, through a combination of all kinds of pressures—political, physical threats—we have made it impossible to find abortions in most counties in this country, and in many hospitals, and that's why they are done in clinics where there are doctors courageous enough to perform them.

And I would, frankly, require that any department of obstetrics and gynecology make available abortions to people who request them and have a constitutional right to them.

Mr. CHABOT. We'll go back to regular order.

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

Mr. FORBES. Thank you, Mr. Chairman.

And I would like to thank each of the members of the panel, whether I agree with you or disagree with you, for being here today. I do take a little exception to the statements that were made earlier, that what we're doing here is silly or what you're doing is silly. I think you have people who have very strong commitments on both sides, and I appreciate your being here.

I would like, Mr. Heller, to ask you a question, and please forgive me for having to cut you off, maybe, on some of your answers. I only have 5 minutes, and you can submit whatever you want to us in writing.

But I'd like to go back to the question that I heard raised earlier about the pain of fetus, when this partial-birth abortion is done. You heard the testimony that was made, that the baby, the fetus—you pick whatever terminology you want to have—feels pain. Do you agree with that or disagree with that?

Mr. HELLER. Well, I'm a lawyer and certainly not an expert on the issue of fetal pain. I will say that—

Mr. FORBES. But you've tried a lot of these cases, and you've heard a lot of testimony.

Mr. HELLER. Let me say this: It's not been an issue in very many of the cases, because none of these statutes, including the bill before Congress, before this Committee today, say anything about fetal pain.

Mr. FORBES. Then it would be a fair statement to say at least that you don't have any evidence to the contrary, that there is pain?

Mr. HELLER. There's a lot of evidence to the contrary of what Dr. Aultman said.

Mr. CHABOT. Would the gentleman yield for a moment?

Mr. FORBES. Yes, sir.

Mr. CHABOT. The statement that was just made is inaccurate. There is a finding of fact in this particular legislation which talks about fetal pain, because it is—there's medical testimony to that this afternoon, as there was in the past.

I yield back to the gentleman.

Mr. FORBES. Mr. Chairman—Mr. Heller, I want you to be able to answer, just they're confining me in a few minutes. Please submit whatever you have to me, whenever you get a chance, in writing, and I'll get it in the record, on the fact that there is no pain.

But let me ask this question, assuming that there is, assuming that there—is there any method of destroying a fetus that would be so egregious that you would be willing to say that it could be constitutionally prohibited?

Mr. HELLER. Well, it's not for me to decide what should be constitutionally prohibited.

Mr. FORBES. I understand that. I'm just asking your opinion. You're a witness testifying before us. All of you are giving us your opinions.

Mr. HELLER. My personal opinion?

Mr. FORBES. Yes, sir.

Mr. HELLER. I think that whatever method is safest for the woman, no matter what its other features, should be available to her.

Mr. FORBES. So it would be fair to say, then, that you would conclude that there is no method of abortion, no matter how egregious it would be, painful it would be to the fetus, as long as it was safe for the woman that was undergoing the abortion?

Mr. HELLER. Again, if it's a safe and medically appropriate procedure, and in fact the safest under some circumstances, then it should be available to women because I believe that the patient's

health should predominate in this situation, as it does in every other form of medical treatment.

Mr. FORBES. Let me ask you then, on partial-birth abortion, can you tell me which situations exist where there is no other safe method? And I understand that we could always argue that one is safer than another, but is there any situation where you would have a partial-birth abortion that there would not be a safer method that would be available?

Mr. HELLER. I suppose that—first, I need to know whether you mean the definition of partial-birth abortion that Nebraska used or the one in this bill or the one that's in the findings or some other one.

Mr. FORBES. Why don't you take whichever one you want or all three?

Mr. HELLER. I don't know what the term means. I don't know what the definition of the term is.

Mr. FORBES. So you don't know what partial-birth abortion means?

Mr. HELLER. It's a term that's been defined in many different ways.

Mr. FORBES. Take the one in this statute.

Mr. HELLER. The one in this statute? I don't think there's been—I'm not aware of medical testimony, which is my only source of information, about the specifics of this statute at all, either way.

Mr. FORBES. Okay. Let's take the previous statute in the *Stenberg* case.

Mr. HELLER. Well, with respect to the *Stenberg* case, the testimony was clear that what was prohibited by that included the dilation and evacuation method, as well as what's called the intact D&X method. It's quite clear that those are the safest for many women in many circumstances.

Are they the only method? No. You could do a hysterectomy as well and deprive the woman of her fertility.

Mr. FORBES. You could. But without being—

Mr. HELLER. Well, that's what you asked: Is it the only method? No, it's not.

Mr. FORBES. The only safe method that was there.

Mr. HELLER. But it depends. I guess it depends on one's definition of safety.

For example, if I have a bruise on my arm, I can have the bruise treated or I can have my arm amputated. They might both be safe in some sense. It's all a matter of relative safety.

Mr. FORBES. I understand. Well, if you get any information, you can submit it to us. Or any of the other members of the panel, if you would submit that, we would like to take that into consideration.

Mr. HELLER. The relative safety of D&E is well-established by the CDC.

Mr. FORBES. You are not a medical doctor, correct?

Mr. HELLER. That's correct.

Mr. FORBES. And you're not a Supreme Court Justice, obviously.

Mr. HELLER. None of us here are.

Mr. FORBES. But do you feel yourself competent to testify today regarding partial-birth abortion, as a witness before this Committee?

Mr. HELLER. Well, what I've testified to is about the constitutionality of prohibitions on what is variously called partial-birth abortion, and I do feel competent to testify about that.

Mr. FORBES. Mr. Chairman.

Mr. CHABOT. I thank the gentleman from Virginia.

The bells that everyone just heard are calling the Members to the floor for a series of three votes. Fortunately, we just concluded the questioning as well, so the timing was very appropriate.

I want to thank the panelists this afternoon for their excellent testimony. It will become part of the record in this very, very important case.

Mr. NADLER. Mr. Chairman?

Mr. CHABOT. The Members and witnesses will have 7 legislative days in which to submit additional materials for the record.

Mr. NADLER. And to revise and extend their remarks.

Mr. CHABOT. And to revise and extend their remarks.

And if there's no further business to come before this Committee, we are adjourned.

[Whereupon, at 3:44 p.m., the Subcommittee was adjourned.]

A P P E N D I X

STATEMENTS SUBMITTED FOR THE HEARING RECORD

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

We have convened this afternoon to receive testimony on H.R. 4965, the “Partial-Birth Abortion Ban Act of 2002.”

Partial-birth abortion is the termination of the life of a living baby just seconds before it takes its first breath outside the womb. The procedure is violent. It is gruesome. It is infanticide.

On June 19, on behalf of a bi-partisan coalition, I introduced H.R. 4965, the “Partial-Birth Abortion Ban Act of 2002.”

H.R. 4965 will ban this dangerous and inhumane procedure during which a physician delivers an unborn child’s body until only the head remains inside the womb, punctures the back of the child’s skull with a sharp instrument, and sucks the child’s brains out before completing delivery of the dead infant. An abortionist who violates this ban would be subject to fines or a maximum of two years imprisonment, or both. H.R. 4965 also establishes a civil cause of action for damages against an abortionist who violates the ban and includes an exception for those situations in which a partial-birth abortion is necessary to save the life of the mother.

A moral, medical, and ethical consensus exists that partial-birth abortion is an inhumane procedure that is never medically necessary and should be prohibited. Contrary to the claims of those who proclaim the medical necessity of this barbaric procedure, partial-birth abortion is, in fact, a dangerous medical procedure that poses serious risks to the long-term health of women. In fact, ten years after Dr. Martin Haskell presented this procedure to the mainstream abortion community, partial-birth abortions have failed to become the standard of medical practice for any circumstance under which a woman might seek an abortion.

As a result, the United States Congress voted to ban partial-birth abortions during the 104th, 105th, and 106th Congresses and at least 27 states enacted bans on the procedure. Unfortunately, the two federal bans that reached President Clinton’s desk were promptly vetoed.

Two years ago in *Stenberg v. Carhart*, the United States Supreme Court struck down Nebraska’s partial-birth abortion ban which was similar, but not identical, to the previous bans passes by Congress. To address the concerns raised by the majority in *Stenberg*, H.R. 4965 differs from previous proposals in two areas.

First, the bill contains a new, more precise, definition of the prohibited procedure to address the Court’s concerns that Nebraska’s definition of the prohibited procedure might be interpreted to encompass a more commonly performed late second trimester abortion procedure.

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

Those factual findings, however, are inconsistent with the overwhelming weight of authority regarding the safety and medical necessity of the partial-birth abortion procedure—including evidence received during extensive legislative hearings during the 104th and 105th Congresses—which indicates that a partial-birth abortion is never medically necessary to preserve the health of a woman, poses serious risks to a woman’s health, and lies outside the standard of medical care. In fact, the American Medical Association has concluded that partial-birth abortion is “not an

accepted medical practice,” and that it has “never been subject to even a minimal amount of the normal medical practice development.”

Under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in *Stenberg* under the “clearly erroneous” standard. Rather, the United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence. To conclude otherwise would forever bind Congress to the factual findings of one federal district court—no matter how questionable those findings may have been or how much those facts may be altered by time. This simply cannot be the case. Thus, the first section of H.R. 4965 contains Congress’s factual findings that, based upon extensive medical evidence compiled during congressional hearings, a partial-birth abortion is never necessary to preserve the health of a woman.

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

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

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

We have been through this debate often enough to know that you will not find the term “partial birth abortion” in any medical text book. There are procedures that you will find in medical text books, but apparently, the authors of this legislation would prefer to use the language of propaganda than of science. This bill, as written, fails every test the Supreme Court has laid down for what may or may not be a constitutional regulation on abortion. It reads almost as if the authors went through the Supreme Court’s recent decision in *Stenberg v. Carhart* and went out of their way to thumb their noses at the Supreme Court, and especially at Justice O’Connor who is generally viewed as the swing vote on such matters, and who wrote a concurring opinion stating specifically what would be needed for her to uphold a statute. Unless the authors think that when the Court has made repeated and clear statements over the years of what the Constitution requires in this area they were just pulling our leg, this bill has to be facially unconstitutional.

First and foremost, it does not contain a life and health exception which the Court has repeatedly said is necessary throughout pregnancy, even post-viability. I know that some of my colleagues do not like this rule, but there it is in the law and not in this bill. Even the Ashcroft Justice Department, in its brief defending an Ohio statute, has acknowledged that a health exception is required by law. While I may disagree with the Department’s views on whether the Ohio statute adequately protects women’s health, there is at least an acknowledgment that the law requires that protection.

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

While I realize that many of the proponents of this bill view all abortion as tantamount to infanticide, that is not a mainstream view. This bill attempts to foist a marginal view on the general public by portraying it as something more extreme, as having to do only with healthy, full term fetuses. If the proponents of this bill want to deal with post viability abortions, where a woman’s life and health are not in jeopardy, then let them write a bill dealing with that issue. But let us not play these kind of games.

As one of the lead sponsors of the Religious Freedom Restoration Act, I know, as does Prof. Destro, what comes of Congress ignoring the will of the Supreme Court. Whatever power Congress had under section 5 of the 14th Amendment as a result of *Katzenbach v. Morgan*, which is copiously cited in the bill’s findings, I think the more recent Boerne decision vastly undercut those powers. Even if *Katzenbach* were

still fully in force, as I wish it were, that case only empowered Congress to expand, not curtail rights under the 14th Amendment. This bill, of course, aims to do the exact opposite.

It is election time, and that means it is the silly season in Washington. This, Mr. Chairman, is about as silly as it gets. Unfortunately, there are dire consequences for American women if this legislation passes.

PREPARED STATEMENT OF THE HONORABLE J. RANDY FORBES, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF VIRGINIA

Thank you Mr. Chairman for holding this important hearing. I am a cosponsor of the Partial-Birth Abortion Ban Act of 2002 and I hope this legislation will be quickly brought to the House floor. This legislation addresses a far more fundamental issue—our intolerance, as a civilized nation, to allow this unparalleled cruelty to continue.

A nation can only be as great as it treats the weakest among us. Throughout our history great social and political movements have led to liberation of the most oppressed in society. From our own Declaration of Independence, to the freeing of the slaves, to the women's suffrage movement, and to the civil rights movement of the 1960's, America has a rich tradition of looking at its own conscience to act on what is right. I believe the next great civil right movement in this country will be the protecting of the unborn.

We see the value of life slowly cheapened everyday in America. Kids are killing kids over clothing. People commit senseless murders that lack the basic understanding that what they did is wrong. And now, the Supreme Court has told us that it is a constitutionally protected act to crush a baby's skull only moments before leaving the safety of his or her mother.

Partial birth abortion is repugnant of a civilized society. Partial birth abortion goes beyond abortion on demand. The baby involved is not unborn. The difference between partial birth abortion procedure and infanticide is a mere 3-inches.

While everyone is entitled to his or her own opinion, people are not entitled to their own facts. On partial birth abortion, the facts are out, the facts are clear. Partial birth abortion is never medically necessary. Partial birth abortion is not a rare procedure. It happens all the time, and it is not limited to mothers and fetuses who are in danger. It is performed on healthy women and healthy babies all the time, and that is what the facts are.

Mr. Chairman, the House and the Senate should vote to ban this horrible procedure, the President should sign the ban, and we should close this horrible chapter in our history.

MATERIAL SUBMITTED FOR THE HEARING RECORD

Material Submitted by the Honorable Steve Chabot, a Representative in Congress From the State of Ohio, and Chairman, Subcommittee on Constitution

The National Abortion Federation letter of June 12 also states, "This is not a different surgical procedure than D&E." This statement is erroneous. The D&E procedure involves dismemberment of the fetus inside the uterus. It is cruel and violent, but it is quite distinct in some important respects from the partial-birth method. Indeed, Dr. McMahon himself has provided to this subcommittee a fact sheet, that he sends to other physicians in which he goes into a detailed discussion of the distinctions between intrauterine dismemberment procedures, which he calls disruptive D&E, and the procedure that he performs, which he calls intact D&E.

This brings us to another important point. There is no uniformly accepted medical terminology for the method that is the subject of this legislation. Dr. McMahon does not even use the same term as Dr. Haskell, while the National Abortion Federation implausibly argues that there is nothing to distinguish this procedure from D&E.

The term you have chosen, partial-birth abortion, is straightforward. Your definition is straightforward, and in my opinion, covers this procedure and no other.

Mr. CANADY. Doctor, if you could summarize and continue and conclude in another couple of minutes, I'd appreciate it.

Dr. SMITH. I'll just summarize by saying partial-birth abortions are being heralded by some as safer alternatives to D&E. But advances in this type of technology do not solve the problem. They only compound it. In part because of its similarity to obstetrical techniques that are designed to save a baby's life and not destroy it, this procedure produces a moral dilemma that is even more acute than that encountered in dismemberment techniques. The baby is literally inches away from being declared a legal person by every State in the Union. The urgency and seriousness of these matters therefore require appropriate legislative action. Thank you.

[The prepared statement of Dr. Smith follows:]

PREPARED STATEMENT OF PAMELA SMITH, M.D., DIRECTOR OF MEDICAL EDUCATION,
MT. SINAI HOSPITAL

Mr. Chairman and honorable members of the subcommittee, I am Dr. Pamela Smith. I am a board-certified obstetrician-gynecologist with 15 years experience. I serve as director of medical education in the department of obstetrics and gynecology at Mt. Sinai Hospital in Chicago, and I am also a member of the Association of Professors of Gynecology and Obstetrics.

I am also testifying as the president-elect of the American Association of Pro-life Obstetricians and Gynecologists.

Abortion providers claim that participation in intrauterine dismemberment or "D & E" (dilation and evacuation) techniques often cause severe psychological ill-effects in counseling staff and surgical providers. Partial-birth abortion techniques, which are distinctly different surgical procedures, compound this problem even further. The partial-birth abortion method is strikingly similar to the technique of internal podalic version, or fetal breech extraction. Breech extraction is a procedure that is utilized by many obstetricians with the intent of delivering a live infant in the management of twin pregnancies, or single-infant pregnancies complicated by abnormal positions of the pre-born infant.

In fact, when I described the procedure of partial-birth abortion to physicians and lay persons who I knew to be pro-choice, many of them were horrified to learn that such a procedure was even legal.

The development and growing use of the partial-birth abortion method is particularly alarming when one considers the recent actions of the Accreditation Council for Graduate Medical Education (ACGME). This Council, whose members include a non-voting federal official, has tremendous power. It is responsible for accrediting medical education programs. Non-accredited programs are not eligible for federal

funding, and students who graduate from non-accredited programs may not be able to obtain state licenses, hospital privileges or Board certification.

ACGME is requiring obstetrics and gynecology residency training programs to provide abortion training either in their own program or at another institution. This policy will undoubtedly be used to coerce individuals and institutions to participate in procedures that violate their moral conscience. Physicians throughout this country therefore will encounter the ethical dilemma of participating in an abortion procedure which even under *Roe versus Wade* is literally seconds and inches away from being classified as a murder by every state in the union. I believe that this factor, among others, fully justifies the banning of this particular abortion technique.

In a total breech extraction, the physician—frequently with the aid of ultrasound—grasps the lower extremities of the baby. With the bag of waters serving as a buffer and cervical wedge, the physician pulls the infant towards the cervix and vagina. To facilitate the delivery of the head by flexion, care is taken to maintain the baby's spine in a position that points towards the mother's bladder.

Depending upon the size of the infant, an attempt may be made to deliver the baby without rupturing the bag of waters. In such a case, the bag of waters facilitates delivery of the head by mechanically maintaining cervical dilation. Should the bag of waters rupture and the head become entrapped, it can be released by cutting the cervix, or a Cesarean section can be performed to deliver the baby abdominally.

Partial-birth abortions, which according to the physicians who perform them have been done on babies from the ages of 19 weeks to full term, represent a perversion of the above technique. In these procedures, one basically relies on cervical entrapment of the head to help keep the baby in place while the practitioner plunges a pair of scissors into the base of the baby's skull to sever the spinal cord. The scissors also creates an opening for the insertion of a suction curette to remove the baby's brains.

If, by chance, the cervix is floppy or loose and the head slips through, the surgeon will encounter the dreadful "complication" of delivering a live baby. The surgeon must therefore act quickly to insure that the baby does not manage to move the inches that are legally required to transform its status from one of an abortus to that of a living human child. Although the defenders of this technique proclaim that it is safe, they have not substantiated these claims. Only two individuals have provided any kind of data to evaluate. Included in this scanty amount of data, there is a report of a hemorrhagic complication that required 100 units of blood products to stabilize the patient, along with an infectious cardiac complication that required six weeks of antibiotic therapy.

I have also been shown a copy of a letter dated June 12, signed by the executive director of the National Abortion Federation, a trade association of abortion providers. This memo makes a number of remarkable claims regarding the partial-birth abortion method—claims that are flatly inconsistent with the recorded statements made by physicians who specialize in performing these procedures. I will refer to statements made by Dr. Martin Haskell, who wrote a monograph explaining in detail how to perform this type of procedure and which was distributed by the National Abortion Federation in 1992. I will also refer to statements made by Dr. James McMahan in various interviews and in written materials that he has distributed.

The National Abortion Federation letter says that "fetal demise is virtually always induced by the combination of steps taken to prepare for the abortion procedure." But in interviews with the American Medical News, quoted in an article published in the July 5, 1993 edition, both Haskell and McMahan "told AM News that the majority of fetuses aborted this way are alive until the end of the procedure."

Dr. Haskell himself further elaborated, in an interview published in the Dec. 10, 1989 Dayton News, that it was the thrust of the scissors that accomplished the lethal act. I quote him: "When I do the instrumentation on the skull . . . it destroys the brain sufficiently so that even if it (the fetus) falls out at that point, it's definitely not alive," Dr. Haskell said.

Professor Watson Bowes of the University of North Carolina at Chapel Hill, a prominent authority on fetal and maternal medicine, and co-editor of the *Obstetrical and Gynecological Survey*, reviewed Dr. Haskell's article and noted that Dr. Haskell quite explicitly contrasts this procedure with other procedures that do induce fetal death within the uterus. Professor Bowes concurred that the fetuses are indeed alive at the time that the procedure is performed.

The National Abortion Federation letter also claims that the drawings of the partial-birth procedure distributed by Congressman Canady and others are "highly imaginative" and "misleading." But Dr. Haskell himself validated the accuracy of these drawings as reported in the American Medical News. Again I quote: "Dr. Has-

kell said the drawings were accurate 'from a technical point of view.' But he took issue with the implication that the fetuses were 'aware and resisting.'"

Professor Bowes also reviewed the drawings and wrote that they are "an accurate representation of the procedure described in the article by Dr. Haskell."

I would invite the members of the subcommittee to review the drawings of the fetal breech extraction method that I have attached to my written testimony, reproduced from Williams Obstetrics, a standard textbook. You can see that the method described by Dr. Haskell is an adaptation—or I would say, a perversion—of the fetal breech extraction, and that the textbook drawings are strikingly similar to the disputed drawings of the partial-birth procedure. I would also invite the members of the subcommittee to examine an accurate model of a fetus at 20 weeks and the Metzenbaum surgical scissors that are used in this procedure, and decide for yourselves who is being misleading.

The National Abortion Federation letter also suggests that these partial-birth abortions are commonly done in a variety of unusual circumstances, such as when the life of the mother is at grave risk. I have practiced obstetrics and gynecology for 15 years. I work with many indigent women. I have never encountered a case in which it would be necessary to deliberately kill the fetus in this manner in order to save the life of the mother. There are cases in which some acute emergency occurs during the second half of the pregnancy that makes it necessary to get the baby out fast—even if the baby is too premature to survive. This would include, for example, HELLP syndrome, a severe form of pre-eclampsia that can develop quite suddenly. But no doctor would employ the partial-birth method of abortion, which—as Dr. Haskell carefully describes—takes three days!

Dr. McMahon also lists maternal conditions such as sickle cell trait, uterine prolapse depression and diabetes as indications for this procedure, when in fact these conditions are frequently associated with the birth of a totally normal child.

The National Abortion Federation letter of June 12 also states: "This is not a different surgical procedure than D&E . . ." This statement is erroneous. The D&E procedure involves dismemberment of the fetus within the uterus. It is cruel and violent, but is quite distinct in some important respects from the partial-birth method. Indeed, Dr. McMahon himself has provided to this subcommittee a factsheet that he sends to other physicians, in which he goes into a detailed discussion of the distinctions between the intrauterine dismemberment D&E procedure—which he calls "disruptive D&E"—and the procedure that he performs, which he calls "intact D&E."

This brings us to another important point: there is no uniformly accepted medical terminology for the method that is the subject of this legislation. Dr. McMahon does not even use the same term as Dr. Haskell, while the National Abortion Federation implausibly argues that there is nothing to distinguish this procedure from the D&E abortions. The term you have chosen, "partial-birth abortion," is straightforward. Your definition is also straightforward and, in my opinion, covers this procedure and no other.

In closing, I would like to read for you the sentiment expressed by an abortion provider at a meeting of the Association of Planned Parenthood Physicians in San Diego in 1978. These comments are in reference to the D&E (dismemberment) abortion technology: "We have reached a point in this particular technology where there is no possibility of denial of an act of destruction by the operator. It is before one's eyes. The sensations of dismemberment flow through the forceps like an electric current. It is the crucible of a raging controversy, the confrontation of a modern existential dilemma. The more we seem to solve the problem, the more intractable it becomes."

Today, partial-birth abortions are being heralded by some as safer alternatives to D&E. But "advances" in this type of technology do not solve the problem . . . they only compound it. In part because of its similarity to obstetrical techniques that are designed to save a baby's life and not to destroy it, this procedure produces a moral dilemma that is even more acute than that encountered in dismemberment techniques. The baby is literally inches from being declared a legal person by every state in the union. The urgency and seriousness of these matters therefore require appropriate legislative action.

Citation	Search Result	Rank 2 of 5	Database
11/17/95 CONGTYM (No Page)			CONGTYM
11/17/95 Cong. Testimony (Pg. Unavail. Online)			
1995 WL 12715929			

Congressional Testimony
Copyright 1995 by Federal Document Clearing House, Inc.

Friday, November 17, 1995

PARTIAL BIRTH ABORTION BAN
PAMELA SMITH

Testimony of Pamela Smith, M.D.

on H.R. 1833, the Partial-Birth Abortion Ban Act
U.S. Senate Judiciary Committee,

Washington, D. C.

November 17, 1995

Mr. Chairman, honorable members of the Judiciary Committee, my name is Pamela Eleashia Smith. I am a medical doctor, board-certified in the specialty of obstetrics and gynecology, having received my training at Cornell University, Yale University, the University of Chicago, and Mt. Sinai Hospital in Chicago.

For the past 15 years I have practiced in the inner city of Chicago. I am currently the Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital; an Assistant Professor at the Finch University/Chicago Medical School; a member of the American College of Obstetricians and Gynecologists; and the President-elect of the American Association of Pro-life Obstetricians and Gynecologists.

Honorable senators, before I testified on this legislation on June 15, before the House Judiciary Committee's Subcommittee on the Constitution, I went around and described the procedure of Partial-birth abortion to a number of physicians and laypersons who I knew to be pro-choice. They were horrified to learn that such a Procedure was even legal.

I believe that it is safe to say that until the recent publicity occasioned by the movement of this legislation, most physicians, including obstetrician gynecologists, knew nothing of this technique as an abortion method. But the partial-birth abortion method is strikingly similar to the technique of internal podalic version, or fetal breech extraction. Breech extraction is a procedure that is utilized by many obstetricians with the intent of delivering a live

11/17/95 CONGTMY (No Page)

infant in the management of twin pregnancies, or single-infant pregnancies complicated by abnormal positions of the pre-born infant.

I would invite the members of the subcommittee to review the drawings of the fetal breech extraction method that I have attached to my written testimony, reproduced from Williams Obstetrics, a standard textbook. Compare this with the partial-birth abortion procedure, as laid out step-by-step by Dr. Martin Haskell in his instructional paper, "Dilation and Extraction for Late Second Trimester Abortion." (in that paper, Dr. Haskell says that he "coined" the term "dilation and extraction." Neither that term nor the term now favored by opponents of HR 1833, "intact dilation and evacuation," can be found in any standard medical literature. There is nothing whatever misleading about the term utilized in the bill, "partial-birth abortion.")

In a total breech extraction, the physician-- frequently with the aid of ultrasound-- grasps the lower extremities of the baby. With the bag of waters serving as a buffer and cervical wedge, the physician pulls the infant towards the cervix and vagina. To facilitate the delivery of the head by flexion, care is taken to maintain the baby's spine in a position that points towards the mother's bladder.

Depending upon the size of the infant, an attempt may be made to deliver the baby without rupturing the bag of waters. In such a case, the bag of waters facilitates delivery of the head by mechanically maintaining cervical dilation. Should the bag of waters rupture and the head become entrapped, it can be released by cutting the cervix, or a Cesarean section can be performed to deliver the baby abdominally.

Partial-birth abortions, which according to the physicians who perform them have been done on babies from the ages of 19 weeks to full term, represent a perversion of the above technique. In these procedures, one basically relies on cervical entrapment of the head, along with a firm grip, to help keep the baby in place while the practitioner plunges a pair of scissors into the base of the baby's skull. The scissors also creates an opening for the insertion of a suction curette to remove the baby's brains.

If, by chance, the cervix is floppy or loose and the abortionist does not keep a good grip, he may encounter the dreadful "complication" of delivering a live baby-- undoubtedly, a constitutional "person" with an inalienable right to life. Thus, the practitioner must take great care to insure that the baby does not move those additional few inches that would transform its status from one of an abortus to that of a living human child.

11/17/95 CONGTMY (No Page)

Another brazen attempt to mislead the American public as to the reality of the pain experienced by the victims of this procedure is the assertion that the anesthesia kills the baby. Such a statement runs contrary to published reports made by abortion practitioners, is not consistent with basic principles of the pharmacology of drug distribution in the pregnant female, and violates common sense. Twenty-five percent of all pregnancies in this country are delivered by Cesarean section and many women receive potent narcotics to relieve their pain during labor. Yet it is essentially unheard of that a human fetus in labor dies secondary to anesthesia given to its mother.

I note that the American Society of Anesthesiologists issued the following statement recently;

Recent debate in the U.S. House of Representatives and Senate regarding late-term abortions has resulted in the distribution of misleading and potentially dangerous information to the public. The procedure, described in the media and during congressional debate, was developed by the late Dr. James T. McMahon. In testimony before Congress last June, Dr. McMahon incorrectly stated that the fetus dies from the anesthesia administered to the mother.

According to the president of the American Society of Anesthesiologists (ASA), Dr. Norig Ellison, the anesthesia administered to the mother in connection with such a procedure does not kill the fetus. Very little anesthesia crosses the placenta when general anesthesia is administered to the mother, and many pregnant women are safely anesthetized every day without ill effects to the fetus.

ASA is concerned that because of publicity given to Dr. McMahon's erroneous testimony, pregnant women may delay necessary and perhaps lifesaving medical procedures due to misinformation regarding the effect of anesthetics on the fetus.

Of course, if a baby really were dead, HR 1833 would not apply, since the definition of "partial-birth abortion" is "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus..."

The cruelty of this treatment of the human fetus is quite evident to those who do not avert their gaze or close their minds. But these abortion procedures also carry with them significant risks to maternal health.

Partial-birth abortion is not a standard of care for anything.

In fact, partial-birth abortion 'is a perversion of a well-known technique used by obstetricians to deliver breech babies when the

11/17/95 CONGTMY (No Page)

intent is to deliver the child alive. However, as the enclosed references in Williams Obstetrics readily document, this technique is rarely used in this country because of the well known associated risks of maternal hemorrhage and uterine rupture. The 19th edition of Williams Obstetrics states the following in regards to the safety of this method of breech delivery:

"Despite numerous attempts to defend or condemn this procedure, there is presently insufficient evidence to document its safety.

There are few, if any indications for internal podalic version other than the delivery of a second twin. The possibility of serious trauma to the fetus and the mother during internal podalic version of a cephalic presentation is apparent. . ."

Why would a procedure that is considered to impose a significant risk to maternal health when it is used to deliver a baby alive, suddenly become the "safe method of choice" when the goal is to kill the baby? And if abortion providers wanted to demonstrate that somehow this procedure would be safe in late-pregnancy abortions, even though its use has routinely been discouraged in modern obstetrics, why didn't they go before institutional review boards, obtain consent to perform what amounts to human experimentation, and conduct adequately controlled, approximately supervised studies that would insure accurate, informed consent of patients and the production of valid scientific information for the medical community?

It is also noteworthy that even leading authorities on late-term abortion methodology have expressed the gravest reservations regarding this technique. Consider, for example, this excerpt from an article in the November 20 edition of American Medical News, the official newspaper of the American Medical Association.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD, the author of Abortion Practice, the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures. [O]f the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure.

But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant woman and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned about causing

11/17/95 CONGTMY (No Page)

amniotic fluid embolism or placental abruption if you do that."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

The behavior of the abortion industry in regards to this current controversy is chillingly reminiscent of the Tuskegee syphilis experiment conducted by medical and public health personnel over two decades ago. In this infamous study, poor black men were deceived and lied to and a known lifesaving treatment option was withheld so that the researchers could follow the "natural course" of the disease. Apparently some individuals in our country failed to learn a valuable lesson from this tragic chapter in our nation's recent history.

Pregnant women should not be experimented upon under the guise of a deceptive rubric called "choice."

Furthermore, since the partial-birth abortion procedure requires three days of forceful dilation of the cervix, the mother could develop cervical incompetence in subsequent pregnancies, resulting in spontaneous second trimester pregnancy losses and necessitating the placement of a cerclage (stitch around the bottom of the womb) to enable her to carry a baby to term. It is therefore a fact that this procedure represents a risk to future fertility of the patient. It does not represent the safest way for the patient to maintain her fertility, as abortion advocates proclaim.

Opponents of HR 1833 have also argued that "decreasing the size of the fetal head to allow delivery" is done to save the mother the risk of ripping and tearing" the bottom of her womb. But in fact, the standard of care for handling a baby who is breech with an entrapped head at the cervix is not partial-birth abortion. Cephalocentesis (drainage of fluid from the head of a hydrocephalic fetus) frequently results in the birth of a living child. Relaxing the uterus with anesthesia, cutting the cervix (Dührssen's incision), and Cesarean section are the recognized options in the medical community to deal with this obstetrical problem.

In short, there are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life or health of the mother.

Opponents of HR 1833 have similarly erroneously declared that the partial-birth abortion method is necessary to protect the "emotional health" of the mother. Certainly, I do not lightly dismiss the accounts of women and families who have experienced the anguish of

11/17/95 CONGTMY (No Page)

learning, late in pregnancy, that their babies have serious or even lethal disorders. In my own years of practice and training, I have taken care of many women who were carrying babies with fatal fetal anomalies. My most recent such patient was a 19-year-old female who was pregnant for the third time. Her previous two pregnancies were remarkable for severe nausea and vomiting, and she delivered two children who died before they were two months old secondary to heart abnormalities. With her current pregnancy the patient was weak, dehydrated, and emotionally torn between the desire to bear a child and the horrible prospect of attending another funeral. Our clinic staff, all of whom are pro-life, counseled her on her options, supported her medically in the hospital, and respected her initial decision to terminate her pregnancy. However, the next day, the patient's nausea and vomiting receded, she changed her mind, and now intends to carry the baby to term.

Which bring to mind another erroneous insinuation presented by opponents of HR 1833: the assertion that as soon as a patient is discovered to have a fetus with an anomaly, the pregnancy must be aborted immediately because the baby has a high chance of dying before labor begins, representing a threat to the life of the mother. Such a claim is deceptive. It is often 'intended to sell the patient on the abortion option.

First of all, it is not the standard of care to immediately terminate the life of a living fetus just because that baby has abnormalities. What is appropriate 'is to inform the patient of your clinical suspicions, discuss with her all of the options, as well as the risks associated with terminating her pregnancy prematurely, and then develop a plan of management that respects the patient's values and emotional needs. Many women opt to continue such pregnancies.

Although it is highly unlikely that the partial-birth abortion procedure would ever be needed to save a woman's life, HR 1833 specifically states that the procedure would be allowed if the doctor "reasonably believed" that it was necessary to save the mother's life, and that no other procedure would suffice. Abortion providers, however, are fully aware that a lot of other procedures would suffice --- but they are primarily interested in making sure that their job of terminating human life can be done according to their own convenience. With the partial-birth method of abortion, the provider is saved the trouble of assembling "baby parts" to make sure that nothing was left inside.

Earlier this year, the late Dr. James McMahon provided to the House Judiciary subcommittee a list of a self-selected sample of 175 cases in which he utilized the partial-birth procedure for so-called "maternal indications. "Of this list, one-third (33%) of the time the partial-birth procedure would be more appropriately classified as a

11/17/95 CONGTMY (No Page)

contraindication, because the mother already had medical problems that are associated with excessive bleeding, infection or a need to be delivered quickly. These conditions include eclampsia, abruptio placenta, amnionitis, premature rupture of membranes, incompetent cervix, and blood clotting abnormalities.

In addition, another 22% (39 cases) were for maternal "depression," and 16% for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, small pelvis).

Opponents of HR 1833 have also asserted that the term "elective" means that the doctor elects to do this procedure rather than to do some other one. I would invite any individual in this country to ask their doctor what the term "elective surgery" means. Or look the word up in the dictionary. It refers to procedures that are optional. In a tape-recorded 1993 interview with American Medical News, Dr. Martin Haskell explicitly distinguished between the 20 percent of his "extraction" procedures (as he calls them) that he said involved fetuses with genetic problems, and the 80 percent that are, in his words, "purely elective."

HR 1833 has already been immensely useful in educating the American public as to the need to keep a watchful eye, in the interest of maternal well being, on the activities of the abortion industry. Enactment of this legislation is needed both to protect human offspring from being subjected to a brutal procedure, and to safeguard the health of pregnant women in America.

---- INDEX REFERENCES ----

ORGANIZATION: DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, MT. SINAI HOSPITAL

NEWS CATEGORY: TESTIMONY

Word Count: 2626

11/17/95 CONGTMY (No Page)

END OF DOCUMENT

of her living baby and drag it down into

and into the vagina.

The baby is then delivered up to the level of the after-coming head, before grasping the baby's chest and stabilizing the skull. The base of the skull is then punctured with a sharp instrument, and a suction instrument is then used to place into the hold after it has been enlarged. The brain contents are then sucked out, thereby killing the fetus and collapsing the skull, allowing the infant to thereby deliver.

This procedure involves several techniques which are concerning to me, the first of which is the forceful placement of multiple dilators into the cervix, leading to potential cervical complications.

We have already heard from women who have undergone this procedure, who have been subsequently unable to carry pregnancies to term thereafter, possibly secondary to weakening of their cervix from this very procedure. They have also described immediate risk, such as bleeding and delayed risk, such as infection.

Finally, it also involves internally rotating the baby within the uterus to a feet-first position before forcibly drawing it through the cervix and into the vagina. This technique called internal podalic version has been largely abandoned in modern obstetrics.

We know the procedure of partial-birth abortion occurs predominantly in the fifth and sixth months of pregnancy and is performed mostly on healthy mothers carrying healthy babies.

This data has been confirmed by independent investigative journalists at the Washington Post, the New Jersey Bergen Record, and the American Medical News, and was included in an article I co-wrote for the Wall Street Journal.

It is also consistent with the acknowledgements of Dr. Haskell and the physicians at the New Jersey clinic in a submitted data to this committee by Dr. McMahon.

Even in the less common situation of an abnormal pregnancy, I know of no data to suppose this technique as any better than existing techniques for delivering infants.

I have personally cared for many women with the exact same diagnoses as the women who have already testified in front of this committee about their need for partial-birth abortion because of their unusual circumstances. I have never required this technique to care for any patients with the same diagnoses and have always been able to deliver them by alternative techniques. None of these women have suffered adverse health consequences of impaired fertility as a result of these deliveries. Therefore, I know of no reason why partial-birth abortion is ever a medical necessity.

In summary, I would state that partial-birth abortion is an unnecessary, unsteady, and potentially dangerous procedure which should be banned since safe alternatives are in existence that already protect the health and future fertility of women.

I thank you for your invitation, and I am willing to answer any questions you may have.

[The prepared statement of Dr. Curtis Cook follows.]

PREPARED STATEMENT OF CURTIS COOK

My name is Dr. Curtis Cook, I am a board-certified Obstetrician/Gynecologist and a subspecialist in Maternal-Fetal Medicine (also known as Perinatology or High Risk Obstetrics). In my practice I take care of referred complicated pregnancies be-

cause of pre-existing chronic medical conditions of the mother, or suspected abnormalities in the baby. I am also the Associate Director of our region's Maternal-Fetal Medicine division and also serve as Assistant Residency Director for our Obstetric and Gynecology training program. I am an Assistant Clinical Professor at Michigan State University College of Human Medicine, and a member of the American College of OB/GYN, The Society of Perinatal Obstetricians, The American Medical Association, and the Association of Professors of Gynecology and Obstetrics. I am a founding member of PHACT (Physicians Ad Hoc Coalition for Truth about Partial Birth Abortion), which I helped organize after hearing the appalling medical misinformation circulated in the media regarding this procedure. PHACT includes in its membership over 400 physicians from Obstetrics, Maternal-Fetal Medicine and Pediatrics. Many of these physicians are educators or heads of departments, and also include the former Surgeon General C. Everett Koop. All that is required of a physician for membership is an interest in maternal and child health, and a desire to educate the population on this single issue.

I must begin my statement by defining partial birth abortion as the feet first delivery of a living infant up to the level of its aftercoming head, before puncturing the base of its skull with a sharp instrument and sucking out the brain contents, thereby killing it and allowing the collapse of its skull and subsequent delivery. This description is based upon the technique of Dr. Haskell of Ohio, who has subsequently identified it as accurate. He has referred to his technique as "D&X" (Dilation and Extraction), while Dr. McMahon of California refers to it as an "intact D&E." An ACOG ad hoc committee came up with the hybrid term "intact D&X". As you can see, many terms are used and are not clear in their description.

Partial birth abortion is mostly performed in the fifth and sixth months of pregnancy. However, these procedures have been performed up to the ninth month of pregnancy. The majority of patients undergoing this procedure do not have significant medical problems. In Dr. McMahon's series, less than ten percent were performed for maternal indications, and these included some ill-defined reasons such as depression, hyperemesis, drug exposed spouse, and youth. Many of the patients undergoing partial birth abortion are not even carrying babies with abnormalities. In Dr. McMahon's series, only about half of the babies were considered "flawed", and these included some easily correctable conditions like cleft lip and ventricular septal defect. Dr. Haskell claimed that eighty percent of his procedures were purely elective, and a group of New Jersey physicians claimed that only a minuscule amount of their procedures were done for genetic abnormalities or other defects. Most were performed on woman of lower age, education, or socioeconomic status who either delayed or discovered late their unwanted pregnancies. It is also clear that this procedure occurs thousands of times a year, rather than a few hundred times a year, as claimed by pro-abortion advocates. This has been independently confirmed by the investigative work of *The Washington Post*, *The New Jersey Bergen Record*, and the *American Medical Association News*.

One of the often ignored aspects of this procedure is that it requires three days to accomplish. Before performing the actual delivery, there is a two day period of cervical dilation that involves forcing up to twenty five dilators into the cervix at one time. This can cause great cramping and nausea for the women, who are then sent to their home or to a hotel room overnight while their cervix dilates. After returning to the clinic, their bag of water is broken, the baby is forced into a feet first position by grasping the legs and pulling it down through the cervix and into the vagina. This form of internal rotation, or version, is a technique largely abandoned in modern obstetrics because of the unacceptable risk associated with it. These techniques place the women at greater risk for both immediate (bleeding) and delayed (infection) complications. In fact, there may also be longer repercussions of cervical manipulation leading to an inherent weakness of the cervix and the inability to carry pregnancies to term. We have already seen women who have had trouble maintaining pregnancies after undergoing a partial birth abortion.

There is no record of these procedures in any medical text, journals, or on-line medical service. There is no known quality assurance, credentialing, or other standard assessment usually associated with newly-described surgical techniques. Neither the CDC nor the Alan Guttmacher Institute have any data on partial birth abortion, and certainly no basis upon which to state the claim that it is a safer or even a preferred procedure.

The bigger question then remains: Why ever do a partial birth abortion? There are and always have been safer techniques for partial birth abortion since it was first described by Dr. McMahon in 1989 and Dr. Haskell in 1992. The usual and customary (and previously studied) method of delivery at this gestation is the medical induction of labor using either intravaginal or intramuscular medications to cause contractions and expulsion of the baby. This takes about twelve hours on av-

erage, and may also include possible cervical preparation with the use of one to three cervical dilators (as opposed to the three-day partial birth abortion procedure, with up to 25 dilators in the cervix at one time). This also results in an intact baby for pathologic evaluation, without involving the other risk of internally turning the baby or forcing a large number of dilators into the cervix. The only possible "advantage" of partial birth abortion, if you can call it that, is that it guarantees a dead baby at time of delivery.

The less common situation of partial birth abortion involving an abnormal baby. These conditions do not threaten a woman over and above a normal pregnancy, and do not require the killing of the baby to preserve her health or future fertility. I have taken care of many such women with the same diagnoses as the women who provided testimony on this issue in the past. Each of these women stated that they needed to have partial birth abortion performed in order to protect their health or future fertility. In these cases of trisomy (extra chromosomal material), hydrocephaly (water on the brain), polyhydramnios (too much amniotic fluid) and arthrogryposis (stiffened baby), there are alternatives to partial birth abortion that do not threaten a woman's ability to bear children in the future. I have personally cared for many cases of all of these disorders, and have never required any technique like partial birth abortion in order to accomplish delivery. Additionally, I have never had a colleague that I have known to have used the technique of partial birth abortion in order to accomplish delivery in this same group of patients. Moreover, there are high profile providers of third trimester abortions who likewise do not use the technique of partial birth abortion.

In the even rarer case of a severe maternal medical condition requiring early delivery, partial birth abortion is not preferred, and medical induction suffices without threatening future fertility. Again, the killing of the fetus is not required, only separation from the mother.

Finally, I wish to address the fetal pain issue, since it has been claimed that a fetus feels no pain at these gestational ages. This is about as ridiculous as the earlier claim that the anesthesia of partial birth abortion put the baby into a medical coma and killed it prior to the performance of the suctioning technique. This was no small claim to the many pregnant women undergoing non-obstetric surgery every day in this country. Fortunately, this was soundly denounced by both the American Society of Anesthesiologists and the Society of Obstetrical Anesthesia and Perinatology. In the course of my practice, we must occasionally perform life-saving procedures on babies while still in the uterus. I have often observed babies of five to six months gestation withdraw from needles and instruments, much like a pain response. Dr. Fisk in England has recently reported an increase in fetal pain response hormones during the course of these procedures at these same gestational ages. In addition, we frequently observe the standard grimaces and withdrawals of neonates born at six months gestational like any other pain response in a more mature infant.

While it is not my desire for legislators to enter into the realm of medical policy making, there are times when the public health risk needs to be addressed if the medical community is either unwilling or unable to address it. We have seen this precedent for female circumcision and forty-eight hour postpartum stays. I believe the unnecessary, unstudied, and potentially dangerous procedure of partial birth abortion is unworthy of continuance in modern obstetrics. It neither protects the life, the health or the future fertility of women, and certainly does not benefit the baby. For these reasons, I urge you to support the ban on partial birth abortion.

I thank you for the opportunity to share my testimony and my concern for the women and children of this country.

The CHAIRMAN. Thank you, Doctor Cook.

Ms. Sullivan, we will turn to you.

STATEMENT OF EILEEN SULLIVAN

Ms. SULLIVAN. Thank you very much, gentlemen, for proceeding.

I need to preface my statement if I can with the fact that I apologize and I beg your patience. This is a very recent thing for me. I had hoped at this time to be home with my 3-month-old son, instead of here in front of you gentlemen. So I hope—I ask for your indulgence and your patience.

My name is Eileen Sullivan, and I thank you, first, for continuing and then allowing me the opportunity to testify.

Citation	Search Result	Rank 1 of 1	Database
11/17/95 CONGIMY (No Page)			CONGIMY
11/17/95 Cong. Testimony (Pg. Unavail. Online)			
1995 WL 12715919			

Congressional Testimony
Copyright 1995 by Federal Document Clearing House, Inc.

Friday, November 17, 1995

PARTIAL BIRTH ABORTION BAN
NANCY ROMER

NANCY G. ROMER, M.D.
1126 South Main Street
Dayton, Ohio 45409
Telephone 222-0297

Testimony of Nancy G. Romer, M.D., F.A.C.O.G. on House Resolution 183 to the United States Senate Committee on the Judiciary.

Members of the Committee,

My name is **Nancy Romer** and for the past nine years I have been a practicing obstetrician and gynecologist in Dayton, Ohio. I am a diplomat of the American Board of Obstetrics & Gynecology, and a Fellow of the American College of Obstetrics & Gynecology. I am a clinical professor in the Dept. of Obstetrics & Gynecology at Wright State University School of Medicine, and vice-chairman of the Dept. of Obstetrics & Gynecology of Miami Valley Hospital both in Dayton. As a physician practicing in Dayton for over nine years, I feel qualified to testify in regards to the D&X procedure, since one of only two clinics in the country performing this procedure routinely is operating in Dayton. I thank the committee for the opportunity to speak before you in regards to this important legislation.

An objection has been made to calling this procedure partial birth abortion and I agree that there is no mention of this procedure in any medical text or literature. In fact there is no mention of this procedure under any name in any medical text or medical journal. The procedure was first described by Dr. Martin Haskell at The National Abortion Federation Risk Management Seminar in September of 1992. He refers to it as a D&X procedure, for dilatation and extraction, as opposed to the more common second trimester procedure D&E, or dilatation and evacuation. In both procedures the cervix or opening to the uterus is progressively dilated over two or three days with the use of a seaweed substance called laminaria. The cervix is given a local anesthetic during this process. The difference in the two procedures is in the method of removal of the fetus. With a D&E a forceps and curette are used to dismember the fetus and allow removal

11/17/95 CONGTMY (No Page)

of all the parts. In the D&X an ultrasound is used to identify the feet and legs of the fetus which are then grasped with a forceps and delivered into the vagina. With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, then the shoulders and the upper extremities. The skull lodges at the cervix and the fetus is oriented spine up. At this point, the surgeon slides his fingers along the back of the fetus and hooks the shoulders of the fetus with the index and ring fingers.

While maintaining tension, the surgeon takes a pair of blunt curved scissors and advances the tip along the spine until he feels it contact the base of the skull. The surgeon then forces the scissors into the base of the skull. Having entered the skull, he spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the brain. With the suction catheter still in place he applies traction to the fetus, removing it completely from the patient.

Dr. Haskell has never published any data with regards to indications, outcomes, complications, or number of procedures. This is clearly not the standard manner that new procedures are evaluated by the medical community. For example, in a communication from the American College of Obstetrics & Gynecology that I received this week the college discusses a new method of first trimester medical abortion. They review three studies of this method done at New York's Mt. Sinai Hospital, the University of Rochester, and the University of Pittsburgh. All three studies were published in peer review medical journals: The New England Journal of Medicine, The Archives of Family Medicine, and JAMA. ACOG however, felt this data was insufficient to recommend widespread usage and urged physician's to wait for more studies before undertaking similar procedures. The D&X procedure has not been subject to this same rigorous scientific review. There is simply no data anywhere in the medical literature in regards to the safety and efficacy of this procedure. We have only the description by Dr. Haskell and his statement that he has done "over 700 procedures with a low rate of complications." Since these procedures are currently being done in an outpatient clinic there is no ongoing peer review of either the procedure or the physician performing it. Complication rates are difficult to assess since any complications are dealt with in more than six local hospitals. Dr. Haskell has no admitting privileges at any of these institutions and his complications are cared for by the most available physician at the time. As a result there is only anecdotal evidence of complications. The one sure thing about this procedure is that is that it does not risk a live birth. In an interview with the Dayton Daily News Dec. 9, 1989 Dr. Haskell stated "It (live births) may happen with other people. It doesn't happen with my technique."

It has also been claimed that the majority of these procedures

11/17/95 CONGTMY (No Page)

are performed for patients facing serious, rare, life-threatening medical conditions and enacting this bill would endanger the lives of women. No one would put the lives of women in danger least of all myself. I take my Hippocratic oath seriously, and I would be opposed to legislation that made second trimester abortion totally unavailable to women in life threatening situations. However, I have been practicing obstetrics for 13 years, 4 as a resident and 9 in private practice, and have never felt compelled to recommend this procedure to save a woman's life. In fact if a woman has a serious, life threatening, medical condition this procedure has a significant disadvantage in that it takes three days. Currently, these procedures are being performed in an outpatient clinic by a physician who is trained as a family practitioner with only four months of obstetric training. A critically ill patient should be treated in a high risk obstetrical center with medical support and under the care of an obstetrician with consultation from maternal fetal medicine specialists. The hospital where I am vice-chair and have spent most of my professional career does over 5,000 deliveries a year and has an active high risk service with two maternal fetal medicine specialists. The physicians at this hospital have never found it necessary to perform this procedure to save the life of a woman, and have found alternatives that we feel are equally efficacious and safe. What is necessary in these cases is not the death of the fetus but the delivery of the fetus from the mother. One week ago a mother with a life threatening illness was treated in our hospital at 26 weeks gestation. She was delivered of the infant who was then cared for in our neonatal intensive care unit. The D&X procedure was not used.

It is also claimed that the majority of these procedures are to deliver horribly malformed fetuses. In my practice I encourage my patients at risk for genetic defects to obtain genetic testing early. Both the emotional decision to terminate a pregnancy and the physical procedure are difficult after 20 weeks and I explain to my patients that acting early makes the decision process less difficult. With current technology, amniocentesis testing for women at risk can be performed as early as 14 weeks. We routinely receive results in 10 to 14 days allowing parents to make the decision for termination will before 20 weeks. Low risk mothers can have alpha fetoprotein testing starting at 16 weeks. This test screens for women at risk for having a fetus with Down's syndrome and neural tube defects such as anencephaly, where the brain is outside the body, and spina bifida, which is a defect in the spine. Again these results are obtained by 18 weeks and obviates the need for abortion past 22 weeks. Thus the need for termination beyond 20 weeks should be a rare event. Even when there is a delay in diagnosis and, subsequently, the decision to terminate, there are safe alternatives. If this procedure offered significant advantages over other termination procedures, and if there were no safe alternatives, there would be more physicians performing it. Instead there are only two clinics to my knowledge performing

11/17/95 CONGTMY (No Page)

this procedure on a routine basis.

You recently heard a litany of tragic stories of women who were in desperate need of this procedure for either fetal or maternal reasons. Unfortunately, patient confidentiality prevents me from reciting a similar litany of patients seeking terminations with healthy fetuses. The reality is that most of these abortions are not being done in rare and tragic circumstances. In an interview in the AMA News in July of 1993 Dr. Haskell stated that the majority of his abortions were elective. My experience with patients in my practice reflects a similar trend. In 13 years of obstetrical practice I have never felt the need to refer a patient for the D&X procedure. Instead I know of three patients who have sought pregnancy termination beyond 20 weeks at the Women's Health Center in Dayton. All three were in emotional crisis pregnancies. However, none of them had a medical complication of their pregnancy, and all had normal fetuses. They sought terminations electively for social reasons. Their pregnancies were all terminated but their social situations remain unchanged. Two of these women remain patients of mine.

It has been noted that this is often the safest procedure for many women seeking late term abortions. The medical reality is more complex. Late term abortion by any method is difficult. The uterus is unresponsive to most labor induction agents and the cervix is difficult to dilate. The fetus can weigh from under a pound to several pounds. All of these conditions make late term abortion technically difficult. I often deal with fetal death during the second trimester and use prostaglandin to effect removal. It can often take up to three days and even when the mother is given adequate pain medication can be emotionally traumatic. The nurses in our hospital find it such a difficult task providing emotional and medical support to these patients, that they rotate this duty. I felt that perhaps I could learn something from techniques of late term abortion. In my research and in talking with physicians who perform late term abortions I found nothing preferable and safer than what I currently do. In fact when reading the description of the D&X procedure I found several things that made this procedure very unattractive. Laminaria are used to dilate the cervix over several days. I quit using laminaria several years ago with the availability of prostaglandin because in my opinion laminaria are not less painful than prostaglandin. In the description of the D&X procedure only a paracervical block is used which is the equivalent to a local anesthetic. The patients are given no intravenous sedation and clearly are not completely anesthetized. In my medical judgment this procedure offers no advantage in safety nor efficacy over other methods of termination.

The American College of Obstetrics & Gynecology had been noted to be opposed to legislation prohibiting the D&X procedure. I find

11/17/95 CONGTMY (No Page)

that rather confusing because the manner in which it is currently being performed does not meet its standards on abortion. In The Standards of Obstetric and Gynecologic Services published by ACOG in 1989 under the heading of abortion it states "Generally, abortions in the physician's office or outpatient clinic should be limited to those performed within 14 weeks from the first day of the last menstrual period. In a hospital-based or free-standing surgical facility, abortions should generally be limited to those performed within 18 weeks from the last menstrual period. In a hospital-based facility where surgical, recovery, and emergency response capabilities are comprehensive, however, abortions may be performed beyond this time." Currently, these procedures are taking place up to 24 weeks gestation in an outpatient clinic without comprehensive capabilities.

In summary, in my medical judgment, legislation to prohibit the D&X procedure or partial birth abortion does not present a substantial barrier to women seeking late term abortion. There is no medical evidence that this procedure is safer nor necessary to provide comprehensive health care to women. As currently practiced, it does not meet medical standards set by ACOG nor has it been adequately proven to be safe nor efficacious. It currently is used in my community not for treatment of rare and tragic pregnancies, but rather for termination of otherwise, normal healthy fetuses.

I thank the members of the committee for their time and attention.

Nancy G. Romer, M.D.

November 14, 1995

---- INDEX REFERENCES ----

ORGANIZATION: DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
NEWS CATEGORY: TESTIMONY

Word Count: 2110
11/17/95 CONGTMY (No Page)
END OF DOCUMENT

NANCY G. ROMER, M.D.
1126 South Main Street
Dayton, Ohio 45409
Telephone 222-0297

Douglas Johnson
National Right to Life

May 28, 1996

Dear Mr. Johnson,

This is in reference to our conversation in regards to the 60 Minutes program on late term abortions. Lisa Binns of 60 Minutes called me on Friday April 26 and we spoke for approximately 45 minutes. I made several points in regard to late term abortions:

1. A handicapped fetus is not a threat to the mother's life. Ms. Binns suggested that a fetus with anencephaly has a higher risk of intrauterine death and this presents a risk to the mother. I told her that intrauterine fetal death under any circumstances is not a medical emergency and can be treated in a few days. Once the fetus dies partial birth abortion ban does not apply.
2. If a mother has a serious medical condition what is required is separation of the fetus from the mother not fetal death. This can be accomplished in several ways, either through induction of labor or cesarean section.
3. There are safe alternatives to partial birth abortion. I FAXed her a copy of Dr. Warren Hearn's article where he described his method of second trimester terminations. He injects the fetal heart with digoxin on day two to allow fetal death. On day three he documents fetal death and again now that the fetus is dead the law no longer applies. I can fax this article to you if you do not have it.

While I was out of the country May 1-10 Ms. Binns called to speak to me. I returned her call on May 14. She said she had a quick question. "Do you personally know of any physicians who would electively terminate a healthy fetus in a healthy mother past viability." I answered yes that I personally had a patient that Dr. Haskell had done an abortion on at 26 weeks. She argued that was not really-viable and we debated viability. She then asked "Do you personally know of any physician who terminated a healthy fetus in a healthy mother at term?" I said Dr. McMahon had reported terminating babies with cleft lip and cleft palate. She suggested these were not healthy. I said they were not PERFECT but arguably healthy. Then I said " So what your asking is do I personally know of

any physician who has terminated a PERFECT baby in a PERFECT mother at term? The answer is no."

I hope this is of some help to you and apologize for taking so long to respond. If I can be of further help or answer any questions please don't hesitate to call.

Sincerely,



Nancy G. Romer, M.D.

A Member of The Mount Sinai Health System
 An Affiliate of
 The Jewish Population of Metropolitan Chicago
 An Affiliate of
 The Mount Sinai Hospital & Care Network
 An Affiliate of
 University of Health Sciences The Chicago Medical School



California Avenue at 15th Street
 Chicago, Illinois 60608-1797
 (312) 542-2000
 T.D.D. # 312-542-0040

October 28, 1995

The Honorable Charles Canady
 Chairman, Subcommittee on the Constitution
 House Committee on the Judiciary
 1222 Longworth House Office Building
 Washington, D.C. 20515

Dear Congressman Canady:

It has recently been brought to my attention that opponents of HR 1833 have stated that this particular abortion technique should maintain its legality because it is sometimes employed by physicians in the interest of maternal health. Such an assertion not only runs contrary to facts but ignores the reality of the risks to maternal health that are associated with this procedure which include the following:

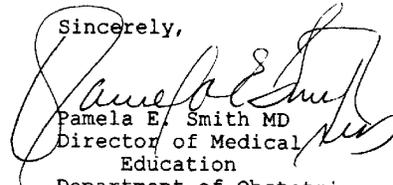
1. Since the procedure entails 3 days of forceful dilatation of the cervix the mother could develop cervical incompetence in subsequent pregnancies resulting in spontaneous second trimester pregnancy losses and necessitating the placement of a cerclage (stitch around the cervix) to enable her to carry a fetus to term.
2. **Uterine rupture is a well known complication associated with this procedure.** In fact, partial birth abortion is a "variant" of internal podalic version...a technique sometimes used by obstetricians in this country with the intent of delivering a live child. However, internal podalic version, in this country, has been gradually replaced by Cesarean section in the interest of maternal as well as fetal well being (see excerpts from the standard text Williams Obstetrics pages 520, 521, 865 and 866).

Furthermore, obstetrical emergencies (such as entrapment of the head of a hydrocephalic fetus or of a footling breech that has partially delivered on its own) are never handled by employing this abortion technique. Cephalocentesis, (drainage of fluid from the head of a hydrocephalic fetus) frequently results in the birth of a living child. Relaxing

the uterus with anesthesia, cutting the cervix (Dührssen's incision) and Cesarean section are the standard of care for a normal, head entrapped breech fetus.

There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the health of the mother. Partial birth abortion is a technique devised by abortionists for their own convenience...ignoring the known health risks to the mother. The health status of women in this country will thereby only be enhanced by the banning of this procedure.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela E. Smith". The signature is written in dark ink and is positioned above the typed name and title.

Pamela E. Smith MD
Director of Medical
Education
Department of Obstetrics
and Gynecology
Mt. Sinai Hospital
Chicago, Illinois

The New York Times, Thursday, September 26, 1996, A27

Why Defend Partial-Birth Abortion?

By C. Everett Koop

THANOVER, N.H. The debate in Congress about the procedure known as partial-birth abortion reveals deep national uneasiness about abortion 23 years after the Supreme Court legalized it. As usual, each side in the debate shades the statistics and distorts the facts. But in this case, it is the abortion-rights advocates who seem inflexible and rigid.

The Senate is expected to vote today on whether to join the House in overriding President Clinton's veto of a bill last April banning partial-birth abortion. In this procedure, a doctor pulls out the baby's feet first, until the baby's head is lodged in the birth canal. Then, the doctor forces scissors through the base of the baby's skull, suctions out the brain, and crushes the skull to make extraction easier. Even some pro-choice advocates wince at this, as when Senator Daniel Patrick Moynihan termed it "close to infanticide."

The anti-abortion forces often imply that this procedure is usually

Pro-choicers twist the medical facts.

performed late in the third trimester on fully developed babies. Actually, most partial-birth abortions are performed late in the second trimester, around 26 weeks. Some of these would be viable babies.

But the misinformation campaign conducted by the advocates of partial-

birth abortion is much more misleading. At first, abortion-rights activists claimed this procedure hardly ever took place. When pressed for figures, several pro-abortion groups came up with 500 a year, but later investigations revealed that in New Jersey alone 1,500 partial-birth abortions are performed each year. Obviously, the national annual figure is much higher.

The primary reason given for this procedure — that it is often medically necessary to save the mother's life — is a false claim, though many people, including President Clinton, were misled into believing this. With all that modern medicine has to offer, partial-birth abortions are not needed to save the life of the mother, and the procedure's impact on a woman's cervix can put future pregnancies at risk. Recent reports have concluded that a majority of partial-birth abortions are elective, involving a healthy woman and normal fetus.

I'll admit to a personal bias: In my 30 years as a pediatric surgeon, I operated on newborns as tiny as some of these aborted babies, and we corrected congenital defects so they could live long and productive lives.

In their strident effort to protect partial-birth abortion, the pro-choice people remind me of the gun lobby. The gun lobby is so afraid of any effort to limit any guns that it opposes even a ban on assault weapons, though most gun owners think such a ban is justified.

In the same way, the pro-abortion people are so afraid of any limit on abortion that they have twisted the truth to protect partial-birth abortion, even though many pro-choice Americans find it reasonable to ban the procedure. Neither AK-47's nor partial-birth abortions have a place in civil society.

Both sides in the controversy need to straighten out their stance. The pro-life forces have done little to help prevent unwanted pregnancies, even though that is why most abortions are performed. They have also done little to provide for pregnant women in need.

On the other side, the pro-choice forces talk about medical necessity and under-represent abortion's prevalence: each year about 1.5 million babies have been aborted, very few of them for "medical necessity." The current and necessarily graphic debate about partial-birth abortion should remind all of us that what some call a choice, others call a child.

C. Everett Koop was Surgeon General from 1981 to 1989.

Partial-Birth Abortion Is Bad Medicine

By NANCY ROMER, PAMELA SMITH, CURTIS R. COOK AND JOSEPH L. DECOOK
The House of Representatives will vote in the next few days on whether to override President Clinton's veto of the Partial Birth Abortion Ban Act. The debate on the subject has been noisy and rancorous. You've heard from the activists. You've heard from the politicians. Now may we speak?

We are the physicians who, on a daily basis, treat pregnant women and their babies. And we can no longer remain silent while abortion activists, the media and even the president of the United States continue to repeat false medical claims about partial-birth abortion. The appalling lack of medical credibility on the side of those defending this procedure has forced us—for the first time in our professional careers—to leave the sidelines in order to provide some sorely needed facts in a debate that has been dominated by anecdote, emotion and media stunts.

Since the debate on this issue began, those whose real agenda is to keep all types of abortion legal—at any stage of pregnancy, for any reason—have waged what can only be called an orchestrated misinformation campaign.

First the National Abortion Federation and other pro-abortion groups claimed the procedure didn't exist. When a paper written by the doctor who invented the procedure was produced, abortion proponents changed their story, claiming the procedure was only done when a woman's life was in danger. Then the same doctor, the nation's main practitioner of the technique, was caught—on tape—admitting that 80% of his partial-birth abortions were "purely elective."

Then there was the anesthesia myth. The American public was told that it wasn't the abortion that killed the baby, but the anesthesia administered to the mother before the procedure. This claim was immediately and thoroughly denounced by the American Society of Anesthesiologists, which called the claim "entirely inaccurate." Yet Planned Parenthood and its allies continued to spread the myth, causing needless concern among

our pregnant patients who heard the claims and were terrified that epidurals during labor, or anesthesia during needed surgeries, would kill their babies.

The latest baseless statement was made by President Clinton himself when he said that if the mothers who opted for partial-birth abortions had delivered their children naturally, the women's bodies would have been "eviscerated" or "ripped to shreds" and they "could never have another baby."

That claim is totally and completely false. Contrary to what abortion activists would have us believe, partial-birth abortion is never medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility. It seems to have escaped anyone's attention that one of the five women who appeared at Mr. Clinton's veto ceremony had five miscarriages after her partial-birth abortion.

Consider the dangers inherent in partial-birth abortion, which usually occurs after the fifth month of pregnancy. A woman's cervix is forcibly dilated over several days, which risks creating an "incompetent cervix." The leading cause of premature deliveries. It is also an invitation to infection, a major cause of infertility. The abortionist then reaches into the womb to pull a child feet first out of the mother (internal podalic version), but leaves the head inside. Under normal circumstances, physicians avoid breech births whenever possible; in this case, the doctor intentionally causes one—and risks tearing the uterus in the process. He then forces scissors through the base of the baby's skull—which remains lodged just within the birth canal. This is a partially "blind" procedure, done by feel, risking direct scissor injury to the uterus and laceration of the cervix or lower uterine segment, resulting in immediate and massive bleeding and the threat of shock or even death to the mother.

None of this risk is ever necessary for any reason. We and many other doctors

across the U.S. regularly treat women whose unborn children suffer the same conditions as those cited by the women who appeared at Mr. Clinton's veto ceremony. Never is the partial-birth procedure necessary. Not for hydrocephaly (excessive cerebrospinal fluid in the head), not for polyhydramnios (an excess of amniotic fluid collecting in the women) and not for trisomy (genetic abnormalities characterized by an extra chromosome). Sometimes, as in the case of hydrocephaly, it is first necessary to drain some of the fluid from the baby's head. And in some cases, when vaginal delivery is not possible, a doctor performs a Caesarean section. But in no case is it necessary to partially deliver an infant through the vagina and then kill the infant.

How telling it is that although Mr. Clinton met with women who claimed to have needed partial-birth abortions on account of these conditions, he has flat-out refused to meet with women who delivered babies with these same conditions, with no damage whatsoever to their health or future fertility!

Former Surgeon General C. Everett Koop was recently asked whether he'd ever operated on children who had any of the disabilities described in this debate. Indeed he had. In fact, one of his patients—"with a huge omphalocele [a sac containing the baby's organs] much bigger than her head"—went on to become the head nurse in his intensive care unit many years later.

Mr. Koop's reaction to the president's veto? "I believe that Mr. Clinton was misled by his medical advisers on what is fact and what is fiction" on the matter, he said. Such a procedure, he added, cannot truthfully be called medically necessary for either the mother or—he scarcely need point out—for the baby.

Considering these medical realities, one can only conclude that the women who thought they underwent partial-birth abortions for "medical" reasons were tragically misled. And those who purport to speak for women don't seem to care.

So whom are you going to believe? The activist-extremists who refuse to allow a little truth to get in the way of their agenda? The politicians who benefit from the activists' political action committees? Or doctors who have the facts?

Dr. Romer is clinical professor of obstetrics and gynecology at Wright State University and chairman of obstetrics and gynecology at Miami Valley Hospital in Ohio. Dr. Smith is director of medical education in the department of obstetrics and gynecology at Chicago's Mt. Sinai Medical Center. Dr. Cook is a specialist in maternal fetal medicine at Butterworth Hospital, Michigan State College of Human Medicine. Dr. DeCook is a fellow of the American College of Obstetricians and Gynecologists. The authors are founding members of the Physicians' Ad Hoc Coalition for Truth, which now has more than 300 members.

Letter from: — Dr. James McMahon
CONGRESSIONAL TESTIMONY
H.R.: 1833
JUNE 23, 1995 — Submitted to Constitution Subcommittee

“induction” and “extraction”, but the basic and characterizing difference is the type of force employed.

An exhaustive discussion of these various approaches is beyond the scope of this submission and not pertinent to the proposed legislation. Intact D and E will be discussed in some detail.

INTACT D AND E (IDE)

In more than 20 years of clinical experience, I have found the intact D and E provides unique advantages and protects the woman from complications better than other methods in certain clinical scenarios. In 1983, I developed the surgical technique that makes possible the intact extraction of the fetus in advanced pregnancies. As you will see from the following testimony, it is certainly one of the safest approaches to the most difficult of abortions. Although IDE was first performed in 1983, it wasn't until 1989 that it was presented in Canada at an international risk management seminar. Experience suggests that it is safe and has special advantages over the classical methods.

D and E probably originates in the medical literature with Van De Venter in the 17th century where he describes it as a lifesaving procedure.

CERVICAL DILATION

To determine the diameter to which the cervical canal should be stretched, an ultrasound is used to measure the fetus. The largest diameter that cannot be reduced in size becomes the target to which the cervical canal must be dilated.

The next clinical problem is pace, that is, how quickly to dilate. Every cervix is different in terms of intrinsic elasticity. The surgeon must acquiesce to cervical authority and proceed at the pace it dictates. To do otherwise, is to risk exceeding the elastic limit, perhaps tearing the cervix, or threatening its competence. The goal is to preserve the cervix so that it can sustain future pregnancies

FETAL EXTRACTION

Once dilation is sufficient, the ultrasound is repeated. Dimensions are double checked. Fetal and placental position are determined.

The most typical lie and presentation are longitudinal with the head first. With the exception of anencephaly where the brain is missing, the cervical diameter is always

CONGRESSIONAL TESTIMONY

H.R.: 1833

JUNE 23, 1995

smaller than the head. Therefore, it must be reduced in size to accommodate intact passage. Using a needle similar to that used in a spinal tap, fluid is removed in sufficient quantity to allow a forceps to apply routine traction and rotation maneuvers bringing the head through the cervix and out.

MISCONCEPTIONS

The fetus feels no pain through the entire series of procedures. This is because the mother is given narcotic analgesia at a dose based upon her weight. The narcotic is passed, via the placenta, directly into the fetal bloodstream. Due to the enormous weight difference, a medical coma is induced in the fetus. There is a neurological fetal demise. There is never a live birth.

BENEFITS OF IDE

In the rare circumstance of a late pregnancy's needing to be aborted, the safest surgical alternative should be used. In my clinical opinion and experience, this has been shown to be IDE. (See appendix, figure 11).

The risk of abortion is based on geometry. Something large must pass through something small. Specifically, the fetus must be brought out through a small, very vascular canal. Also, in late pregnancy, the tissue integrity of the fetus is quite substantial compared to that of the cervix. This poses an increasing threat to the cervix as the gestation gets larger. In addition, as time passes, the cervix becomes softer and its blood supply increases rapidly. This makes for a daunting situation which repays the heavy handed surgeon with brisk bleeding. The seat of risk, therefore, are these two disparities - size and tissue constitution. Before any attempt is made to remove the pregnancy, the endocervical canal must be enlarged. The critical difference in this method is the specific goal of eliminating the size difference between the fetus and the canal by simply making the cervix larger and the fetus smaller. The main benefit is the extraction requires a minimum of force which translates into less trauma to the lower uterine segment. This approach, although tedious, is remarkably atraumatic. The average blood loss is 63 ccs, less than half of a cupful. (See appendix, figure 9.) If the IDE is removed from the therapeutic armamentarium of the surgeon, unnecessary complications will occur.

Furthermore, there are emotional benefits to the family. The fetus can be dressed, photographs taken, and taken to the family so that they can hold it and spend time together. Also, since there is no disruption, a careful autopsy can be performed and a

CONGRESSIONAL TESTIMONY

H.R.: 1833

JUNE 23, 1995

more precise diagnosis made. This is critical for the genetic counseling that is a very important part of these services. In vast majority of these families they are keenly interested in having more children. More specific prenatal care can be instituted and a more precise prenatal evaluation can be done with the next pregnancy.

SAFETY

In our series, since IDE was begun in 1983, there have been no deaths, no uterine perforations, and no hysterectomies. For the same period, there have been no major complications in any case of a gestation of less than 24 weeks.

In the 3rd trimester, the most rare and difficult of cases, there have occurred a total of only 5 major complications. (See appendix - figures 11 and 26.) This is a 1% complication rate. Nothing lower than this is reported in the scientific literature.

CHOICES

In the desired pregnancy, when the baby is damaged or the mother is at risk, the decision to abort may be intellectually obvious, but emotionally it is always a personal anguish of enormous proportions. It is not referred to nor is it thought of as a fetus. This is this mother's baby. Even though I have counseled parents for more 20 years, I only know that I cannot know. I cannot possibly know what this kind of choice is like.

For the physician who is willing to help the patient in this dilemma, choices are few. Intact D and E can often be the best among a short list of difficult options.

CONCLUSION

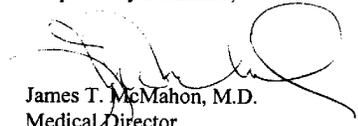
A woman late in pregnancy, i.e., beyond 18 weeks., who is considering the option of interrupting her pregnancy must analyze the options and the risks. The physician's primary duty is to educate her. The explanation must be complete, unbiased, and scientifically based. The atmosphere should be unhurried, non-judgmental, and respectful of her personal sovereignty.

Dealing with the tragic situations that I confront daily makes me constantly aware that I can only limit the hurt by doing gentle surgery and giving sympathetic counsel. Medical science cannot offer what is presently out of its reach and save this family's child. The best it can do is spare these families the worse alternative of continuing the pregnancy, which would only increase the risk and perpetuate the misery.

CONGRESSIONAL TESTIMONY
H.R.: 1833
JUNE 23, 1995

My colleagues and I are driven by our concern for the health and well-being of our patients. To be able to do our best for them, we must be unfettered and be allowed the professional freedom to offer the safest alternatives. This attempt by congress to micro-manage one of the most difficult and private problems that can befall any of us is folly of the highest order.

Respectfully submitted,



James T. McMahon, M.D.
Medical Director
Eve Surgical Centers

The Record

THURSDAY, FEBRUARY 27, 1997

ABORTION: Activists lied

Pro-choice advocates admit to deception

By RUTH PADAWER
Staff writer

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

Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, said he "lied" in a November 1996 interview for ABC's "Nightline," when he said the procedure was rare and done only when the mother or fetus was gravely ill. It was a line pushed by virtually all the top leadership of the pro-choice movement, and is still held as true by many pro-choice groups.

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

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

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

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

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

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

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

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

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

To counter that campaign, the National Abortion Federation — the leader in the fight against a ban — produced several women

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

who used the procedure to abort pregnancies terminated for medical reasons. Standing by Clinton as he vetoed the bill, they told anguishing tales that forced even some abortion foes to relent.

The deception came when pro-choice leaders claimed that these were the typical intact D&E cases. For example, a Planned Parenthood Federation of America 1996 release said the procedure is "done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality."

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

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

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

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

we do is honorable; it's for the health of women and society in general."

But the abortion federation and others were determined to stick with their original public claims. And when The Record and The Washington Post reported that the procedure was more common, and only rarely done for medical reasons, pro-choice leaders dismissed the stories. In November, the National Organization for Women issued a release saying such reports were "planted by abortion opponents," when in fact they were not; they were based on interviews with providers who used the procedure.

Nevertheless, groups such as the abortion federation continue with their claims. On its Web page on Wednesday, the group claims that "this particular procedure is used only in about 500 cases per year, generally after 50 weeks of pregnancy, and most often when there is a severe fetal anomaly or maternal health problem detected late in pregnancy." NOW's home page makes the same claim, failing to distinguish between 2nd and 3rd trimester, and saying that fewer than 600 intact D&Es are performed annually.

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

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

ON SOCIETY

BY JOHN LEO

The first crack in the wall

So Ron Fitzsimmons can't stand it anymore. He wants us to know that he can't live with the untruths he told for the abortion cause. He's the executive director of the National Coalition of Abortion Providers, now saying he "lied through my teeth" on *Nightline* in November '95, when he "just went out there and spouted the party line" about how partial-birth abortions are rare and confined to serious threats to mother and fetus.

Oddly, Fitzsimmons is expressing moral anguish over quotes that hadn't reached the American people—his *Nightline* lies wound up on the cutting-room floor. But his statement makes it clear that he is really troubled by his participation in the broader campaign of untruths by defenders of partial-birth abortion.

"When . . . the leaders of your movement appear before Congress and go on network news and say these procedures are done in only the most tragic of circumstances, how do you think it makes you feel?" he asks, then answers: "Like a dirty little abortionist with a dirty little secret."

Along the way, Fitzsimmons paid tribute to my good friend Richard Cohen, the *Washington Post* columnist who retracted a column broadly defending partial-birth abortion, writing that he was wrong to take at face value the misinformation supplied by abortion groups. This is an example of how one honest man, an abortion-rights supporter, encouraged honesty in another, thus providing the first crack in the stone wall of movement propaganda.

Brutal candor. Astonishingly, most of the misinformation was an attempt to deny facts already put on the record by the two doctors best known for performing partial-birth abortions: Dr. Martin Haskell, owner of two Ohio abortion clinics, and the late Dr. James McMahon of Los Angeles.

In the early days of the controversy, both spoke with almost brutal candor about what they were doing. Haskell provided a vivid and detailed description of the operation, which became the basis of the now famous drawings of a baby halfway down the birth canal being stabbed in the skull with surgical scissors. Haskell said these drawings were accurate "from a technical point of view." But they were later repeatedly attacked by abortion activists as misleading.

McMahon said he had moral compunctions about the operation and considered the fetus to be a child at 20 weeks. In papers given to Congress, he made clear that he performed partial-birth procedures during all 40 weeks of pregnancy for a long litany of reasons, including cleft lip, maternal de-

pression, and what he called "pediatric indications," which, he explained to a congressional aide, meant that the mother-to-be was very young. Haskell, too, acknowledged that most of his partial-birth abortions were elective and that he stopped doing them at about 25 weeks. In a taped interview, Haskell told the *American Medical News* that the fetus was usually alive when the stabbing and brain suction took place. (Q: Let's talk first about whether or not the fetus is dead beforehand. Haskell: No, it's not. No, it's really not.)

Then, McMahon died, Haskell went into seclusion, and the abortion activists circled the wagons. Though the McMahon-Haskell testimony showed a great many procedures done on healthy mothers with healthy fetuses, the chorus of

activists said otherwise. "It's not only a myth, it's a lie" that these abortions were done for minor defects such as cleft palates, said Kate Michelman of the National Abortion and Reproductive Rights Action League. Planned Parenthood said the procedure "is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." Michelman made similar statements over and over, and much of the media fell into line. National Public Radio announced, for instance, that "Doctors resort to this rare procedure only for late-term abortions if the fetuses have severe abnormalities and no chance of survival." All untrue and well known inside the movement.

Activists began to insist that the fetus can't feel pain because anesthesia kills it peacefully. (Anesthesia "causes fetal demise," said Michelman. "The fetus dies of an overdose of anesthesia given to the mother intravenously," said Planned Parenthood.) But the American Society of Anesthesiologists debunked this claim as "entirely inaccurate."

Standards dipped so low that doctors started to deny quotes that reporters had on tape. Dr. Warren Hern, a Colorado specialist in late abortions, told Diane Gianelli of *American Medical News* that he "would dispute that [partial-birth abortion] is the safest procedure to use." Then, he went on *60 Minutes* and vehemently denied the quote, though Gianelli has a tape. Another Gianelli article quoted Haskell saying that 80 percent of his partial-birth abortions are elective. He wrote a letter strongly implying he was misquoted, but again Gianelli had a tape showing that he wasn't.

Fitzsimmons is right to separate himself from all this. It's a dishonest campaign aimed at keeping the truth from the American people.



'It's a dishonest campaign aimed at keeping the truth from the American people.'

ILLUSTRATION BY HAL WATKIN FOR USNEWS

AMERICAN MEDICAL NEWS
Published by the AMA ↘

NEWS

Published by the American Medical Association 515 North Dearborn Street/Chicago, Illinois 60610(312) 464-5000
Barbara Boisen, Editor

July 11, 1995

The Hon. Charles T. Canady
Chairman, Subcommittee on the Constitution
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Bldg.
Washington, D.C. 20515-6216

Dear Representative Canady:

We have received your July 7 letter outlining allegations of inaccuracies in a July 5, 1993, story in American Medical News, "Shock-tactic ads target late-term abortion procedure."

You noted that in public testimony before your committee, AMNews is alleged to have quoted physicians out of context. You also noted that one such physician submitted testimony contending that AMNews misrepresented his statements. We appreciate your offer of the opportunity to respond to these accusations, which now are part of the permanent subcommittee record.

AMNews stands behind the accuracy of the report cited in the testimony. The report was complete, fair, and balanced. The comments and positions expressed by those interviewed and quoted were reported accurately and in context. The report was based on extensive research and interviews with experts on both sides of the abortion debate, including interviews with two physicians who perform the procedure in question.

We have full documentation of these interviews, including tape recordings and transcripts. Enclosed is a transcript of the contested quotes that relate to the allegations of inaccuracies made against AMNews.

Let me also note that in the two years since publication of our story, neither the organization nor the physician who complained about the report in testimony to your committee has contacted the reporter or any editor at AMNews to complain about it. AMNews has a longstanding reputation for balance, fairness and accuracy in reporting, including reporting on abortion, an issue that is as divisive within medicine as it is within society in general. We believe that the story in question comports entirely with that reputation.

Thank you for your letter and the opportunity to clarify this matter.

Respectfully yours,

Barbara Boisen
Barbara Boisen
Editor

Attachment

American Medical News transcript - page 1

Relevant portions of recorded interview with Martin Haskell, MD:

AMN: Let's talk first about whether or not the fetus is dead beforehand...

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

AMN: Is the skull procedure also done to make sure that the fetus is dead so you're not going to have the problem of a live birth?

Haskell: It's immaterial. If you can't get it out, you can't get it out.

AMN: I mean, you couldn't dilate further? Or is that riskier?

Haskell: Well, you could dilate further over a period of days.

AMN: Would that just make it... would it go from a 3-day procedure to a 4- or a 5-?

Haskell: Exactly. The point here is to effect a safe legal abortion. I mean, you could say the same thing about the D&E procedure. You know, why do you do the D&E procedure? Why do you crush the fetus up inside the womb? To kill it before you take it out?

Well, that happens, yes. But that's not why you do it. You do it to get it out. I could do the same thing with a D&E procedure. I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

AMN, wrapping up the interview: I wanted to make sure I have both you and (Dr.) McMahon saying 'No' then. That this is misinformation, these letters to the editor saying it's only done when the baby's already dead, in case of fetal demise and you have to do an autopsy. But some of them are saying they're getting that information from NAF. Have you talked to Barbara Radford or anyone over there? I called Barbara and she called back, but I haven't gotten back to her.

Haskell: Well, I had heard that they were giving that information, somebody over there might be giving information like that out. The people that staff the NAF office are not medical people. And many of them when I gave my paper, many of them came in, I learned later, to watch my paper because many of them have never seen an abortion performed of any kind.

AMN: Did you also show a video when you did that?

American Medical News transcript - page 2

Haskell: Yeah. I taped a procedure a couple of years ago, a very brief video, that simply showed the technique. The old story about a picture's worth a thousand words.

AMN: As National Right to Life will tell you.

Haskell: Afterwards they were just amazed. They just had no idea. And here they're rabid supporters of abortion. They work in the office there. And...some of them have never seen one performed...

Comments on elective vs. non-elective abortions:

Haskell: And I'll be quite frank: most of my abortions are elective in that 20-24 week range... In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective...

NEWS

AMERICAN MEDICAL ASSOCIATION

JULY 5, 1983

Shock-tactic ads target late-term abortion procedure

Do these drawings shock you?

We're sorry, but we think you should see the truth. Shock-tactic drawings were abortion techniques being used in procedures and their consequences.

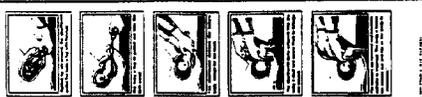
The abortion involves the body of the fetus and the woman's cervix. The fetus is removed... and is then shown step by step... by Dr. Martin Harkoff at St. Mary's Hospital, a center for abortion procedures.

Harkoff said he previously has done 700 of these "procedures."

Congress is considering the "Freedom of Choice Act" which would prohibit the practice of abortion at all stages... that apply from day one.

There is no "no. 1" way to do an abortion. But if you are particularly shocked by the drawings, you should contact your state's attorney general.

Write: American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.



These drawings help this and a similar law that would ban late-term abortion procedures.

By Dana M. Giannelli

WASHINGTON — In an attempt to detail an abortion rights bill maneuvering toward a congressional showdown, opponents have launched a full-scale campaign against late-term abortions.

The centerpiece of the effort are newspaper advertisements and brochures that graphically illustrate a technique used in some second- and third-trimester abortions. A handful of newspapers have printed the ads, and they are distributed to millions of the brochures, which were inserted into about a dozen other papers.

By depicting a procedure expected to make most readers squeamish, campaign sponsors hope to convince voters and elected officials that a proposed federal abortion-rights bill is so extreme that states would have no authority to limit abortions — even on potentially viable fetuses.

According to the Alan Guttmacher Institute, a research group affiliated with Planned Parenthood, the cost of the estimated 1.5 million advertisements alone each year are in the second and

third trimesters.

Barbara Radford of the National Abortion Federation denounced the ad campaign as disingenuous, saying its "real agenda is to outlaw virtually all abortions, not just late-term ones." But she acknowledged it is having an impact, reporting scores of calls from congressional staffers and others who have seen the ads and brochures, and are asking for more information about the procedure depicted.

The *Minneapolis Star-Tribune* ran the ad May 12, on its Minnesota Citizens Concerned for Life paid for it.

In a series of drawings, the ad illustrates a procedure called "dilation and extraction," or D&X, in which forceps are used to remove second- and third-trimester fetuses. The head remains inside the uterus.

The surgeon is then shown jam

ming scissors into the skull. The ad says this is done to create an opening large enough to insert a catheter that suction the brain, while at the same time making the skull small enough to pull through the cervix.

"Do these drawings shock you?" the ad reads. "We're sorry, but we think you should know the truth."

The ad depicts a Minnesota woman who described the procedure at a Sen. Robert Dole (R-Kan.) hearing in 1982.

It then states that the proposed "Freedom of Choice Act" now moving through Congress would "protect the practice of abortion at all stages and would lead to an increase in the use of this grisly procedure."

Accuracy questioned
Some abortion rights advocates have questioned the ad's accuracy. See **ABORTION**, page 21

Abortion

Continued from page 3

A letter to the *Star-Tribune* said the procedure shown "is only performed after fetal death when an autopsy is necessary or to save the life of the mother." And the *Morrisville, Vt., Transcript*, which said in an editorial that it allowed the brochure to be inserted in its paper only because it feared legal action if it refused, quoted the abortion federation as providing similar information. "The fetus is dead 24 hours before the pictured procedure is undertaken," the editorial stated.

But Dr. Haskell and another doctor who routinely use the procedure for late-term abortions told *AMNews* that the majority of fetuses aborted this way are alive until the end of the procedure.

Dr. Haskell said the drawings were accurate "from a technical point of view." But he took issue with the implication that the fetuses were "aware and resisting."

Radford also acknowledged that the information her group was quoted as providing was inaccurate. She has since sent a letter to federation members, outlining guidelines for discussing the matter. Among the points:

- Don't apologize; this is a legal procedure.
- No abortion method is acceptable to abortion opponents.
- The language and graphics in the ads are disturbing to some readers. "Much of the negative reaction, however, is the same reaction that might be invoked if one were to listen to a surgeon describing step-by-step almost any other surgical procedure involving blood, human tissue, etc."

Late-abortion specialists

Only Dr. Haskell, James T. McMahon, MD, of Los Angeles, and a handful of other doctors perform the D&X procedure, which Dr. McMahon refers to as "intact D&E." The more common late-term abortion methods are the classic D&E and induction, which usually involves injecting digoxin or another substance into the fetal heart to kill it, then dilating the cervix and inducing labor.

Dr. Haskell, who owns abortion clinics in Cincinnati and Dayton, said he started performing D&Es for late abortions out of necessity. Local hospitals did not allow inductions past 18 weeks, and he had no place to keep patients overnight while doing the procedure.

But the classic D&E, in which the fetus is broken apart inside the womb, carries the risk of perforation, tearing and hemorrhaging, he said. So he turned to the D&X, which he says is far less risky to the mother.

Dr. McMahon acknowledged that the procedure he, Dr. Haskell and a handful of other doctors use makes some people queasy. But he defends it. "Once you decide the uterus must be emptied, you then have to have 100% allegiance to maternal risk. There's no justification to doing a more dangerous procedure because somehow this doesn't offend your sensibilities as much."

Brochure cites N.Y. case

The four-page anti-abortion brochures also include a graphic depiction of the D&X procedure. But the cover features a photograph of 16-month-old Ana Rosa Rodriguez, whose right arm was severed during an abortion attempt when her mother was 7 months pregnant.

The child was born two days later, at 32 to 34 weeks' gestation. Abu Hayat, MD, of New York, was convicted of assault and performing an illegal abortion. He was sentenced to up to 29 years in prison for this and another related offense.

New York law bans abortions after 24 weeks, except to save the mother's life. The brochure states that Dr. Hayat never would have been prosecuted if the federal "Freedom of Choice Act" were in effect, because the act would invalidate the New York statute.

The proposed law would allow abortion for any reason until viability. But it would leave it up to individual practitioners — not the state — to define that point. Postviability abortions, however, could not be restricted if done to save a woman's life or health, including emotional health.

The abortion federation's Radford called the Hayat case "an aberration" and stressed that the vast majority of abortions occur within the first trimester. She also said that later abortions usually are done for reasons of fetal abnormality or maternal health.

But Douglas Johnson of the National Right to Life Committee called that suggestion "blatantly false."

"The abortion practitioners themselves will admit the majority of their late-term abortions are elective," he said. "People like Dr. Haskell are just trying to teach others how to do it more efficiently."

Numbers game

Accurate figures on second- and third-trimester abortions are elusive because a number of states don't require doctors to report abortion statistics. For example, one-third of all abortions are said to occur in California, but the state has no reporting requirements. The Guttmacher Institute estimates there were nearly 168,000 second- and third-trimester abortions in 1988, the last year for which figures are available.

About 60,000 of those occurred in the 16- to 20-week period, with 10,660

See *ABORTION*, next page

Abortion

Continued from preceding page
at week 21 and beyond, the institute says. Estimates were based on actual gestational age, as opposed to last menstrual period.

There is particular debate over the number of third-trimester abortions. Former Surgeon General C. Everett Koop, MD, estimated in 1984 that 4,000 are performed annually. The abortion federation puts the number at 300 to 500. Dr. Haskell says that "probably Koops numbers are more correct."

Dr. Haskell said he performs abortions "up until about 25 weeks" gestation, most of them elective. Dr. McMahon goes abortions through all 40 weeks of pregnancy, but said he won't do an elective procedure after 26 weeks. About 80% of those he does after 21 weeks are nonelective, he said.

Mixed feelings

Dr. McMahon admits having mixed feelings about the procedure in which he has chosen to specialize.

"I have two positions that may be internally inconsistent, and that's probably why I fight with this all the time," he said.

"I do have moral compunctions. And if I see a case that's later, like after 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.'

"On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother."

Dr. McMahon says he doesn't want to "hold patients hostage to my technical skill. I can say, 'No, I won't do that,' and then they're stuck with either some criminal solution or some other

desperate maneuver."

Dr. Haskell, however, says whatever qualms he has about third-trimester abortions are "only for technical reasons, not for emotional reasons of fetal development."

"I think it's important to distinguish the two," he says, adding that his cut-off point is within the viability threshold noted in *Roe v. Wade*, the Supreme Court decision that legalized abortion. The decision said that point usually occurred at 28 weeks "but may occur earlier, even at 24 weeks."

Viability is generally accepted to be "somewhere between 25 and 26 weeks," said Dr. Haskell. "It just depends on who you talk to."

"We don't have a viability law in Ohio. In New York they have a 24-week limitation. That's how Dr. Hayat got in trouble. If somebody tells me I have to use 22 weeks, that's fine. . . . I'm not a trailblazer or activist trying to constantly press the limits."

Campaign's impact debated

Whether the ad and brochures will have the full impact abortion opponents intend is yet to be seen.

Congress has yet to schedule a final showdown on the bill. Although it has already passed through the necessary committees, supporters are reluctant to move it for a full House and Senate vote until they are sure they can win.

In fact, House Speaker Tom Foley (D. Wash.) has said he wants to bring the bill for a vote under a "closed rule" procedure, which would prohibit consideration of amendments.

But opponents are lobbying heavily against Foley's plan. Among the amendments they wish to offer is one that would allow, but not require, states to restrict abortion — except to save the mother's life — after 24 weeks.

American Medical

NEWS

AMERICAN MEDICAL ASSOCIATION

NOVEMBER 20, 1995

VOLUME 38 • NUMBER 43

Outlawing abortion method

Veto-proof majority in House votes to prohibit late-term procedure

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON — His strategy was simple: Find an abortion procedure that almost anyone would describe as "gruesome," and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about "partial birth" abortions, he was set. He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming — and veto-proof — margin: 288-139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a "pro-life" trifecta in both the House and the Senate, massive crossover voting occurred, with a significant number of "pro-choice" representatives voting to pass the measure.

The controversial procedure, done in second- and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, "partially vaginally delivers a living fetus before killing the fetus and completing the delivery."

"Partial birth" abortions, also called "intact D&E" (for dilation and evacuation), or "D&X" (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton, Ohio, and until his recent death, James T. McMahon, MD, of the Los Angeles area. Dr. McMahon said in a 1993 AMNews interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere, but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure,

after considering a number of other options. An Ohio law passed earlier this year, for instance, bans "brain suction" abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

Mixed feelings in medicine

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD. The author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures, Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. But of the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant women, and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned about causing amniotic fluid embolism or placental abruption if you do that."

Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

"There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother," Dr. Smith wrote in a letter to Canady.

See ABORTION, page 70

Partial-Birth Abortion Ban Act of 1995

The bill: HR 1833

Summary: Bans abortions in which provider partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

Exceptions: Life of mother and physician belief that no other procedure would suffice as affirmative defense to prosecution or civil action.

Penalties: Possibility of suits, fines and/or imprisonment of up to two years.

Proponents: Procedure is medically and morally indefensible.

Opponents: Congress has no business legislating medical standards and procedures; bill begins erosion of abortion rights.

Abortion

Continued from page 3

The procedure also has its defenders. The procedure is a "well-recognized and safe technique by those who provide abortion care," Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the *Congressional Record*.

"The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown," Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were "many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?"

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R, N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of "a woman's right to choose," and focus on the reality of abortion. And, he said, to expose those who support "abortion on demand" as "the real extremists."

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D, Calif.) said, "Despite the other side's spin doctors — real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the wom-

an, and, if possible, preserve her ability to have children."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with *AMNews*, Dr. Haskell conceded that 80% of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, "depression" was listed most often as the reason for late-term nonelective abortions with maternal indications. "Cleft lip" was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted "out of context." *AMNews* Editor Barbara Bolsen defended the article, saying *AMNews* "had full documentation of the interviews, including tape recordings and transcripts."

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

"No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress — intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken."

"So in my case, I would say probably about a third of those are definitely are dead before I actually start to remove the fetus. And probably the other two-thirds are not," said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce "a medical coma" in the fetus, and "there is neurological fetal demise."

But Watson Bowes, MD, a maternal-fetal specialist at University of North

Continued from preceding page

Carolina, Chapel Hill, said in a letter to Canady that Dr. McMahon's statement "suggests a lack of understanding of maternal-fetal pharmacology. . . . Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die."

Next move in the Senate

At *AMNews* press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word "veto." But he said he "cannot support" a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D, Colo.) says that's not sufficient. "This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way," she said during the House debate.

Canady disagrees. "No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother."

Organized medicine positions vary

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as "an unwarranted intrusion into the physician-patient relationship." The American College of Obstetricians and Gynecologists also opposes it on grounds it would "supersede the medical judgment of trained physicians and . . . would criminalize medical procedures that may be necessary to save the life of a woman," said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

Rep. Nita Lowey (D, N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were "attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions," Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse, Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it "the most horrifying experience of my life.

"The baby's body was moving. His little fingers were clasping together. He was kicking his feet." Afterwards, she said, "he threw the baby in a pan." She said she saw the baby move. "I still have nightmares about what I saw."

Dr. Hem says if the bill becomes law, he expects it to have "virtually no significance" clinically. But on a political level, "it is very, very significant."

"This bill's about politics," he said, "it's not about medicine."

2nd trimester ABORTION

An interview with W. Martin Haskell, MD

Last summer, *American Medical News* ran a story on abortion specialists. Included was W. Martin Haskell, MD, a Cincinnati physician who introduced the D&X procedure for second trimester abortions. The Academy received several calls requesting information about D & X. The following interview provides an overview.

Q: What motivated you to become an abortion specialist?

A: I stumbled into it by accident. I did an internship in anesthesia. I worked for a year in general practice in Alabama. I did two years in general surgery, then switched into family practice to get board certified. My intentions at that time were to go into emergency medicine. I enjoyed surgery, but I realized there was an abundance of really good surgeons here in Cincinnati. I didn't feel I'd make much of a contribution. I'd be just another good surgeon. While I was in family practice, I got a part-time job in the Women's Center. Over the course of several months, I recognized things there could be run a lot better, with a much more professional level of service—not necessarily in terms of medical care—in terms of counseling, the physical facility, patient flow, and in the quality of people who provided support services. The typical abortion patient spends less than ten minutes with the physician who performs the surgery. Yet, that patient might be in the facility for three hours. When I talked to other physicians whose patients were referred here, I saw problems that could be easily corrected. I realized there was an opportunity to improve overall quality of care, and make a contribution. I own the center now.

Q: Back in 1979 when you were making these decisions, did you consider yourself pro-choice?

A: I've never been an activist. I've always felt that no matter what the issue, you prove your convictions by your hard work—not by yelling and screaming.

Q: Have there been threats against you?

A: Not directly. Pro-life activist Randall Terry recently said to me that he was going to do everything within his power to have me tried like a Nazi war criminal.

Q: A recent American Medical News article stated that the medical community hadn't really established a point of fetal viability. Why not?

A: Probably because it can't be established with uniform certainty. Biological systems are highly variable. The generally accepted point of fetal viability is around 24-26 weeks. But you can't take a given point in fetal development and apply that 100 percent of the time. It just doesn't happen that way. If you look at premature deliveries and survival percentages at different weeks of gestation, you'll get 24-week fetuses with some survival rate. The fact that you get some survivors demonstrates the difficulty in defining a point.

Q: Most women who get abortions end pregnancies during the first trimester. Who is the typical second-trimester patient?

A: I don't know that there is a typical second-trimester abortion. But if you look at the spectrum of abortions (most women are between the ages of 19 and 29) they tend to be younger. Some are older. The typical thing that happens with older women is that they never realized they were pregnant because they were continu-

ing to bleed during the pregnancy. The other thing we see with older women is fetal malformations or Down's Syndrome. These are being diagnosed much earlier now than they used to be. We're seeing a lot of genetic diagnoses with ultrasound and amniocentesis at 17-18 weeks instead of 22-24 weeks. With the teenagers, anybody who has ever worked with or had teenagers can appreciate how unpredictable they can be at times. They have adult bodies, but a lot of times they don't have adult minds. So their reaction to problems tends to be much more emotional than an adult's might be. It's a question of maturity. So even though they may have been educated about all kinds of issues in reproductive health, when a teenager becomes pregnant, depending upon her relationship with her family, the amount of peer support she has—every one is a highly individual case—sometimes they delay until they can no longer contain their problem and it finally comes out. Sometimes it's money. It takes them a while to get the money. Sometimes it's just denial.

Q: Do you think more information on abstinence and contraceptives would decrease the number of teenage pregnancies?

A: I grew up in the sixties and nobody talked about contraception with teenagers in the sixties. But today, though it may be controversial in some areas, there's a lot being taught about reproductive health in the high school curricula. I think a lot more is being done, but the bottom line is we're all still just human—with human emotions, and particularly with teenagers, a sense of invulnerability; it can't happen to me. So education helps a lot, but it's not going to eliminate the problem. You can teach a person the skills, but you can't make them use them.

Q: Does it bother you that a second trimester fetus so closely resembles a baby?

A: I really don't think about it. I don't have a problem with believing the fetus is a fertilized egg. Sure it becomes more physically developed but it lacks emotional development. It doesn't have the mental capacity for self-awareness. It's never been an ethical dilemma for me. For people for whom that is an ethical dilemma, this certainly wouldn't be a field they'd want to go into. Many of our patients have ethical dilemmas about abortion. I don't feel it's my role as a physician to tell her she should not have an abortion because of her ethical feelings. As individuals grow and mature, learn more, feel more, experience more, their perspective about themselves and life, morality and ethics change. Facing the situation of abortion is a part of that passage through life for some women—how they resolve that is their decision. I can be their advisor much as a lawyer can be; he can tell you your options, but he can't make you file a suit or tell you not to file a suit. My role is to provide a service and, to a limited degree, help women understand themselves when they make their decision. I'm not to tell them what's right or wrong.

Q: Do your patients ever reconsider?

A: Between our two centers, that happens maybe once a week. There's a patient who changes her mind or becomes truly ambivalent and goes home to reconsider, then might come back a week or two later. I feel that's one of the strengths of how we approach things here. We try not to create pressure to have an abortion. Our view has always been that there are enough women who want abortions that we don't have to coerce anyone to have one. We've always been strongly against pressure on our patients to go ahead with an abortion.

Q: How expensive is a second trimester abortion?

A: Fees range from \$1,200-1,600 depending on length of pregnancy. More insurance companies cover abortion than don't cover it. About 15 percent of our patients won't use insurance because they want to maintain privacy. About 10-20 percent use insurance. The rest pay out of pocket.

Q: What led you to develop D & X?

A: D & E's, the procedure typically used for later abortions, have always been somewhat problematic because of the roughness and development of the fetal tissues. Most physicians do terminations after 20 weeks by saline infusion or prostaglandin induction, which terminates the fetus and allows tissue to soften. Here in Cincinnati, I never really explored it, but I didn't think I had that option. There certainly weren't hospitals willing to allow inductions past 18 weeks—even Jewish, when they did abortions, their limit was 18 weeks. I don't know about University. What I saw here in my practice, because we did D & Es, was that we had patients who needed terminations at a later date. So we learned the skills. The later we did them, the more we saw patients who needed them still later. But I just kept doing D & Es because that was what I was comfortable with, up until 24 weeks. But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D & Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have

a foot length presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. At first, I would reach around trying to identify a lower extremity blindly with the tip of my instrument. I'd get it right about 30-50 percent of the time. Then I said, 'Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it.' I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Q: Does the fetus feel pain?

A: Neurological pain and perception of pain are not the same. Abortion stimulates fibers, but the perception of pain, the memory of pain that we fear and dread are not there. I'm not an expert, but my understanding is that fetal development is insufficient for consciousness. It's a lot like pets. We like to think they think like we do. We ascribe human-like feelings to them, but they are not capable of the same self-awareness we are. It's the same with fetuses. It's natural to project what we feel for babies to a 24-week old fetus. □

The D & X Procedure—Dilation and Extraction (D & X), a method for second trimester abortion up to 26 weeks, was developed in 1992 by Cincinnati physician W. Martin Haskell, MD. It is a modification of Disembodiment and Extraction (D & E) which has been used in the US since the 1970s. Haskell has performed more than 700 D & X procedures in his office.

Step One—The patient's cervix is dilated to 9-11 mm. over a period of two days using Diapan hydroscopic dilators. The patient remains at home during the dilation period.

Step Two—In the operating room, patients are given Valium, the Diapan are removed and the cervix is scrubbed, anesthetized and grasped with a tenaculum. Membranes are ruptured.

Step Three—The surgical assistant scans the fetus with ultrasound, locating the lower extremities.

Step Four—Using a large forceps, the surgeon opens and closes its jaws to firmly grasp a lower extremity. The surgeon turns the fetus if necessary and pulls the extremity into the vagina.

Step Five—The surgeon uses his fingers to deliver the opposite lower extremity, then the torso, shoulders, and upper extremities.

Step Six—The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is spine up.

Step Seven—A right-handed surgeon slides the fingers of his left hand along the back of the fetus and hooks the shoulders of the fetus with the index and ring fingers (palm down). He slides the tip of his middle finger along the spine towards the skull while applying traction to the shoulder and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

Step Eight—While maintaining this tension, the surgeon takes a pair of blunt curved scissors in the right hand. He advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger. The surgeon forces the scissors into the base of the skull and spreads the scissors to enlarge the opening.

Step Nine—The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents.

Step Ten—With the catheter still in place, he applies traction to the fetus, removing it completely from the patient, then removes the placenta.



Suite 500, 419 7th Street, N.W.
Washington, D.C. 20004-2293 -- (202) 626-8820 (FAX) 737-9189 or 347-5927

(202) 626-8820

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

The Clinton Veto: Defending Euthanasia for the Partly Born?

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

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

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

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

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

Ades: Oh, well, that's very simple. There's two reasons. A Caesarian section is an emergency surgery that was designed [for] when an emergency is at hand, when the baby's life is at risk-- when the baby needs to survive, and it's an emergency situation. "A," this is not an emergency. And "B," we *wanted* to take our son out of torture. The purpose of this is so that my son would not be tortured anymore. Douglas would have it that I delivered this baby and held him 'til he died, while he gasped for breath.

EXCERPTS FROM 4/12/96 ADES-JOHNSON RADIO, 2

Malone: Douglas, is that true? What would you have told her to do?

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

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

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

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

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

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

[material omitted]

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

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

EXCERPTS FROM 4/12/96 ADES-JOHNSON RADIO, 3

Ades: [interrupting] Correct. That's correct!

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

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

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

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

PHACT

Physicians' Ad Hoc Coalition for Truth

FOUNDING MEMBERS

Nancy Romer, M.D.
Fellow, American College of
Obstetricians & Gynecologists
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn,
Miami Valley Hospital, OH

Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

James Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Burnsworth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Stalter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

Denis Cavanagh, M.D.
Professor, Ob/Gyn
University of South Florida
College of Medicine, Tampa
FACOG

1421 Prince Street
Alexandria, VA 22314
T: (703) 684-8352
F: (703) 684-5813
Communications Counsel:
Gene Tame

CONTACT: Gene Tame
703-684-8352

SCIENCE FACT VS. SCIENCE FICTION:

DOCTORS REPORT THE MEDICAL FACTS ABOUT PARTIAL-BIRTH ABORTION

"People deserve to know that the partial-birth abortion is never medically indicated either to save the health of a woman or preserve her future fertility."

-- *Dr. Nancy Romer, FACOG, Chairman, Dept. of Obstetrics and Gynecology, Miami Valley Hospital, Ohio*

On the Claimed "Medical Necessity" of this Procedure:

"I am insulted to be told that I am tearing women's bodies apart by not doing this procedure. I am not. ...As physicians, we can no longer stand by while abortion advocates, the President of the United States and newspapers and television shows continue to repeat false medical claims to members of Congress and to the public."

-- *Dr. Nancy Romer*

"This procedure is currently not an accepted medical procedure. A search of medical literature reveals no mention of this procedure and there is no critically evaluated or peer review journal that describes this procedure. ...There is currently also no peer review or accountability of this procedure. It is currently being performed by a physician who is not an obstetrician, in an outpatient facility behind closed doors and no peer review."

-- *Dr. Nancy Romer*

On Claims that Unborn Children with Certain Disabilities Must be Aborted by the Partial-Birth Method to Preserve Their Mother's Health or Fertility:

In vetoing the Partial-Birth Abortion Ban, President Clinton showcased the stories of 5 women who, he said "had to make a life-saving -- certainly, health saving -- but still tragic decision" to have partial-birth abortions, given the severe disabilities suffered by the children they carried. He said that "their own lives, their health, and in some cases their capacity to have children in the future were in danger" on account of these children. Six weeks later, the President defended the necessity of partial-birth abortion on the grounds that, without it, these women would be "eviscerated," their bodies "ripped...to shreds and you could never have another baby, even though the baby you were carrying couldn't live." The conditions suffered by the aborted children included: hydrocephalus, polyhydramnios, Trisomy and anencephaly.

Responding to these specific claims, medical experts from PHACT made clear:

1. "[T]hese are honest women who were sadly misinformed and whose decision to have a partial birth abortion was based on a great deal of misinformation."

-- *Dr. Joseph DeCook*

2. "[T]he presence of *fetal disabilities or fetal anomalies* are not a reason to have a termination of pregnancy to preserve the life of the mother."

– Dr. Curtis Cook

3. Regarding "a *genetic abnormality* where there is an extra chromosome or a *Trisomy*...These abnormalities do not pose a risk to the mother per se, do not require early delivery, and can be safely delivered vaginally by methods that we use on a regular basis."

– Dr. Curtis Cook

4. Regarding "*hydrocephalus*...excessive cerebrospinal fluid... that causes a very large-shaped head in proportion to the rest of the body. ...These patients can be safely delivered by cesarean section. They can even be delivered safely vaginally. We can do that by first decompressing some of the fluid around the baby's head. ...Again, the baby can be delivered safely, without a risk to the mother, and without a risk to her fertility."

– Dr. Curtis Cook

5. Regarding "*polyhydramnios*...an excessive amount of amniotic fluid around the baby. ...They can be delivered vaginally, safely, and in the need for it in such situations, a cesarean section can be performed."

– Dr. Curtis Cook

On Claims for the "Safety" of the Partial-Birth Abortion Procedure

-- "*[The procedure] sounds like science fiction. It ought to be science fiction!*"

-- "*It is a maverick medical procedure made up by maverick doctors for the purpose of delivering a dead fetus.*"

– Dr. Joseph DeCook

1. "Dilation [forcible opening] of the cervix" -- the first step -- risks creating the condition of "incompetent cervix," a leading cause of future premature deliveries. It can also lead to "infection," which is "the main cause of subsequent infertility."

– Dr. Joseph DeCook

2. "Internal podalic version" -- reaching into the uterus to pull the baby feet first through the cervix -- the second step -- "is a very dangerous procedure," "frightening" because of the chance that it might "tear the uterus." This is the "reason this was abandoned 30 or more years ago." There is also the danger of "perforating the uterus" with the instrument used to grab the baby's leg. Such a tear or perforation could result in severe hemorrhage, necessitating immediate hysterectomy to save the life of the mother.

– Dr. Joseph DeCook

3. The third step of partial-birth abortion -- "putting the scissors through the foramen magnum, spread them and out comes the brain" -- is a partially "blind" sharp instrumentation within the uterus. It may expose sharp shards of skull bone within the uterus. Both the scissors and the sharp bone risk lacerating the lower uterine segment or cervix, which again could result in severe hemorrhage necessitating hysterectomy to save the mother's life.

– Dr. Joseph DeCook

PHACT

CONTACT: Gene Tarne
703-684-8352

Physicians' Ad Hoc Coalition for Truth

FOUNDING MEMBERS

Nancy Romer, M.D.
Fellow, American College of
Obstetricians & Gynecologists
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn,
Miami Valley Hospital, OH

Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

James Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Butterworth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Salter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

Denis Cavanaugh, M.D.
Professor, Ob/Gyn
University of South Florida
College of Medicine, Tampa
FACOG

1421 Prince Street
Alexandria, VA 22314
T: (703) 684-8352
F: (703) 684-5813
Communications Counsel:
Gene Tarne

The Physicians' Ad-hoc Coalition for Truth (PHACT) about partial-birth abortion brings together experts in the fields of obstetrics and gynecology, perinatology (maternal -fetal medicine), pediatrics and other medical specialties for one purpose: to bring the medical facts to bear on the public policy debate over partial birth abortion.

Those of us who practice and teach a medical specialty that must, at all times, be responsible for the well-being of two patients -- mother and child -- feel compelled to take this course of action in order to counter the very widespread and dangerous misstatements, misperceptions and outright distortions surrounding this procedure.

The most serious such distortion is the claim that a partial-birth abortion can be *medically necessary* to protect the life or health of a woman carrying a child diagnosed with severe congenital or genetic disabilities, and also to protect that woman's future fertility and ability to carry other children.

There is no medical basis for such an assertion. Given the many potential risks the procedure entails for the mother, far from ever being medically indicated, partial-birth abortion is actually *counterindicated*. Far from ever being a medical necessity, partial-birth abortion is not even a procedure recognized by the medical community. Statements by practitioners of partial-birth abortion indicate that the vast majority of such procedures are elective in nature. There is only one reason to ever consider the partial-birth abortion procedure "necessary:" to ensure the delivery of a dead child rather than a living one.

Because of the dangers posed to women, the distortions regarding the so-called "medical necessity" of partial-birth abortion must not be allowed to stand. Already we have seen the harm done to women by other false statements made by those who defend partial-birth abortions. Proponents of partial-birth abortion have claimed, for example, that the anesthesia given the woman kills the child in her womb even before the procedure begins. Though leading experts in the field of anesthesiology have repeatedly denounced this claim, partial-birth abortion advocates and the media have repeated it often enough to frighten some pregnant women in need of surgery. The medical community's efforts to dispel this lie have gone largely unreported.

As members of the Physicians' Ad-hoc Coalition for Truth (PHACT) about partial-birth abortion, we will take every opportunity presented to correct the misinformation and educate the public as to the medical facts regarding the partial birth abortion procedure. We ask our fellow professionals in the field of journalism and communications in particular to give these facts the attention they deserve by reporting them in a clear, evenhanded and objective fashion.

--###--

PHACT

Physicians' Ad Hoc Coalition for Truth

CONTACT: Gene Tarné
703/684-8352

FOUNDING MEMBERS

Nancy Romer, M.D.
Fellow, American College of
Obstetricians & Gynecologists
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn,
Miami Valley Hospital, OH

Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

James Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Butterworth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Salter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

Denis Cavanagh, M.D.
Professor, Ob/Gyn
University of South Florida
College of Medicine, Tampa
FACOG

1421 Prince Street
Alexandria, VA 22314
T: (703) 684-8352
F: (703) 684-5813
Communications Counsel:
Gene Tarné

CARING FOR WOMEN WITH HIGH RISK PREGNANCIES: PARTIAL-BIRTH ABORTION VS. ACCEPTED MEDICAL CARE

Throughout the national debate on partial-birth abortion, the more than 500 doctors nationwide who make up the Physicians' Ad-hoc Coalition for Truth have insisted that it is never medically necessary -- in order to protect a woman's life, health or future fertility, during the fifth or sixth month (when most partial-birth abortions take place) and after -- to partially deliver a living fetus and then destroy it. *Partial-birth abortion is never medically indicated*: the procedure is too lengthy, too risky and there are too many other alternatives.

The following analysis contrasts the partial-birth abortion method with accepted medical practice for emptying a womb in the second trimester. At this stage of a pregnancy, if it becomes necessary to empty a womb, what is required is separation of the child from the mother, not the death of the child.

Note that the standard method described below can be used safely for delivery of children with severe genetic abnormalities, including trisomy, anencephaly, omphalocele, hydrocephaly (see below) and other situations often cited to justify partial-birth abortion.

Moreover, in considering the supposed desirability of abortion in the second trimester and after, as against the medically recognized method of delivery described below, one should recognize that later term abortion is *twice as risky* for the woman's life as childbirth: the risk of maternal death is 1 in 6,000 for abortions at 21 weeks and after, and 1 in 13,000 for childbirth.

Writing in *The New England Journal of Medicine*, PHACT members John Thorp, M.D. and Watson Bowes, M.D., note: "Many experts have suggested that the cutoff point between maternal mortality from abortion and maternal mortality from continuation of pregnancy occurs at 15 to 16 weeks of gestation, with abortion being riskier beyond that point."

PARTIAL BIRTH ABORTION VS. MEDICALLY RECOGNIZED METHOD

Medically Recognized Method	Partial-Birth Abortion*
<p>First Stage</p> <p><i>Latent Phase:</i> The delivery process begins by inducing labor physiologically (as opposed to mechanically) with prostoglandins or pitocins. This produces uterine contractions that dilate the cervix. The cervix is dilated up to 4 centimeters (cm), taking between 4 to 8 hours. Medication for pain usually consists of injectable analgesics, administered by medical personnel.</p> <p><i>Accelerated Phase:</i> The cervix is further dilated, traditionally to 10 cm (but this may be less in the case of very small infants), generally taking another 3 to 6 hours. Pain relief usually consists of injectable analgesics or epidural anesthesia, administered by medical personnel.</p>	<p>First Stage</p> <p><i>Latent Phase:</i> Dilatation up to about 4 cm, but taking up to 48 hours or more. The cervix is dilated mechanically (as opposed to more desirable physiological methods) with repeated insertion of laminaria into the cervix until sufficient dilatation is obtained. Such mechanical dilatation exposes the woman to the risk of developing an incompetent cervix - a leading cause of future premature deliveries - thus potentially threatening her ability to have children in the future. Throughout the dilatation process, the woman is regularly in a hotel/motel room with no direct nursing or medical supervision. Pain is treated only with oral medication, administered by the patient herself.</p> <p><i>Accelerated Phase:</i> Not comparable to standard delivery procedures. Cervical dilatation of 4 cm is all that is done.</p>
<p>Second Stage:</p> <p>Normal expulsive efforts by the mother push the child through the completely dilated cervix, through the birth canal, and into the waiting hands of the doctor or midwife. Depending on the patient, this phase takes from 15 minutes to two hours.</p> <p>Throughout this entire delivery process, the mother will be in a hospital, attended by physicians and hospital staff.</p>	<p>Second Stage</p> <p>The child is manipulated into breech position by grasping a leg, usually by instrumentation through the 4 cm dilated cervix. This is a very dangerous part of the entire procedure, as it is partially or totally blind and can result in laceration of the cervix or uterus, with potentially disastrous results (e.g., massive blood loss from uterine hemorrhage, leading to shock or maternal death).</p> <p><i>Elective conversion to a breech position (as is done here) has been abandoned for at least 50 years because of the risks to the mother and child. Williams Obstetrics, a standard medical textbook, notes that the risk of "serious trauma" to both mother and child from conversion to breech is "apparent." If it is not in the mother's best interest to perform an elective breech conversion when the intent is to deliver the baby alive, and when the mother is in the hospital with trained anesthesiologists nearby, it is difficult to understand, from a medical perspective, how it should suddenly become the best, safest and least traumatic option, when the mother is in an outpatient clinic, with local anesthesia, and the intent is to deliver a dead child.</i></p>

*The following information is based on Dr. Martin Haskell's paper "Second Trimester Abortion: From Every Angle," presented at the National Abortion Federation's Fall Risk Management Seminar, September 13-14, 1992, in Dallas, TX.

<p>In cases of hydrocephaly, (an enlarged head due to excess fluid on the fetal brain), the excess fluid is drained <i>prior</i> to beginning the delivery process through a transabdominal cephalocentesis. This reduces the size of the child's head (without causing death), thus allowing the head to fit through the birth canal. If it is not possible to reduce the head size sufficiently with cephalocentesis, a standard C-Section is done.</p>	<p>The child is then delivered by traction on the leg or legs, pulling the body through the incompletely dilated cervix. However, the head, being the largest diameter part of the child, will not come through the cervix for delivery, because the cervix has been dilated only 4 cm. At this point, a sharp scissors is plunged through the base of the skull and the brain is sucked out through the scissors' wound. This kills the child and decompresses the skull; delivery of the now dead infant is then completed. There is danger to the mother from the relatively blind manipulation with sharp scissors to pierce the child's skull while it is still within the cervix, as well as from sharp bone shards from the infant's decompressed skull which could lacerate the cervix.</p> <p>Anesthesia: Varies from intravenous sedation, analgesics, paracervical block, or general anesthesia, depending on where the procedure is being done.</p> <p>Estimated operation time: 20 to 30 minutes.</p>
<p>Third Stage</p> <p>Usually 2 to 10 minutes. The uterus, now empty of the baby, contracts, shearing off the placenta which is then delivered through the cervix.</p>	<p>Third stage</p> <p>Placenta may deliver spontaneously, but often requires curettage of walls of uterus to assure no retained fragments remain. Estimated time: 2 to 10 minutes.</p>

NEW YORK POST, FRIDAY, MARCH 22, 1996

Leading doc tells Congress pro-choicers 'misinformed'

By MARILYN RAUBER
Post Correspondent

WASHINGTON — The head of the American Society of Anesthesiologists yesterday accused abortion-rights activists of spreading medical "misinformation" and scaring moms-to-be.

The furor erupted during a testy House hearing on late-term "partial birth" abortion — and recent claims by pro-choicers that anesthesia given to the patient kills the fetus before the controversial procedure does.

ASA President Norig Ellison blasted that claim as an "entirely inaccurate" myth provoking "fear" in some pregnant patients who need surgery.

"Pregnant women are routinely heavily sedated ... for a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death," Ellison told the panel.

The hearing, with graphic drawings of the gruesome abortion procedure on display, was held days before the House is scheduled to vote on a Senate-backed bill banning the rarely-used procedure except to save the mother's life.

During the procedure, the fetus brains are removed by suction through an incision in the neck.

Pro-choice activists didn't produce any medical experts to support the claim that the fetus is killed by anesthesia — instead, pro-choice Rep. Patricia Schroeder (D-Colo.) dismissed the hearing as "political theater."

"This is a distraction ... This is a new American witchcraft trial," said Schroeder, adding that the real issue is "a bill that would take away doctors' choices" to save women's lives and preserve their fertility.

Anesthesia
information

But David Birnbach, head of obstetric anesthesiology at New York's St. Luke's-Roosevelt Hospital Center, warned the misinformation "may cause some to unnecessarily delay emergency surgery ... Pregnant women must get the message that should they need anesthesia, they may do so without worrying."

GOP House members specifically rebuked National Abortion Rights Action League President Kate Michelman for publicly claiming "the anesthesia that they give the woman already causes the demise of the fetus" before the brain suctioning.

"If it was a mistake, say it was a mistake ... that would be the responsible thing to do," fumed panel chairman Charles Canady (R-Fla.).

NARAL political director, Jo Blum, told The Post her organization "relied on credible medical testimony" from doctors who performed the procedure.

When asked if NARAL still stood by its original position, she said, "there is clearly a difference of opinion" among doctors.

In moving testimony, two California women who underwent the unusual abortion procedure after discovering they were carrying babies with fatal deformities, pleaded with House members not to ban the procedure.

They argued it was a safe method that didn't risk infertility. Both are now pregnant again.



Suite 500, 419 7th Street, N.W.
Washington, D.C. 20004-2293 -- (202) 626-8800 (FAX) 737-9189 or 347-5907

**Members of Congress
Propagate the "Anesthesia Myth"**

Senator Carol Moseley-Braun (D-Ill.) said during U.S. Senate floor debate on the bill (Nov. 8), "The fetus dies during the first dose of anesthesia."

Congresswoman Sheila Jackson-Lee (D-Tx.) said during U.S. House floor debate on the bill (Nov. 1), "This debate has injected an ugly picture of incorrect representation about this medical procedure simply to inflame your emotions. The fetus is already deceased based on an excessive amount of anesthesia."

Congressman Sam Gedjenson (D-Ct.) said in letters to constituents, "Particularly in cases of severe fetal abnormality, it is misleading to imply that the fetus is alive or experiencing sensation during the abortion, because neurological fetal demise (brain death) is confirmed before the procedure begins."

MAJORITY MEMBERS
 HENRY J. HYDE, ILLINOIS, CHAIRMAN
 CARLOS J. MOORHEAD, CALIFORNIA
 J. JAMES SENECHENBERGER, JR., WISCONSIN
 BILL MCCOLLUM, FLORIDA
 GEORGE W. GEEKS, PENNSYLVANIA
 HOWARD COBLE, NORTH CAROLINA
 LAMAR S. SMITH, TEXAS
 STEVEN ROBERT, NEW MEXICO
 ELTON GALLEGLY, CALIFORNIA
 CHARLES T. CANADY, FLORIDA
 BOB INGLE, SOUTH CAROLINA
 BOB GOODLATTE, VIRGINIA
 STEVE BUYER, INDIANA
 MARTIN F. HOLE, OHIO
 SONNY BONO, CALIFORNIA
 FRED HEINEMAN, NORTH CAROLINA
 CO. BRYANT, TENNESSEE
 STEVE CHARLOT, OHIO
 MICHAEL PATRICK FLANAGAN, ILLINOIS
 BOB BARR, GEORGIA

GENERAL COUNSEL
 ALAN F. COFFEY, JR.

ONE HUNDRED FOURTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON THE JUDICIARY

2138 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6216

(202) 225-3951

March 19, 1996

MINORITY MEMBERS
 JOHN CONYERS, JR., MICHIGAN
 PATRICIA SCHROEDER, COLORADO
 BARNEY FRANK, MASSACHUSETTS
 CHARLES E. SCHUMER, NEW YORK
 HOWARD L. Berman, CALIFORNIA
 PICK BOUCHER, VIRGINIA
 JOHN BRYANT, TEXAS
 JACK REED, RHODE ISLAND
 JERROLD HADLER, NEW YORK
 ROBERT C. TOBIY, SCOTLAND
 MELVIN L. WATT, NORTH CAROLINA
 JAYNER BECKER, CALIFORNIA
 JOSE E. SERRANO, NEW YORK
 JOE LOFCHEN, CALIFORNIA
 SHERA JACKSON LEE, TEXAS

MINORITY STAFF DIRECTOR
 JULIAN ERSTEIN

The Honorable Barney Frank
 Ranking Member
 Subcommittee on the Constitution
 2210 Rayburn H.O.B.
 Washington, D.C. 20515

Dear Barney:

My staff has just informed me that the minority has not requested that any medical experts be invited to testify on the effects of anesthesia during a partial-birth abortion, the subject of Thursday's hearing before the Subcommittee on the Constitution.

As you know, the claim that anesthesia administered to a mother kills her unborn child before a partial-birth abortion has begun has been disseminated throughout the country by Kate Michelman of the National Abortion Rights Action League, Dr. Mary Campbell of Planned Parenthood, and the National Abortion Federation. Planned Parenthood and the National Abortion Federation represent hundreds of abortion providers. Surely one of their experts is willing to defend their claims. I find it disturbing that there is not a single medical expert to defend this claim which has been so prominent in the attacks on H.R. 1833.

In accordance with Committee procedures, I expect that I will receive the testimony of the minority's witnesses today. If you are able to find a witness with medical credentials, I would be happy to extend the deadline for that witness's testimony to 10:00 a.m. tomorrow.

Sincerely yours,

Chos.

Charles T. Canady
 Chairman
 Subcommittee on the Constitution

NARAL Promoting Reproductive Choices



March 15, 1996

The Honorable Henry J. Hyde
Chairman
Committee on the Judiciary
2138 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Hyde:

Thank you for offering me the opportunity to testify on March 21, 1996 before the Subcommittee on the Constitution.

I regret that I will be unable to testify before the Subcommittee due to a previous commitment located outside of the District of Columbia.

Sincerely,

Kate Michelman

Kate Michelman

cc: The Honorable Barney Frank

National Abortion
and Reproductive Rights
Action League
1120 18th Street, NW
Suite 702
Washington, DC 20036
Phone (202) 871-3000
Fax (202) 871-3006

SUBCOMMITTEE ON THE CONSTITUTION
Committee on the Judiciary
U.S. House of Representatives

**Oversight Hearing: "Fetal Death" or Dangerous Deception?
The Effects Of Anesthesia During A Partial-Birth Abortion**
2141 Rayburn House Office Building
Thursday, March 21, 1996
9:00 a.m.

WITNESS LIST

PANEL I:

Honorable Tom A. Coburn, M.D.
U.S. House of Representatives, Oklahoma/2nd District

PANEL II:

Norig Ellison, M.D.
President, American Society of Anesthesiologists
Clinical Director, Department of Anesthesia, University of Pennsylvania Hospital
Professor and Vice Chair, Department of Anesthesia, University of Pennsylvania School of Medicine

David J. Birnbach, M.D.
President-Elect, Society for Obstetric Anesthesia and Perinatology
Director of Obstetric Anesthesiology, St. Luke's-Roosevelt Hospital Center, Columbia University

David Hill Chestnut, M.D.
Chairman, Department of Anesthesiology, University of Alabama, Birmingham Hospital
Professor, Department of Obstetrics and Gynecology and Department of Anesthesiology
University of Alabama, Birmingham School of Medicine
Editor, Obstetric Anesthesia: Principles and Practice, 1994

Jean A. Wright, M.D., M.B.A.
Medical Director, Egleston Children's Hospital, Emory University
Associate Professor, Department of Pediatrics and Anesthesiology, Emory University

PANEL III

Brenda Pratt Shafer, R.N.
Franklin, Ohio

Coreen Costello
Agoura, California

Mary-Dorothy Line
Marina del Ray, California

Helen M. Alvare
Director of Planning and Information, Secretariat for Pro-Life Activities, National Conference of Catholic Bishops



**STATEMENT OF NORIG ELLISON, M.D., PRESIDENT
AMERICAN SOCIETY OF ANESTHESIOLOGISTS**

Before the
Subcommittee on the Constitution
U.S. House of Representatives
March 21, 1996

Chairman Canady, members of the Subcommittee. My name is Norig Ellison, M.D. I am the President of the American Society of Anesthesiologists (ASA), a national professional society consisting of over 34,000 anesthesiologists and other scientists engaged or specially interested in the medical practice of anesthesiology. I am also Professor and Vice-Chair of the Department of Anesthesiology at the University of Pennsylvania School of Medicine in Philadelphia and a staff anesthesiologist at the Hospital of the University of Pennsylvania.

I appear here today for one purpose, and one purpose only: to take issue with the testimony of James T. McMahon, M.D., before this Subcommittee last June. According to his written testimony, of which I have a copy, Dr. McMahon stated that anesthesia given to the mother as part of dilation and extraction abortion procedure eliminates any pain to the fetus and that a medical coma is induced in the fetus, causing a "neurological fetal demise", or --in lay terms -- "brain death".

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary, even life-saving, medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus. Annually over 50,000 pregnant women are anesthetized for such necessary procedures.

Although it is certainly true that some general analgesic medications given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant women are routinely heavily sedated during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death or "brain death". In my medical judgment, it would be necessary -- in order to achieve "neurological demise" of the fetus in a "partial birth" abortion -- to anesthetize the mother to such a degree as to place her own health in serious jeopardy.

As you are aware, Mr. Chairman, I gave the same testimony to a Senate committee four months ago. That testimony received wide circulation in anesthesiology circles and to a lesser extent in the lay press. You may be interested in the fact that since my appearance, not one single anesthesiologist or other physician has contacted me to dispute my stated conclusions. Indeed, two eminent obstetric anesthesiologists appear with me today, testifying on their own behalf and not as ASA representatives. I am pleased to note that their testimony reaches the same conclusions that I have expressed.

Thank you for your attention. I am happy to respond to your questions.

STATEMENT OF DAVID J. BIRNBACH, M.D.
before the
SUBCOMMITTEE ON THE CONSTITUTION
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES
March 21, 1996

Mr. Chairman, Members of the Subcommittee:

My name is David Birnbach, M.D. and I am presently the Director of Obstetric Anesthesiology at St. Luke's-Roosevelt Hospital Center, a teaching hospital of Columbia University College of Physicians and Surgeons in New York City. I am also president-elect of the Society for Obstetric Anesthesia and Perinatology, the society which represents my subspecialty.

I am here today to take issue with the previous testimony before committees of the Congress that suggests that anesthesia causes fetal demise. I believe that I am qualified to address this issue because I am a practicing obstetric anesthesiologist. Since completing my anesthesiology and obstetric anesthesiology training at Harvard University, I have administered analgesia to more than five thousand women in labor and anesthesia to over a thousand women undergoing cesarean section. Although the majority of these cases were at full term gestation, I have provided anesthesia to approximately 200 patients who were carrying fetuses of less than 30 weeks gestation and who needed emergency non-obstetric surgery during pregnancy. These operations have included appendectomies, gall bladder surgeries, numerous orthopedic procedures such as fractured ankles, uterine and ovarian procedures (including malignant tumor removal), breast surgery, neurosurgery, and cardiac surgery.

The anesthetics which I have administered have included general, epidural, spinal and local. The patients have included healthy as well as very sick pregnant patients. Although I often use spinal and epidural anesthesia in pregnant patients, I also administer general anesthesia to these patients and, on occasion, have needed to administer huge doses of general anesthesia in order to allow surgeons to perform cardiac surgery or neurosurgery.

In addition, I believe that I am also especially qualified to discuss the effect of maternally-administered anesthesia on the fetus, because I am one of only a handful of anesthesiologists who has administered anesthesia to a pregnant patient undergoing in-utero fetal surgery, thus allowing me to watch the fetus as I administered general anesthesia to the mother. A review of the experiences that my associates and I had while administering general anesthesia to a mother while a surgeon operated on her unborn fetus was published in the Journal of Clinical Anesthesia vol.1, 1989, pp363-367. In this paper, we suggested that general

②

anesthesia provides several advantages to the fetus who will undergo surgery and then be replaced in the womb to continue to grow until mature enough to be delivered. Safe doses of anesthesia to the mother most certainly did not cause fetal demise when used for these operations.

Despite my extensive experience with providing anesthesia to the pregnant patient, I have never witnessed a case of fetal demise that could be attributed to an anesthetic. Although some drugs which we administer to the mother may cross the placenta and affect the fetus, in my medical judgment fetal demise is definitely not a consequence of a properly administered anesthetic. In order to cause fetal demise it would be necessary to give the mother dangerous and life-threatening doses of anesthetics. This is not the way we practice anesthesiology in the United States.

Mr. Chairman, I am deeply concerned that the previous congressional testimony and the widespread publicity that has been given this issue will cause unnecessary fear and anxiety in pregnant patients and may cause some to unnecessarily delay emergency surgery. As an example, several newspapers across the US have stated that anesthesia causes fetal demise. Because this issue has been allowed to become a "controversy" several of my patients have recently expressed concerns about anesthesia, having seen newspaper or heard radio or television coverage of this issue. Evidence that patients are still receiving misinformation regarding the fetal effects of maternally administered anesthesia can be seen by review of an article that a pregnant patient recently brought with her to the labor and delivery floor. In last month's edition of Marie Claire, a magazine which many of my pregnant patients read, an article about partial birth abortion states "The mother is put under general anesthetic, which reaches the fetus through her bloodstream. By the time the cervix is sufficiently dilated, the fetus has overdosed on the anesthetic and is brain-dead." These incorrect statements continue to find their way into newspapers and magazines around the country. Despite the previous testimony of Dr. Ellison, I have yet to see an article that states, in no uncertain terms, that anesthesia when used properly does not harm the fetus. This supposed controversy regarding the effects of anesthesia on the fetus must be finally and definitively put to rest.

In order to address this complex issue, I believe that it is necessary to comment on three of the statements which have recently been made to the Congress.

I) Dr. James McMahon, now deceased, testified that anesthesia causes neurologic fetal demise.

II) Dr. Lewis Koplick supported Dr. McMahon and stated "I am certain that anyone who would call Dr. McMahon a liar is speaking from ignorance of abortions in late pregnancy and of Dr. McMahon's technique and integrity."

3

III) Dr. Mary Campbell of Planned Parenthood has addressed this issue by writing the following: "Though these doses are high, the incremental administration of the drugs minimizes the probability of negative outcomes for the mother. In the fetus, these dosage levels may lead to fetal demise (death) in a fetus weakened by its own developmental anomalies."

My responses to these statements are as follows:

1. There is absolutely no scientific or clinical evidence that a properly administered maternal anesthetic causes fetal demise. To the contrary, there are hundreds of scientific articles which demonstrate the fetal safety of currently used anesthetics.

2. Dr. Koplick has stated that the "massive" doses used by Dr. McMahon are responsible for fetal demise. This again, is incorrect and there is no scientific or clinical data to support this allegation. I have personally administered "massive" doses of narcotics to intubated critically ill pregnant patients who were being treated in an intensive care unit. I am pleased to say that the fetuses were born alive and did well.

3. Dr. Campbell has described the narcotic protocol which Dr. McMahon had used during his D & X procedures: it includes the administration of Midazolam(10-40 mg) and Fentanyl (900-2500 µg). Although there is no evidence that this massive dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death. These doses are far in excess of any anesthetic that would be used by an anesthesiologist and even if they were incrementally given over a two to three hour period these doses would in all probability cause enough respiratory depression of the mother, to necessitate intubation and/or assisted respiration. Since Dr. McMahon can not be questioned regarding his "heavy handed" anesthetic practice, I am unable to explain why he would willingly administer such huge amounts of drugs. If he did indeed administer 2500 µg of fentanyl and 40 mg of midazolam to a patient in a clinic, without an anesthesiologist present, he was definitely placing the mother's life at great risk.

In conclusion, I would like to say that I believe that I have a responsibility as a practicing obstetric anesthesiologist to refute any and all testimony that suggests that maternally administered anesthesia causes fetal demise. It is my opinion that in order to achieve that goal one would need to administer such huge doses of anesthetic to the mother as to place her life at jeopardy. Pregnant women must get the message that should they need anesthesia for surgery or analgesia for labor, they may do so without worrying about the effects on their unborn child.

Thank you for your attention. I am happy to respond to your questions.



EMORY UNIVERSITY SCHOOL OF MEDICINE
 DEPARTMENT OF PEDIATRICS
 Egleston Children's Hospital at Emory University
 1405 Clifton Road, N.E. Atlanta, Georgia 30322

Division of Critical Care Medicine
 Jean A. Wright, M.D., Division Director
 Robert Perrigano, M.D.
 James D. Fortenberry, M.D.
 Kirtwaljeet S. Anand, M.B.B.S., D.Phil.
 C. Robert Chambliss, M.D.

(404) 325-6167

Statement of Jean A. Wright, M.D., M.B.A
 Associate Professor of Pediatrics and Anesthesia

Division Director, Pediatric Critical Care & Emergency Medicine
 Emory University School of Medicine

before the

Subcommittee on the Constitution
 Oversight Hearing

Chairman Canady, and members of the Subcommittee. My name is Jean A. Wright, MD., MBA. I am an Associate Professor of Pediatrics and Anesthesia at Emory University School of Medicine in Atlanta. I am also an Associate Professor at the Emory Center for Clinical Evaluation Sciences. I am board certified in Pediatrics, Anesthesia, and in both sub-boards of Critical Care Medicine. I have been a faculty member and a practicing physician since 1983.

I appreciate the invitation to testify before the Committee on the topic of the effects of anesthesia administered to a mother during a partial birth abortion. I understand that this committee was considering legislation which would ban 'partial birth abortions', and that this is the second hearing on this topic. I will focus my testimony on the **ability of the fetus to feel and respond to pain during this procedure**, and on the effects of the anesthetic upon the fetus while administered to the mother.

My testimony will be divided into three parts. 1) The developmental aspects of pain in the fetus; 2) The increased sensitivity of preterm infants to pain compared to term or older infants; and 3) the effects of maternally administered anesthetics to blunt or alter the effect of this pain.

1. Development of the pain system in the human fetus and neonate:

Very preterm neonates have the **neuroanatomic substrate** and functional physiologic and chemical processes in the brain responsible for mediating pain or noxious stimuli (known as nociception). [Fitzgerald and Anand]. [See Chart from Anand & Hickey, NEJM, 1987]. **Anatomic studies** have shown that the density of the skin pain fibers (cutaneous nociceptive nerve endings) in the late fetus and newborn infant may equal or exceed that of adult skin. Early studies by Hooker showed that cutaneous sensory perception appears around the mouth of the human fetus in the **seventh week of gestation** and gradually spreads to all skin and mucous surfaces by 20 weeks.

Traditionally, lack of myelination (or the layer around the nerve fibers) has been proposed as an index of immaturity in the neonatal nervous system and used frequently to support the argument that neonates and infants are not capable of pain perception. However, pain (nociceptive) impulses in adults are conducted by unmyelinated or thinly myelinated fibers. Furthermore, Gilles has shown that nerve tracts associated with pain in the spinal cord and brain stem are completely myelinated (up to the thalamus) by 30 weeks of gestation.

Several types of observations speak for the **functional maturity** of the brain (cerebral cortex) in the fetus and neonate. First are reports of **fetal and neonatal EEG patterns**, including cortical components of visual and auditory evoked potentials, that have been recorded in preterm babies of less than 28 weeks gestation. Cortical evoked potentials to somatosensory stimuli (touch, pain, heat, cold) were also recently documented in preterm neonates from 26 weeks gestation. Well defined periods of sleep and wakefulness are present in utero from 28 weeks gestation onward.

Ultrasonographic findings report **specific fetal movements in response to needle punctures *in utero*** (Robinson & Smotherman, 1992; Sival 1993). Moreover, a controlled study of intrauterine blood sampling and blood transfusions in fetuses between 20 and 34 weeks of gestation showed that hormonal responses that were consistent with fetal perception of pain, and were correlated with the duration of the painful stimulus (Giannakoulopuolos et al, 1994). Preterm neonates born at 23 weeks gestation show **highly specific and well-coordinated physiologic and behavioral responses to pain**, similar to those seen in full-term neonates, older infants, and small children (summarized in "*Pain in Neonates*", Anand & McGrath, 1993).

2. Increased sensitivity to pain in preterm infants.

Contrary to previous teaching, current data indicate that preterm neonates have greater pain sensitivity than term neonates or older age groups. Several lines of scientific evidence support this concept. I will review these from the most basic science, to that which reflects clinical practice.

1. Studies of reflex responses:

The Cutaneous Flexor Reflex - has a lower threshold in preterm neonates than in term neonates or adults [Fitzgerald; Woolf]. The study of this reflex has been used to establish when connections between the skin and the spinal cord are first made in the fetus, and they have been used to study the maturation of ascending motor pathways. This reflex has been shown in man to **parallel pain perception exactly** in terms of threshold, peak intensity, and sensitivity to analgesics.

2. **Studies of neurotransmitting substances in the spinal cord:**

Neurotransmitter development in the dorsal horn of the spinal cord has demonstrated the early and abundant expression of the neurotransmitters mediating pain (e.g. substance P, L-glutamate, VIP, CGRP), and increased somatosensory excitability in the premature spinal cord. In contrast, the neurotransmitters contained in descending inhibitory fibers from supraspinal centers (5-HT, Norepi, Dopamine) were expressed postnatally, [Anand & Carr, 1989] implying **poorly developed gate control mechanisms for pain in preterm infants.**

3. **Receptors for pain in the fetal brain:**

Opioid receptor labeling in the brain stem of fetuses 19-21 weeks gestation demonstrated very high densities in supraspinal centers associated with sensory perception [Kinney et al, 1990]. (These inhibitory Opioid receptors may protect developing neuronal systems from constant over stimulation, given the underdeveloped gate control mechanism in the dorsal horn of the spinal cord.)

4. **Pain and stress are reflected in the hormones produced by the fetus.**

Pain in the fetus and neonate can be measured in two dimensions. Pain and surgical stress are demonstrated by a coordinated outpouring of pituitary, adrenal, and pancreatic hormones. Secondly, cardiovascular responses, such as increases in blood pressure, heart rate, dysrhythmias, or poor cardiac output may signal pain. The magnitude of hormonal (endocrine-metabolic) and other stress responses to invasive procedures or surgical operations was **much greater in neonates** as compared to adults; with neonatal catecholamine and metabolic responses up 3 - 5 times those of adult patients undergoing similar types of surgery [Anand].

5. **Pain felt as a fetus or neonate has a long term effect on the child's well-being:**

The effects of anesthesia on the neonatal stress responses are important and may contribute to the effects of stress suppression on postoperative clinical outcome. In a randomized controlled trial, preterm babies undergoing ligation of the patent ductus arteriosus were given nitrous oxide and curare, with or without the addition of intravenous fentanyl. The hormonal responses of neonates receiving nitrous oxide alone were associated with significant increases in blood glucose, lactate, and pyruvate; these were prevented in neonates given therapeutic doses of fentanyl. This study went on to show that **aggressive anesthesia not only decreased the stress responses of neonates undergoing surgery but also improved their postoperative clinical outcome.** Similarly, neonatal intensive care patients who are exposed to a single (circumcision) or repeated painful events (heelsticks) have been shown to have procedural memory for the event, and may have long term effects, even into adulthood.

6. **The amount of medicine needed to achieve a desired effect:**

Pharmacokinetic studies of anesthetic drugs have shown **higher plasma concentrations were required to maintain effective surgical anesthesia in preterm neonates** as compared to old age groups [Yaster; Greeley & de Bruijn].

Developmental changes occur in the expression of pain which differentiate preterm from term or older infants; however, these findings illustrate a **communicational specificity and not changes in pain threshold during development** [Johnston]. The studies cited above indicate a lower pain threshold in preterm neonates, and the occurrence of further decreases in pain threshold following exposure to a painful stimulus or experience [Fitzgerald].

3. **Effects of Anesthesia on the fetus**

Obstetrical anesthesia has become a very safe practice, with many women a year receiving an anesthetic during the time of their pregnancy. These women are in addition to those who receive an anesthetic at the time of delivery. It is from this patient population that the effects of anesthesia on the fetus can be derived.

Local anesthetics rarely have any affect on the fetus. By their nature, their affect is to numb the nerves and tissues around the injection site, and only minuscule amounts of drug enter the mother's circulation, and even less reach the fetus.

The administration of intravenous sedation/anesthesia has minimal effects on the unborn due to two mechanisms: 1) The mother's liver clears much of the drug, and 2) the drug must cross from the mother's blood stream into the placenta before reaching the fetus.

Since the fetus has a much higher density of Opioid (pain) receptors, scientific reasoning postulates that higher doses of Opioids will be required to saturate the increased number of receptors, and achieve a therapeutic response.

Preliminary evidence for this therapeutic response is obtained from the decreased levels of steroid stress hormones in the amniotic fluid of fetuses whose mothers had received anesthesia as compared to the those that did not receive anesthesia in response to fetoscopy performed at 16-21 weeks gestation (Parsch et al, 1991). The mothers who had received anesthesia had a infant that was less stressed by the procedure.

CONCLUSIONS

The scientific literature reviewed above and my clinical experience in the delivery of general anesthesia, systemic analgesia, conscious sedation, local and regional anesthesia to a wide variety of patients lead me to believe that:

1. The anatomical and functional processes responsible for the perception of pain have developed in human fetuses that may be considered for 'partial birth abortions'. (At this stage of neurologic development, human fetuses respond to the pain caused by needle puncture *in utero* in a similar manner as older children or adults, within the limits of their behavioral repertoire).
2. It is likely that the threshold for such pain perception is lower than that of older preterm newborns, full-term newborns, and older age groups. Thus, the pain experienced during 'partial birth abortions' by the human fetus would have a much greater intensity than any similar procedures performed in older age groups.
3. Current methods for providing maternal anesthesia during 'partial birth abortions' are unlikely to prevent the experience of pain and stress in the human fetuses before their death occurs after partial delivery.

After Dr. Norig Ellison presented his prepared testimony at the Nov. 17 public hearing before the Senate Judiciary Committee, the following exchange occurred among Senator Spence Abraham (R-Mi.); Dr. Mary Campbell, medical director of Planned Parenthood of Metropolitan Washington; and Dr. Ellison.

SEN. ABRAHAM [to Dr. Campbell]: Would you make the statement then that the fetus dies due to the anesthesia? Is that your position?

DR. CAMPBELL (Medical Director, Planned Parenthood of Metropolitan Washington): I think the fetus has no pain because of the anesthesia. I do not...

SEN. ABRAHAM: No, I'm asking you whether you think that's what causes the fetus to die?

DR. CAMPBELL: I do not know what causes the fetus to die. The fetuses are dead when delivered.

SEN. ABRAHAM: Well, let me just direct you, if I could -- I have here a factsheet that indicates it was prepared by you which relates to the House legislation in which...

[Sen. Abraham was referring to "H.R. 1833, Medical Questions and Answers," which contains the caption, "Fact Sheet Prepared by Mary Campbell, M.D." This document was circulated to members of the House of Representatives in October, before HR 1833 came to a vote in that house. This document contains the following passage:

"Q: When does the fetus die?

"A: The fetus dies of an overdose of anesthesia given to the mother intravenously. A dose is calculated for the mother's weight which is 50 to 100 times the weight of the fetus. The mother gets the anesthesia for each insertion of the dilators, twice a day. This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb."]

DR. CAMPBELL: I was quoting Dr. McMahon at that time. [EDITOR'S NOTE: There is no reference to Dr. McMahon anywhere in Dr. Campbell's five-page factsheet.] On thinking it over in more depth, I believe because there are no EEG studies available...

SEN. ABRAHAM: So you no longer adhere to the position that you say in here, "the fetus dies of an overdose of anesthesia given to the mother intravenously." That is no longer your position?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: You believe that is true?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: Dr. Ellison, would you like to comment on that?

DR. ELLISON (President, American Society of Anesthesiologists): There is absolutely no basis in scientific fact for that statement. There is -- I can present you a study in the American Journal of Obstetrics and Gynecology, 1989, by [names inaudible] et al, of 5,400 cases of women having surgery having general anesthesia or regional anesthesia in which the fetus did not suffer demise. I think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of the fetus is without basis of fact.

DR. CAMPBELL: I have not said brain death. I'm saying no spontaneous respirations, no movement.

SEN. ABRAHAM: Well, that's what you are saying today, but in this fact sheet, which you prepared I believe fairly recently, it says, "The fetus dies"-- there's no qualifying regarding breathing or anything else-- "of an overdose of anesthesia." I mean, that is a very clear statement assertion.

DR. CAMPBELL: [Pause] I simplified that for Congress. [Outburst of laughter from audience.] I do not actually believe that you want a full discussion of when death occurs.

SEN. ABRAHAM: Well, we are forced to make those decisions, and I guess my question is that how many other things would you say in the fact sheet or in your statements today have been likewise simplified in this dramatic fashion?

DR. CAMPBELL: Since I have over 28 years of education and experience in medicine, I would say that is a great deal less and a great deal more simple than what I know.

SEN. ABRAHAM: Well, it seems to me that there's a rather substantial disparity between what Dr. Ellison says and what you are both saying now and have certainly written here. I just am wondering how that bears on other comments that have been made.

Testimony of Abortionist LeRoy Carhart

Editor's note. The following excerpt is taken from Nebraska Life, the state newsletter of Nebraska RTL. LeRoy Carhart testified July 17, 1997, in a federal district courtroom in a challenge to the state's ban on partial-birth abortions. What he said has to be read to be believed. ["Question" refers to one of the lawyers challenging the law.]

Question: At what point is the fetus...does the fetus die during that process?

Carhart: I don't really know. I know that the fetus is alive during the process most of the time because I can see fetal heartbeat on the ultrasound.

The Court: Counsel, for what it's worth, it still is unclear to me with regard to the intact D&E when fetal demise occurs.

Question: Okay, I will try to clarify that. In the procedure of an intact D&E where you would start foot first, with the situation where the fetus is presented feet first, tell me how you are able to get the feet out first.

Carhart: Under ultrasound, you can see the extremities. You know what is what. You know what the foot is, you know what the arm is, you know what the skull is. By grabbing the feet and pulling down on it or by grabbing a knee and pulling down on it, usually you can get one leg out, get the other leg out and bring the fetus out. I don't know where this...all the controversy about rotating the fetus come from. I don't attempt to do that. I just attempt to bring down whatever is the most proximal portion of the fetus.

Question: At the time that you bring out the feet in this example, is the fetus still alive?

Carhart: Yes.



512 10th Street, NW Washington, DC 20004-1401
(202) 626-8800 FAX: (202) 737-9189 Website: www.nrlc.org

(202) 626-8820

June 19, 2002

Re: Partial-Birth Abortion Ban Act (H.R. 4965)

Dear Member of Congress:

The National Right to Life Committee (NRLC) urges you to cosponsor the Partial-Birth Abortion Ban Act (H.R. 4965), introduced today by Congressman Steve Chabot.

The bill would prohibit the performance of a "partial-birth abortion," the only exception being if this abortion method is "necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself."

It is well documented that partial-birth abortions are performed thousands of times annually, and that the vast majority are performed on healthy babies of healthy mothers during the fifth and sixth months of pregnancy. (Some are performed at even later points in the pre-natal period, and not only in circumstances involving problems with maternal or fetal health.) In much-publicized interviews in 1997, Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, admitted that he and leaders of other pro-abortion groups were well aware that partial-birth abortions are performed routinely during the fifth and sixth months. "In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said." (*The New York Times*, Feb. 26, 1997, page A11.) (20 weeks is the halfway point in pregnancy – 4½ months in layperson's terms.)

The abortion method that H.R. 4965 seeks to ban was well described by U.S. Supreme Court Justice Clarence Thomas in his dissent in *Stenberg v. Carhart* (2000): "After dilating the cervix, the physician will grab the fetus by its feet and pull the fetal body out of the uterus into the vaginal cavity. . . . While the fetus is stuck in this position, dangling partly out of the woman's body, and just a few inches from a completed birth, the physician uses an instrument such as a pair of scissors to tear or perforate the skull. The physician will then either crush the skull or will use a vacuum to remove the brain and other intracranial contents from the fetal skull, collapse the fetus' head, and pull the fetus from the uterus." [citations omitted]

The House approved bills to ban partial-birth abortion in the 104th, 105th, and 106th congresses. Those bills were similar (but not identical) to a Nebraska law that was struck down by a five-justice majority of the U.S. Supreme Court in *Carhart* on June 28, 2000, in which the Court extended *Roe v. Wade* to cover even the brutal practice of partial-birth abortion.

IN SUPPORT OF BAN ON PARTIAL-BIRTH ABORTION, 2

Because of the *Stenberg v. Carhart* ruling, H.R. 4965 differs in two significant respects from the bans approved in past congresses. The first change is in the definition of “partial-birth abortion.” The five-justice majority in *Carhart* thought that Nebraska’s definition of “partial-birth abortion” was vague and could be construed to cover not only abortions in which the baby is mostly delivered alive before being killed, but also the more common “dilation and evacuation” (D&E) method, in which a well-developed unborn child is dismembered piece by piece while he or she is still inside the uterus, during which attached extremities are sometimes pulled into the birth canal. In order to avoid any possibility of such confusion, the new bill defines a prohibited partial-birth abortion as one in which “the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, *the entire fetal head is outside the body of the mother*, or, in the case of breech presentation, *any part of the fetal trunk past the navel is outside the body of the mother*,” and then kills the baby. [italics added for emphasis]

Justice O’Connor was part of the five-justice majority that struck down the Nebraska law, but we believe language in her concurrence strongly suggests that the revised definition contained in H.R. 4965 would satisfy her desire to exclude internal-dismemberment (D&E) abortions from the scope of any ban. The change might also satisfy the vagueness objection of some or all of the other justices who were in the majority in *Carhart*.

Secondly, the five-justice majority ruled that an abortionist must be allowed to use the partial-birth abortion method if he believes that it is the method which has the lowest risk of side effects for any particular woman seeking an abortion in the second trimester or third trimester. The news media often say that the Supreme Court ruled that a ban on partial-birth abortions must contain a “health exception,” but that is misleading, because the majority said that the abortionist must be allowed to use the method even when the pregnant woman has no health problem whatever -- that is, when abortion is being sought for purely non-medical reasons, which is the case with the vast majority of second-trimester abortions. Indeed, the majority explicitly rejected the suggestion that the “exception” could be limited “to situations where the pregnancy itself creates a threat to health.”

The majority reached this result by deferring to findings of fact by the trial court, which were based on acceptance of assertions by late-term abortionist Dr. LeRoy Carhart and others that the partial-birth abortion method was sometimes the method least likely to cause side effects. H.R. 4965 addresses this issue by incorporating congressional findings that partial-birth abortion is never necessary to protect the health of a woman and, indeed, exposes a woman to substantial and additional health risks. The findings summarize certain past rulings in which the Supreme Court has recognized and deferred to the broad fact-finding powers of Congress. The bill concludes that, based on the extensive congressional hearing record on partial-birth abortion, “Congress finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line

IN SUPPORT OF BAN ON PARTIAL-BIRTH ABORTION, 3

between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.”

In an effort to prevent enactment of a ban on partial-birth abortions, prominent pro-abortion leaders in the House have proposed counter-legislation that they claim would restrict “late-term” abortions, such as H.R. 2702, by Congressmen Hoyer and Greenwood. When the Partial-Birth Abortion Ban Act reaches the House floor, there may be an attempt to offer similar language as a substitute amendment or as a motion to recommit. We urge you to oppose these phony bans. The Hoyer-Greenwood proposal would apply *absolutely no restrictions* to partial-birth abortions until after a baby is provably “viable” -- which abortionists generally claim is in the seventh month or even later -- even though the great majority of partial-birth abortions are performed in the fifth and sixth months. Moreover, the Hoyer-Greenwood proposal would allow even the killing of provably “viable” babies *in the seventh, eighth, and ninth months* to enhance the “mental health” of the mother, as the sponsors have explicitly confirmed in a “Dear Colleague” letter dated March 16, 2000.

In short, expressing support for a measure such as H.R. 2702 by cosponsoring it or voting for a motion or amendment based on it would put a Member on record as favoring (1) allowing *partial-birth* abortions without meaningful limitation, and (2) allowing even *third-trimester* abortions, by whatever method, for “mental health,” which Mr. Hoyer elsewhere has explained includes “psychological trauma.”

We are enclosing a factsheet titled “Key Facts on Partial-Birth Abortion,” which you may find helpful. Extensive further information on the subject (including NRLC’s thoroughly footnoted congressional testimony of March 11, 1997) is posted on the NRLC website at www.nrlc.org/abortion/pba/index.html. Please contact us if you require additional information on any facet of the debate over partial-birth abortions.

NRLC urges you to support the Partial-Birth Abortion Ban Act and to oppose any amendments not accepted by the prime sponsor of the bill. NRLC will include the roll call vote on passage of the Partial-Birth Abortion Ban Act, and any preceding roll calls necessary to protect the bill, in its scorecard of key roll call votes for the 107th Congress.

Sincerely,



David N. O'Steen, Ph.D.
Executive Director



Douglas Johnson
Legislative Director

Legfederal@aol.com



512 10th Street, NW Washington, DC 20004-1401
 (202) 626-8800 FAX: (202) 737-9189 Website: www.nrlc.org
 (202) 626-8820

Key Facts on Partial-Birth Abortion
June 18, 2002

- The Partial-Birth Abortion Ban Act would ban performance of a *partial-birth abortion* except if it were necessary to save a mother's life. The bill defines *partial-birth abortion* as an abortion in which "the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother," and then kills the baby. The bill would permit use of the procedure if "necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself."
- In a partial-birth abortion, the abortionist pulls a *living* baby feet-first out of the womb and into the birth canal (vagina), except for the head, which the abortionist purposely keeps lodged just inside the cervix (the opening to the womb). The abortionist punctures the base of the baby's skull with a surgical instrument, such as a long surgical scissors or a pointed hollow metal tube called a trochar. He then inserts a catheter (tube) into the wound, and removes the baby's brain with a powerful suction machine. This causes the skull to collapse, after which the abortionist completes the delivery of the now-dead baby.
- Under state laws, a "live birth" occurs when a baby is entirely expelled from the mother and shows any signs of life, however briefly -- *regardless of whether the baby is "viable," i.e., developed enough to be sustained outside the womb with neo-natal medical assistance*. Even at 4½ months (20 weeks), perinatologists say that if a baby is expelled or removed completely from the uterus, she will usually gasp for breath and sometimes survive for hours, even though lung development is usually insufficient to permit successful sustained respiration until 23 weeks. Thus, the term "partial-birth" is perfectly accurate.
- According to Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers (1997), and other sources, it appears that partial-birth abortions are performed 3,000 to 5,000 times annually. (Even those numbers may be low.) Based on published interviews with numerous abortionists, and interviews with Fitzsimmons in 1997, the "vast majority" of partial-birth abortions are performed in the fifth and sixth months of pregnancy, on healthy babies of healthy mothers.
- Legislative counterproposals advanced by Reps. Hoyer and Greenwood, and by Sen. Durbin, would place *no limits* on partial-birth abortions in the fifth and sixth months of pregnancy -- when the vast majority of partial-birth abortions occur. Furthermore, these "phony bans" would allow an abortion *even in the seventh month and later* if an abortionist

KEY FACTS ON PARTIAL-BIRTH ABORTION, 2

asserts that a baby is not “viable” *or* that an abortion is required by “health” problems. Reps. Hoyer and Greenwood admitted that this would allow third-trimester abortions even for (in their words) “*mental health*” reasons. (“Dear Colleague” letter, March 16, 2000)

- In January, 1997, the PBS program *Media Matters* showed that in 1995-96, the media largely swallowed a pro-abortion “party line” that partial-birth abortions are performed rarely and only in extreme medical circumstances -- claims later entirely discredited.
- Although usually used in the fifth and sixth months, the partial-birth abortion method has also been used to perform abortions in the third trimester -- that is, the seventh month and later -- most notably by the developer of the method, the late Dr. James McMahon. In a written submission to the House Judiciary Committee in June, 1995, McMahon explicitly acknowledged that he performed such abortions on babies with no “flaw” whatever, even in the third trimester, for such reasons as mere *youth* of the mother or for “psychiatric” difficulties. Indeed, even at 29 weeks -- well into the seventh month -- one-fourth of the babies that McMahon aborted had no “flaw,” however minor. McMahon’s submission showed that in a “series” of about 2,000 such abortions that he performed, only 9% were performed for “maternal [health] indications,” and of that group, the most common reason was “depression.”
- The Physicians’ Ad Hoc Coalition for Truth (PHACT) -- a group of over 600 physician-specialists (mostly in obstetrics, perinatology, and related disciplines) -- has spoken out to dispute claims that some women need partial-birth abortions to avoid serious physical injury. PHACT said: “We, and many other doctors across the United States, regularly treat women whose unborn children suffer these and other serious conditions. Never is the partial-birth procedure medically indicated. Rather, such infants are regularly and safely delivered live, vaginally, with no threat to the mother’s health or fertility.” In September, 1996, former Surgeon General C. Everett Koop and other PHACT members issued a statement that “partial-birth abortion is never medically necessary to protect a mother’s health or her future fertility. On the contrary, this procedure can pose a significant threat to both.”
- In May, 1997, the Partial-Birth Abortion Ban Act (H.R. 1122) was endorsed by the American Medical Association. In a letter to Senator Rick Santorum, AMA Executive Vice President P. John Seward, M.D., wrote, “Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.”
- Some prominent defenders of partial-birth abortions, such as NARAL’s Kate Michelman and syndicated columnist Ellen Goodman, insisted that anesthesia kills the babies before they are removed from the womb. This myth has been refuted by professional societies of anesthesiologists. In reality, the babies *are alive and experience great pain* when subjected to a partial-birth abortion. [Documentation on request.]

The New York Times

VOL. CXI.VI No. 50,715 WEDNESDAY, FEBRUARY 26, 1997 A11

An Abortion Rights Advocate Says He Lied About Procedure

By DAVID STOUT

WASHINGTON, Feb. 25 — A prominent member of the abortion rights movement said today that he lied in earlier statements when he said that doctors are not performing primarily to save the health of women bearing severely handicapped babies.

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

Ken Fitzsimmons, the executive director of the National Abortion Providers, said the information he gave in an interview about the procedure, called intact dilation and evacuation by those who believe it should remain legal and perform it, should be outlawed, because he lied about the truth about the procedure. Fitzsimmons said he is now convinced he said that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

But he is now convinced he said that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth. In a column in American Medical News, to be published today, Fitzsimmons said he lied through my teeth when he said the procedure was used

rarely and only on women whose lives were in danger or whose fetuses were damaged.

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

Mr. Fitzsimmons said that, after the interview he stayed on the sidelines for a while, but then he decided to come back and disagree with the National Right to Life Committee and others who say that the procedure is performed on women who are not in danger.

The procedure is partly elective, he said, and he said he was accurate when they said the procedure was common.

Mr. Fitzsimmons said he is partly accurate when they said the procedure was common. He said he was accurate when they said the procedure was common. He said he was accurate when they said the procedure was common.

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist should be outlawed and some abortion rights advocates and some others should be outlawed as well. Fitzsimmons said he is now convinced he said that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

hibit all third-trimester abortions, except in cases involving the "life of the mother and severe impairment of her health."

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

The abortion lobby manufactures disinformation, Douglas Johnson, the chairman of the legislative committee on this procedure, which is expected to be renewed in Congress.

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

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist should be outlawed and some abortion rights advocates and some others should be outlawed as well.

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

cause them to die either just before, during or just after childbirth," he said.

And these women, among other things, cannot preserve the ability to have further children because of the damage to the uterus before being extracted from their bodies.

A spokeswoman for Mr. Clinton said tonight that the White House knew nothing of Mr. Fitzsimmons's announcement and would not comment further.

In the vast majority of cases, the procedure is performed on a healthy woman who is not in danger, she said.

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

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

FOR A COPY OF THE AMERICAN MEDICAL NEWS ARTICLE AND OTHER DOCUMENTATION, PLEASE CALL NRIC, (202) 626-1820, fax (202) 347-3666

American Medical Association
Physicians dedicated to the health of America



P. John Seward, MD 516 North State Street 312 464-5000
Executive Vice President Chicago, Illinois 60610 312 464 4184 Fax
May 19, 1997

The Honorable Rick Santorum
United States Senate
120 Russell Senate Office Bldg.
Washington, DC 20510

Dear Senator Santorum:

The American Medical Association (AMA) is writing to support HR 1122, "The Partial Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122 now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,

A handwritten signature in cursive script that reads "P. John Seward, MD".

P. John Seward, MD

150 *Years of Caring for the Country*
1847 • 1997

**Second Trimester Abortion:
From Every Angle**

Fall Risk Management Seminar

September 13-14, 1992

Dallas, Texas

Presentations, Bibliography & Related Materials



© 1992

1400 U Street, NW Suite 100 Washington, DC 20009

Table of Contents

Presentations, Bibliography, and Related Materials

Demographics of Second Trimester Abortion - Stanley Henshaw, PhD Second Trimester Abortions in the United States (Grimes)	1
Genetic Indications - Nathan Slotnick, MD Medical Genetics for the Practitioner (Slotnick)	7
Designing an Appropriate Facility - Jacqueline Barbic When Clinics Need Help (DHHS)	11
Second Trimester D&E, 14-19 Wks - E. Steven Lichtenberg, MD, MPH Early D&E Procedure, 13.5 - 19.0 Wks (Lichtenberg)	17
Second Trimester D&E, 14-19 Wks - Gene Glick, MD Second Trimester Abortion (14-20 Wks) (Glick)	21
Second Trimester D&X, 20 Wks and Beyond - Martin Haskell, MD D & E for Late Second Trimester Abortion (Haskell)	27
Second Trimester D&X, 20 Wks and Beyond - James T. McMahon, MD Late Pregnancy Interruption: Key Points (McMahon)	35
Second Trimester D&E, 20 Wks and Beyond - Paul Wright, MD Method for Late Trimester Abortions (Wright)	37
Second Trimester Techniques: Medical Induction - Vanessa Cullins, MD Abortion: Epidemiology, Safety & Technique (Blumenthal)	39
Prevention of Complications - Warren Hern, MD, MPH, PhD Correlation of Fetal Age & Measurements (Hern)	47
Serial Multiple Laminaria & Adjunctive Urea (Hern)	55
Use of Prostaglandins as Abortifacients	61
Ethical Issues in Second Trimester Abortions - Joan Callahan, PhD Elective Abortion: The Moral Debate (Knight & Callahan)	69
Patient Responses to Late Procedures - Anne Baker, MA Reasons for Second Trimester Abortion (Baker)	83
<u>Comprehensive Bibliography</u> on Second Trimester Abortion	87

Dilation and Extraction
for Late Second Trimester Abortion

Martin Haskeil, M.D.

Presented at the National Abortion Federation
Risk Management Seminar, September 13, 1992

INTRODUCTION

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term *Dilation and Extraction* or *D&X* to distinguish it from dismemberment-type D&E's.

This procedure can be performed in a properly equipped physician's office under local anesthesia. It can be used successfully in patients 20-26 weeks in pregnancy.

The author has performed over 700 of these procedures with a low rate of complications.

BACKGROUND

D&E evolved as an alternative to induction or instillation methods for second trimester abortion in the mid 1970's. This happened in part because of lack of hospital facilities allowing second trimester abortions in some geographic areas, in part because surgeons needed a "right now" solution to complete suction abortions inadvertently started in the second trimester and in part to provide a means of early

second trimester abortion to avoid necessary delays for instillation methods.¹ The North Carolina Conference in 1978 established D&E as the preferred method for early second trimester abortions in the U.S.^{2, 3, 4}

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.⁵

However, most surgeons find dismemberment at twenty weeks and beyond to be difficult due to the toughness of fetal tissues at this stage of development. Consequently, most late second trimester abortions are performed by an induction method.^{6, 7, 8}

Two techniques of late second trimester D&E's have been described at previous NAF meetings. The first relies on sterile urea intra-amniotic infusion to cause fetal demise and lysis (or softening) of fetal tissues prior to surgery.⁹

The second technique is to rupture the membranes 24 hours prior to surgery and cut the umbilical cord. Fetal death and ensuing autolysis soften the tissues. There are attendant risks of infection with this method.

In summary, approaches to late second trimester D&E's rely upon some means to induce early fetal demise to soften the fetal tissues making dismemberment easier.

PATIENT SELECTION

The author routinely performs this procedure on all patients 20 through 24 weeks LMP with certain exceptions. The author performs the procedure on selected patients 25 through 26 weeks LMP.

The author refers for induction patients falling into the following categories:

- Previous C-section over 22 weeks
- Obese patients (more than 20 pounds over large frame ideal weight)
- Twin pregnancy over 21 weeks
- Patients 26 weeks and over

DESCRIPTION OF DILATION AND EXTRACTION METHOD

Dilation and extraction takes place over three days. In a nutshell, D&X can be described as follows:

Dilation
 MORE DILATION
 Real-time ultrasound visualization
 Version (as needed)
 Intact extraction
 Fetal skull decompression
 Removal
 Clean-up
 Recovery

Day 1 - Dilation

The patient is evaluated with an ultrasound, hemoglobin and Rh. Hadlock scales are used to interpret all ultrasound measurements.

In the operating room, the cervix is prepped, anesthetized and dilated to 9-11 mm. Five, six or seven large Dilapan hydroscopic dilators are placed in the cervix. The patient goes home or to a motel overnight.

Day 2 - More Dilation

The patient returns to the operating room where the previous day's Dilapan are removed. The cervix is scrubbed and anesthetized. Between 15 and 25 Dilapan are placed in the cervical canal. The patient returns home or to a motel overnight.

Day 3 - The Operation

The patient returns to the operating room where the previous day's Dilapan are removed. The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized and grasped with a tenaculum. The membranes are ruptured, if they are not already.

The surgical assistant places an ultrasound probe on the patient's abdomen and scans the fetus, locating the lower extremities. This scan provides the surgeon information about the orientation of the fetus and approximate location of the lower extremities. The transducer is then held in position over the lower extremities.

The surgeon introduces a large grasping forcep, such as a Bierer or Hern, through the vaginal and cervical canals into the corpus of the uterus. Based upon his knowledge of fetal orientation, he moves the tip of the instrument carefully towards the fetal lower extremities. When the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws to firmly and reliably grasp a lower extremity. The surgeon then applies firm traction to the instrument causing a version of the fetus (if necessary) and pulls the extremity into the vagina.

By observing the movement of the lower extremity and version of the fetus on the ultrasound screen, the surgeon is assured that his instrument has not inappropriately grasped a maternal structure.

With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.

The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.

At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). Next he slides the tip of the middle finger along the spine towards the skull while applying traction to the shoulders and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down,

along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

Reassessing proper placement of the closed scissors tip and safe elevation of the cervix, the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

The surgeon finally removes the placenta with forceps and scrapes the uterine walls with a large Evans and a 14 mm suction curette. The procedure ends.

Recovery

Patients are observed a minimum of 2 hours following surgery. A pad check and vital signs are performed every 30 minutes. Patients with minimal bleeding after 30 minutes are encouraged to walk about the building or outside between checks.

Intravenous fluids, pitocin and antibiotics are available for the exceptional times they are needed.

ANESTHESIA

Lidocaine 1% with epinephrine administered *intra-cervically* is the standard anesthesia. Nitrous-oxide/oxygen analgesia is administered nasally as an adjunct. For the Dilapan insert and Dilapan change, 12cc's is used in 3 equidistant locations around the cervix. For the surgery, 24cc's is used at 6 equidistant spots.

Carbocaine 1% is substituted for lidocaine for patients who expressed lidocaine sensitivity.

MEDICATIONS

All patients not allergic to tetracycline analogues receive doxycycline 200 mgm by mouth daily for 3 days beginning Day 1.

Patients with any history of gonorrhea, chlamydia or pelvic inflammatory disease receive additional doxycycline, 100mgm by mouth twice daily for six additional days.

Patients allergic to tetracyclines are not given prophylactic antibiotics.

Ergotrate 0.2 mgm by mouth four times daily for three days is dispensed to each patient.

Pitocin 10 IU intramuscularly is administered upon removal of the Dilapan on Day 3.

Rhogam intramuscularly is provided to all Rh negative patients on Day 3.

Ibuprofen orally is provided liberally at a rate of 100 mgm per hour from Day 1 onward.

Patients with severe cramps with Dilapan dilation are provided Phenergan 25 mgm suppositories rectally every 4 hours as needed.

Rare patients require Synalogs DC in order to sleep during Dilapan dilation.

Patients with a hemoglobin less than 10 g/dl prior to surgery receive packed red blood cell transfusions.

FOLLOW-UP

All patients are given a 24 hour physician's number to call in case of a problem or concern.

At least three attempts to contact each patient by phone one week after surgery are made by the office staff.

All patients are asked to return for check-up three weeks following their surgery.

THIRD TRIMESTER

The author is aware of one other surgeon who uses a conceptually similar technique. He adds additional changes of Dilapan and/or laminaria in the 48 hour dilation period. Coupled with other refinements and a slower operating time, he performs these procedures up to 32 weeks or more.¹⁰

SUMMARY

In conclusion, Dilation and Extraction is an alternative method for achieving late second trimester abortions to 26 weeks. It can be used in the third trimester.

Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.

Among its disadvantages are that it requires a high degree of surgical skill, and may not be appropriate for a few patients.

REFERENCES

-
- ¹ Cates, W. Jr., Schulz, K.F., Grimes D.A., et al: The Effects of Delay and Method of Choice on the Risk of Abortion Morbidity, *Family Planning Perspectives*, 9:266, 1977.
 - ² Borell, U., Emberey, M.P., Bygdeman, M., et al: Midtrimester Abortion by Dilation and Evacuation (Letter), *American Journal of Obstetrics and Gynecology*, 131:232, 1978.
 - ³ Centers for Disease Control: *Abortion Surveillance 1978*, p. 30, November, 1980.
 - ⁴ Grimes, D.A., Cates, W. Jr., (Berger, G.S., et al, ed): Dilation and Evacuation, *Second Trimester Abortion—Perspectives After a Decade of Experience*, Boston, John Wright-PSG, 1981, p. 132.
 - ⁵ *Ibid*, p. 121-128.
 - ⁶ *Ibid*, p. 121.
 - ⁷ Kerenyi, T.D. (Berger, G.S., et al, ed): Hypertonic Saline Instillation, *Second Trimester Abortion— Perspectives After a Decade of Experience*, Boston, John Wright-PSG, 1981, p. 79.
 - ⁸ Hanson, M.S. (Zatuchni, G. I., et al, ed): Midtrimester Abortion: Dilation and Extraction Preceded by Laminaria, *Pregnancy Termination Procedures, Safety and New Developments*, Hagerstown, Harper and Row, 1979, p. 192.
 - ⁹ Hem, W.M., *Abortion Practice*, Philadelphia, J.B. Lippincott, 1990, p. 127, 144-8.
 - ¹⁰ McMahon, J., personal communications, 1992.

**Additional Testimony of
Dr. Norig Ellison, President, American Society of Anesthesiologists,
Before the Senate Judiciary Committee
November 17, 1995**

After Dr. Ellison presented his prepared testimony to the Judiciary Committee, which is reproduced elsewhere, the following exchange occurred among Senator Spence Abraham (R-Mi.); Dr. Mary Campbell, medical director of Planned Parenthood of Metropolitan Washington; and Dr. Ellison.

SEN. ABRAHAM [to Dr. Campbell]: Would you make the statement then that the fetus dies due to the anesthesia? Is that your position?

DR. CAMPBELL (Medical Director, Planned Parenthood of Metropolitan Washington): I think the fetus has no pain because of the anesthesia. I do not...

SEN. ABRAHAM: No, I'm asking you whether you think that's what causes the fetus to die?

DR. CAMPBELL: I do not know what causes the fetus to die. The fetuses are dead when delivered.

SEN. ABRAHAM: Well, let me just direct you, if I could -- I have here a factsheet that indicates it was prepared by you which relates to the House legislation in which...

[Sen. Abraham was referring to "H.R. 1833, Medical Questions and Answers," which contains the caption, "Fact Sheet Prepared by Mary Campbell, M.D." This document was circulated to members of the House of Representatives in October, before HR 1833 came to a vote in that house. This document contains the following passage:

"Q: When does the fetus die?

"A: The fetus dies of an overdose of anesthesia given to the mother intravenously. A dose is calculated for the mother's weight which is 50 to 100 times the weight of the fetus. The mother gets the anesthesia for each insertion of the dilators, twice a day. This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb."]

ADDITIONAL TESTIMONY OF DR. ELLISON, P. 2

DR. CAMPBELL: I was quoting Dr. McMahon at that time. [EDITOR'S NOTE: There is no reference to Dr. McMahon anywhere in Dr. Campbell's five-page factsheet.] On thinking it over in more depth, I believe because there are no EEG studies available...

SEN. ABRAHAM: So you no longer adhere to the position that you say in here, "the fetus dies of an overdose of anesthesia given to the mother intravenously." That is no longer your position?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: You believe that is true?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: Dr. Ellison, would you like to comment on that?

DR. ELLISON (President, American Society of Anesthesiologists): There is absolutely no basis in scientific fact for that statement. There is -- I can present you a study in the American Journal of Obstetrics and Gynecology, 1989, by [names inaudible] et al, of 5,400 cases of women having surgery having general anesthesia or regional anesthesia in which the fetus did not suffer demise. I think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of the fetus is without basis of fact.

DR. CAMPBELL: I have not said brain death. I'm saying no spontaneous respirations, no movement.

SEN. ABRAHAM: Well, that's what you are saying today, but in this fact sheet, which you prepared I believe fairly recently, it says, "The fetus dies"-- there's no qualifying regarding breathing or anything else-- "of an overdose of anesthesia." I mean, that is a very clear statement assertion.

DR. CAMPBELL: [Pause] I simplified that for Congress. [Outburst of laughter from audience.] I do not actually believe that you want a full discussion of when death occurs.

SEN. ABRAHAM: Well, we are forced to make those decisions, and I guess my question is that how many other things would you say in the fact sheet or in your statements today have been likewise simplified in this dramatic fashion?

ADDITIONAL TESTIMONY OF DR. ELLISON, P. 3

DR. CAMPBELL: Since I have over 28 years of education and experience in medicine, I would say that is a great deal less and a great deal more simple than what I know.

SEN. ABRAHAM: Well, it seems to me that there's a rather substantial disparity between what Dr. Ellison says and what you are both saying now and have certainly written here. I just am wondering how that bears on other comments that have been made.



Suite 500, 419 7th Street, N.W. Washington, D.C. 20004-2293
(202) 626-8800 (FAX) 737-9189 or 347-5907 <http://www.nrlc.org>

(202) 626-8820

**Testimony of Douglas Johnson
Legislative Director, National Right to Life Committee
on the Partial-Birth Abortion Ban Act (H.R. 929, S. 6)
at a Joint Hearing Before
the U.S. Senate Judiciary Committee
and
the Constitution Subcommittee of the U.S. House Judiciary Committee
March 11, 1997**

Chairman Hatch, Chairman Hyde, Chairman Canady, and distinguished members of the Judiciary committees, I thank you for this opportunity to present the views of the National Right to Life Committee on the subject of partial-birth abortions and the Partial-Birth Abortion Ban Act.

The National Right to Life Committee (NRLC) is the nation's largest organization devoted entirely to defending the right to life of all members of the human family from the lethal threats of abortion, infanticide, and euthanasia. NRLC is a federation of state right-to-life organizations in all 50 states.

NRLC strongly supports the Partial-Birth Abortion Ban Act (H.R. 929, S. 6). This bill would prohibit the practice of partial-birth abortion, unless this procedure were ever necessary to prevent the death of a mother. [1] Since Congressman Canady first authored and introduced the Partial-Birth Abortion Ban Act in June, 1995, NRLC has been in the forefront of the coalition of secular and religious organizations that have worked to enact this legislation.

NRLC is strongly opposed to the "phony ban" proposal currently being promoted by President Clinton, Senator Daschle, and a number of their allies in the media. The Clinton-Daschle phony ban would allow the 4,000 or more partial-birth abortions that are performed annually on perfectly healthy babies of perfectly healthy mothers, in the fifth and sixth months of pregnancy, to continue with no limitation whatsoever. Leon Panetta, then the White House chief of staff, confirmed when pressed by NBC News' Tim Russert on *Meet the*

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 2

Press on December 15 that President Clinton will *not* sign the bill unless its scope is narrowed to the seventh month and later.

The Clinton-Daschle proposal is a political construct, designed to provide political cover for lawmakers who want to appear to their constituents as if they have voted to restrict partial-birth abortions, while actually voting for a hollow measure that is not likely to prevent a single partial-birth abortion, and which therefore is inoffensive to the pro-abortion lobby. This political ploy will become increasingly transparent as time goes on.

Regarding the Phrase "Late-Term Abortions"

On a related point: the news media does the public a disservice with its sloppy use of the phrase "late-term abortion." Many organs of the press say that the bill before these committees would ban certain "late-term abortions." However, when the pro-abortion lobby and the White House use the phrase "late-term abortion" nowadays, it is code for "third-trimester abortion." So this bill and President Clinton would both restrict so-called "late-term" abortions, according to the news media. Yet, more than 90% of the abortions that would be banned by the Partial-Birth Abortion Ban Act are *not* third-trimester abortions.

Therefore, this careless use of the phrase "late-term abortion" -- usually adopted in an effort to avoid the term adopted by Congress, *partial-birth abortion* -- engenders a confusion that is very much to President Clinton's advantage. This confusion misleads the public into the erroneous belief that the Clinton-Daschle proposal largely overlaps with this bill to ban partial-birth abortions -- and that is exactly the impression that President Clinton and Vice-president Gore have worked hard to create. But this is a deception, because the Clinton-Daschle proposal would place *no limitations* on the thousands of partial-birth abortions performed on healthy babies of healthy mothers in the fifth and sixth months of pregnancy.

Pro-abortion Disinformation Campaign Revealed

Since this legislation was originally introduced in June, 1995, we have seen a concerted disinformation campaign by the leadership of the major pro-abortion lobbies. They emphatically insisted, in writing and on the airwaves, that the procedure banned by the Partial-Birth Abortion Ban Act is performed only 500 or so times annually, and only in the most extreme medical circumstances.

This disinformation campaign experienced a setback in late January with the release of an edition of the PBS media-criticism program *Media Matters* that examined how the press has covered the partial-birth abortion issue [2], and then received a far harder blow last month when Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers (NCAP), admitted in interviews first with the *American Medical News* and then with

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 3

numerous other news outlets that he had lied when he made such claims in an interview with *ABC News Nightline*. [3]

The importance of this admission was not that Fitzsimmons himself had lied on one occasion -- after all, that portion of his *Nightline* interview never even aired. The important point is found in Fitzsimmons' explanation for what he said during the *Nightline* interview: "I just went out there and spouted *the party line*." [Knight-Ridder, Feb. 28, emphasis added.]

The "party line" referred to, of course, was the "party line" disseminated by the leaders of the major Washington-based pro-abortion lobbies-- the National Abortion and Reproductive Rights Action League (NARAL), the Planned Parenthood Federation of America (PPFA), and the National Abortion Federation (NAF). I will discuss this campaign in more detail later in this testimony.

Dr. Martin Haskell Starts the Debate

The debate over the partial-birth abortion method -- as a discrete facet of the overall debate on the practice of abortion -- really began in earnest in 1993, when NRLC obtained a copy of a paper in which Ohio abortionist Martin Haskell described in detail, step-by-step, how to perform the procedure.

Dr. Haskell is a family practitioner who has performed over 1,000 such abortions in his walk-in abortion clinics. Anyone who is seriously seeking the truth behind the conflicting claims regarding partial-birth abortions should start by reading Dr. Haskell's paper, and the transcripts of the explanatory interviews that Haskell gave in 1993 to two medical publications, *American Medical News* (the official AMA newspaper) and *Cincinnati Medicine*. [4] (I have included these materials with several other attachments to my written testimony, and would ask that they be made part of the hearing record.) Here is how Haskell explained a key part of the abortion method:

With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. The skull lodges at the internal cervical os [the opening to the uterus]. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up. At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down).... [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.... [T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents." [5]

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 4

Haskell wrote that he "routinely performs this procedure on all patients 20 through 24 weeks LMP [i.e., from 4½ to 5½ months after the last menstrual period] with certain exceptions," these "exceptions" involving complicating factors such as being more than 20 pounds overweight. He also wrote that he used the procedure through 26 weeks [six months] "on selected patients." [p.28] He added, "Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia." [p. 33]

So, the partial-birth abortion method is generally used *beginning* at 20 weeks-- which is the middle of the fifth month of pregnancy. The plastic medical models displayed by NRLC since this debate began in 1995 is a medically accurate representation of the average human being at 20 weeks. The seven-inch surgical scissors, which we also regularly displayed at hearings and press conferences, is the Metzenbaum surgical scissors specified in Haskell's paper. It is used to pierce a human being's skull.

The NRLC Drawings

NARAL and other prominent pro-abortion voices say that the drawings used by NRLC since 1993 show a full-term or nearly full-term baby. This claim was repeated by syndicated columnist Ellen Goodman in a column just last week. Goodman wrote that "in 1995 . . . pro-life members of the 104th Congress introduced drawings of full-term perfect Gerber babies being aborted."

Yet anyone with a ruler can quickly ascertain the falsity of such claims, by comparing the length of the baby to the length of the doctor's hand. You will discover that these drawings show a baby 8-10 inches long, which corresponds exactly to average length during the 20-24 week range, as shown in charts in obstetrical textbooks, one of which I have attached to my testimony.

As to "perfect Gerber babies," Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, recently conceded that the overwhelming majority of fetuses/babies aborted during this period are indeed completely normal, and their mothers are healthy. Thus, the drawings show the typical case.

Moreover, Professor Watson Bowes, eminent authority in fetal and maternal medicine and co-editor of the *Obstetrical and Gynecological Survey*, certified in writing before we ever published the drawings in 1993 that these drawings accurately depict what Dr. Haskell's paper describes. Even Dr. Haskell in 1993 told the *American Medical News* that these same drawings are "technically accurate."

Why Not Use "Medical" Terminology?

Pro-abortion groups also dispute the terminology used in the bill. Dr. Haskell referred to this

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 5

procedure as "dilation and extraction," a name he said he had "coined." In 1995, Haskell said the method is "somewhat equivalent to a breech type of delivery," and said he had learned that this breech delivery process had been developed as an abortion method by Dr. James McMahan of Los Angeles.

Dr. McMahan performed thousands of these abortions before he died in October, 1995. He referred to the method by his own coined term, "intact dilation and evacuation."

When the Partial-Birth Abortion Ban Act was written in 1995, neither "dilation and extraction" nor "intact dilation and evacuation" appeared in any medical dictionary or in the Medline medical database. Nor did either term appear in the textbook on abortion methods, *Abortion Practice*, by late-term abortion specialist Dr. Warren Hern.

Thus, these terms were merely a kind of pseudo-medical jargon. Idiosyncratic jargon cannot be employed in a criminal law, or the courts will declare that law to be "void for vagueness." Moreover, both Haskell and McMahan used their coined terms to apply to a variety of quite different operations. For example, McMahan's written submission to the House Judiciary Constitution Subcommittee showed that he often performed what he called an "intact dilation and evacuation" procedure to remove a baby who had died in utero *of a natural causes* -- which is not an abortion and which no one wants to ban.

Therefore, Congressman Canady had to develop a precise term for the procedure he sought to prohibit, and then define that term with the clarity required for a criminal law. The definition incorporated into the bill is crystal clear, so clear that any doctor or layperson can immediately grasp what the bill prohibits: an abortion in which "the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."

Opponents of the bill say that the term "partial-birth" is misleading and that the definition of "partial-birth abortion" is vague, but their real problem is that they find the name and the definition convey to the public all too *explicitly* exactly how these abortions are performed. Therefore, they demand that the press avoid the term adopted by Congress and instead employ pseudo-medical terms, even though they have no genuine medical pedigrees and are inaccurate, since they refer to broader classes of procedures than those banned by the bill.

But Is This Really a Partial Birth?

Opponents of the bill often object to the term "partial-birth" because they claim that the term is misleading. For example, in response to the recent publicity surrounding interviews given by Ron Fitzsimmons, a World Wide Web site called *The Abortion Rights Activist*, which is very closely allied with the National Abortion Federation, offered these complaints on or about March 1:

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 6

Supporters of the bill spoke of fetuses that would be born alive if fully extracted, and often referred to "inches" as the only difference between an aborted fetus and a living baby. Illustrations were produced showing a fetus that, by its size and level of development, was clearly in the final stages of pregnancy. . . . A fetus in the 20th, or even the 24th, week of pregnancy is not viable. It does not possess the neural capacity to feel pain. It is not "inches" away from life -- life outside the womb is not possible for it. It is not the large, fully-developed fetus shown in the National Right to Life Committee illustrations . . .

Every sentence in the above quotation from *The Abortion Rights Activist* contains at least one demonstrable error of fact or interpretation. Because the new "party line" from the pro-abortion lobbies largely mirrors (or is mirrored by) *The Abortion Rights Activist's* objections, it is worthwhile to refute them in detail. (As explained earlier, the NRLC drawings accurately depict a baby in the 20-24 week range.)

First, the term "partial-birth" is legally perfectly accurate. "Full-term" and "birth" are too entirely different things. A baby expelled alive from the womb, whether by a deliberate act or otherwise, has indeed been "born." As a matter of law, in every state, if a baby emerges completely from the uterus, and shows even the briefest signs of life, legally a *live birth* has occurred. That is true *regardless* of whether or not the baby has yet reached the stage where she can survive independently of the mother (23-24 weeks), and *whether or not* the baby suffers from profound or even lethal medical disorders. (By 23 weeks, lung development has advanced to the point that the baby has a 1-in-4 chance of sustained survival with assistance, and the survival rate rises sharply over the next few weeks.)

Obstetricians and perinatologists confirm that even during the 20 to 23-week range, if a baby is expelled or removed completely from the uterus, she will usually gasp for breath for some time, even though her lung development is still insufficient to permit successful sustained respiration until 23 weeks. So the victim is indeed only "inches from her first breath," when the surgical scissors penetrates her skull.

Moreover, even at 20 to 23 weeks, there will be movements and a heartbeat after the child is expelled -- sometimes for an hour or more -- as the infant struggles to hold on to life.

What is at Stake In This Debate

Under the doctrine of the Supreme Court, a living just-delivered baby, no matter how premature, is a person under the Constitution. The deliberate killing of such a just-delivered baby-- regardless of stage of development or handicap -- is legally murder.

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 7

A partial-birth abortion is really a lethal adaptation of a long-known procedure for delivering babies, feet first, in certain unusual circumstances. But when used as an abortion method, the abortionist must take care that he does not dilate the cervix a little too much, because if he did so, the head could slip across the Supreme Court's constitutional "line of personhood." That must not happen until after the surgical scissors and the suction machine have done their deadly work.

But if we step back for a moment from the Supreme Court's doctrine, we all really know-- don't we?-- that it is *the same* little girl or boy *whether or not* she or he has traveled that extra three inches. And each of us once was there.

Each individual member of the human family killed in a partial-birth abortion is *at most* a few weeks short of the point at which she could survive to experience a full lifespan of experiences as wondrous and varied as those of anyone here today, or anyone who views this hearing. Many of the victims of partial-birth abortion are actually *past* the point at which they could survive in our nation's neonatal units. Even at 23 weeks, the survival rate is now between one-fourth and one-third, and the survival rate curves sharply upward week by week after that. According to the landmark survey of neonatal units in the National Institute of Child Health and Human Development Neonatal Research Network, conducted in 1987 and 1988 by Dr. Maureen Heck, et al, babies born at 23 weeks had on average a 23% chance of survival, rising to 34% at 24 weeks, and 54% at 25 weeks.

Opponents of this legislation continue to insist that partial-birth abortions are "rare" -- by which they mean, rare compared to the total number of all types of abortions. But for each human being who is at the pointed end of the surgical scissors, a partial-birth abortion is a one-hundred-percent proposition. As Senator Daniel Patrick Moynihan said on March 2, 1997, "it is infanticide, and one would be too many."

And what does "rare" mean, anyway? Human beings cannot be reduced to statistics. Ron Fitzsimmons of the National Coalition of Abortion Providers now puts the number as high as 5,000. Even that number may turn out to be low, because we do not know how much of the "iceberg" we are seeing. If a new virus swept through neo-natal units and killed even 500 premature babies, that would be a top news story -- not dismissed as an event too "rare" to be of consequence.

Rare is the man or woman who, upon reflection, would disagree with the following statement: "If *my* individual life had been cut off before birth, whether by accident or otherwise, *no other human being* could ever have become the unique, irreplaceable individual that I am -- not even another child born later to my same parents." You see, to each person, his or her *own* intrinsic uniqueness, his or her own unrepeatable "personhood," and its infinite value, are really self-evident.

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 8

Those of us who hold the right-to-life position simply recognize that the same applies to the individual unborn or partly born human beings whom we seek to protect. Regardless of how many of these procedures actually occur, not one of the victims is disposable, and not one is interchangeable with anyone else who ever came before or who will ever come after. As they now are, we each once were.

Why Use this Method?

Some press accounts suggest that the baby's skull must be collapsed because "the head is too big to pass through." But the head is "too large" only in the sense that the abortionist dilates the cervix (the opening to the womb) just enough to get the shoulders out, but not the small additional amount that would allow the head to emerge. (If the procedure is performed according to instructions, "*usually* there is not enough dilation for it to pass through," says Dr. Haskell in his paper. [emphasis added])

Last year, Chairman Hyde, you posed this question: "A partial-birth abortion involves the almost complete delivery of a living baby, who is then killed. Now, if the entire baby has been delivered alive, except for the head, supposedly without jeopardy to the mother, why can't the doctor simply deliver the head as well, without killing the baby?" And as you went on to note, when a reporter for the *American Medical News* put essentially that very question to Dr. Haskell, he replied, "The point here is you're attempting to do an abortion... not to see how do I manipulate the situation so that I get a live birth instead."

Is the Baby Alive?

Doctors Haskell and McMahon were the subjects of tape-recorded interviews with the *American Medical News* in 1993, in which they addressed many of the disputed issues surrounding this abortion method. For example, Haskell said that 80% of these abortions were "purely elective" in his practice. The transcript also contains the following exchange:

American Medical News: Let's talk first about whether or not the fetus is dead beforehand.

Dr. Haskell: ~~No it's not. No, it's really not.~~ A percentage are for various numbers of reasons.... **And so in my case, I would think probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not.** [6]

In an interview in the Dec. 10, 1989 *Dayton News*, Haskell conveyed that the scissors thrust is usually the lethal act:

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 9

"When I do the instrumentation on the skull . . . it destroys the brain tissue sufficiently so that even if it (the fetus) falls out at that point, it's definitely not alive," Dr. Haskell said. [7]

Brenda Pratt Shafer, a registered nurse from Dayton, Ohio, stood at Dr. Haskell's side while he performed three partial-birth abortions in 1993. In testimony before the House Judiciary Constitution Committee, Nurse Shafer described in detail the first of the three procedures-- which involved, she said, a baby boy at 26½ weeks (over 6 months). According to Mrs. Shafer, the baby was alive and moving as the abortionist

delivered the baby's body and the arms -- everything but the head. The doctor kept the baby's head just inside the uterus. The baby's little fingers were claspng and unclaspng, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when he thinks that he might fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening and sucked the baby's brains out. Now the baby was completely limp. [8]

The Anesthesia Myth

Recognizing how distressing such accounts are to persons of normal moral sensibilities, on numerous occasions, leading opponents of the bill, including syndicated columnist Ellen Goodman and NARAL President Kate Michelman, repeatedly insisted that anesthesia given to the mother peacefully induces a painless death in the fetus before the rest of the procedure is performed. This claim was widely accepted and repeated as fact in news stories and editorial commentaries. Here is how Michelman put it on one occasion:

The other side grossly distorted the procedure. There is no such thing as a 'partial-birth.' ... before the procedure begins, the anesthesia that they give the woman already causes the demise of the fetus. That is, it is not true that they're born partially. (KMOX-AM radio, St. Louis, Nov. 2, 1995)

Thus, Ms. Michelman argued that it was misleading to call this process a "partial-birth," *precisely because, she claimed, these fetuses were already dead from the anesthesia before they were removed.*

Likewise, Planned Parenthood distributed to Congress a "fact sheet" signed by Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington, which stated:

The fetus dies of an overdose of anesthesia given to the mother intravenously....This

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 10

induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb. [9]

However, this claim that anesthesia kills the baby was just another fabrication. The "anesthesia myth" was emphatically refuted in authoritative testimony presented to the Senate and House committees in late 1995 and early 1996 (yet the myth still sometimes appears in press accounts). [10]

In his initial testimony before the Senate Judiciary Committee on November 17, 1995, Dr. Norig Ellison, the president of the 34,000-member American Society of Anesthesiologists (ASA), said "I think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of the fetus is without basis of fact." [11]

Under questioning by Senator Abraham, Planned Parenthood's Dr. Campbell, who wrote the "fact sheet" quoted above, admitted, "I do not know what causes the fetus to die. . . . I simplified that for Congress. I do not believe that you want a full discussion of when death occurred."

Dr. Ellison also told the Senate committee:

Drugs administered to the mother, either local anesthesia administered in the paracervical area or sedatives/analgesics administered intramuscularly or intravenously, will provide little-to-no analgesia [pain relief] to the fetus. [12]

In a hearing on anesthesia and fetal pain before the House Judiciary Constitution Subcommittee on March 21, 1995, the "anesthesia myth" was again emphatically refuted by Dr. Ellison and by Dr. David Birnbach, the president-elect of the Society for Obstetric Anesthesia and Perinatology. They testified that a *local* anesthetic -- which is what Dr. Martin Haskell's paper specifies -- *does not affect* the fetus. These experts also testified that dosages of *general* anesthesia, safe for the mother, would provide little if any pain relief to the baby, much less induce "fetal demise."

Dr. Birnbach testified, "Having administered anesthesia for fetal surgery, I know that on occasion we need to administer anesthesia directly to the fetus because even at these early ages the fetus-moves-away-from-the-pain-of-the-stimulation." [hearing record, page 288]

In an attempt to recover, the proponents of the anesthesia myth claimed that Dr. McMahon had given his patients doses of narcotic anesthesia of 36 to 100 times the normal dose. Dr. Birnbach responded, "Although there is no evidence that this massive dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death."

Other medical experts at that hearing gave un rebutted testimony that the partial-birth abortion

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 11

procedure must subject the baby to great pain. For example, Professor Jean A. Wright, associate professor of pediatrics and anesthesia at Emory University School of Medicine in Atlanta, testified that recent research (which she described) shows that by the stage of development that a baby could be a "candidate" for a partial-birth abortion, the fetus "is more sensitive to pain than a full-term infant would be if subjected to the same procedures."

Prof. Wright also said that these fetuses have "the anatomical and functional processes responsible for the perception of pain," and have "a much higher density of Opioid (pain) receptors" than older humans.

Documentation and Disinformation

Beginning in early 1995, the House Judiciary Constitution Subcommittee collected the available literature and did further research on the subject of partial-birth abortion. Among other new material, the subcommittee counsel received detailed and lengthy written submissions from Dr. McMahon, including a breakdown of a "series" of over 2,000 of these procedures that he had performed. [13]

Thus, by the time the legislation was introduced in June, 1995, there was already a considerable body of primary documentation on the issue, including Dr. Haskell's instructional paper, published interviews with Haskell and McMahon by Diane Gianelli of *American Medical News* and others, and McMahon's written submissions to the House subcommittee. From the start, the materials published by NRLC regarding partial-birth abortion relied very heavily on this body of primary documentation.

Certainly, the mass of such material has grown as the debate has proceeded. But as John Leo points out in his column in the March 10 edition of *U.S. News & World Report* [14], at the time that Congressman Canady introduced the bill on June 15, 1995, the basic facts regarding partial-birth abortions were already amply documented, and those facts were as follows: the method was being employed by some abortionists as a routine abortion technique in the fifth and sixth months of pregnancy, mostly for entirely non-medical reasons; that it had often been employed even later, at least by Dr. McMahon, and not only in cases involving medical difficulties of the mother or baby; and that the babies were alive when they were removed from the womb, dying from the thrust of the surgical instrument through the base of the skull, and the subsequent suctioning out of the brain.

In June, 1995, the leaders of the major pro-abortion lobbies were well familiar with that body of documentation. Yet, from the day this bill was introduced in June, 1995, the major Washington-based abortion-advocacy and abortion-industry lobbies, notably the National Abortion Federation (NAF), the Planned Parenthood Federation of America (PPFA), and the National Abortion and Reproductive Rights Action League (NARAL), spouted to the media and to the Congress a "party line" on partial-birth abortion that departed radically from this

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 12

body of primary documentation. They asserted that the procedure that the bill would ban was very rare, performed only around 500 times annually in the U.S.. And more importantly, they asserted that the procedure was performed only or almost only to save the mother's life and in cases of profound malformations of the baby.

The abortion industry's "cover story" would have been of limited consequence, except that so many journalists and commentators who covered the bill, both here in Washington and elsewhere, eagerly adopted these assertions and presented them to the public as simple fact.

Indeed, it was striking and frustrating to us how little interest there was among many in the press corps in examining the primary documentation. NRLC distilled this documentation into factsheets which we very energetically disseminated from the time this bill was introduced. More than that, we repeatedly and widely distributed the underlying primary documentation, such as Dr. Haskell's paper and the interviews conducted with Haskell and McMahon by the *American Medical News*. I know that Mr. Canady's office also made strenuous efforts to place this material in the hands of the press and lawmakers. Yet in all too many cases, it was clear that many -- not all-- of those covering the issue already had the set of "facts" that fit their preconceptions -- and those were the assertions that they had received from the abortion-industry lobby.

For example, on December 8, 1995, the day after the bill passed the Senate, the Associated Press bureau in Washington -- despite being repeatedly provided with that documentation -- sent its clients a dispatch that contained this unattributed explanation: "Late second- or third-trimester abortions are performed to remove a severely deformed or already dead fetus that could cause the mother to die, become infertile or otherwise desperately ill."

Another example: On April 10, 1996, the day after President Clinton vetoed the bill, NRLC Senior Congressional Liaison Maureen Malloy Ferguson telephoned the *Washington Post* reporter who was writing the story on the veto, Ann Devroy, to offer documentation refuting the claims that Mr. Clinton had made at the "veto ceremony." Ms. Devroy coolly replied, "I have everything I need." The next morning, her story asserted in the *Post's* own voice, "The procedure is said to be rarely used and usually only when severe birth defects, such as the absence of brain development or conditions threatening the life of the woman, are discovered too late in pregnancy to use other abortion methods." [15]

In September, 1996, even *after* the *Record* (Bergen, N.J.) and the *Washington Post* had published reports concluding that such claims were false, on the basis of interviews with numerous additional abortionists, the pro-abortion disinformation continued to be presented to the American people as fact by many news outlets.

For example: CBS's *This Morning*, Sept. 20, 1996, correspondent Linda Douglass, "[The bill would ban] rare, late-term abortions, usually done only in cases where the fetus is severely

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 13

deformed." *Time*, Sept. 30, 1996: "Experts estimate that partial-birth abortion accounts for perhaps 600 of the 1.5 million abortions performed in the U.S. each year," and, "In many such abortions, the fetus is so severely deformed or the pregnancy so complicated that carrying the child to term would threaten the life or health of the mother." *Los Angeles Times*, Sept. 27, 1996: "The [partial-birth abortion] procedure is generally used when the fetuses have fatal birth defects or when the mother's health is in jeopardy." We have, I estimate, hundreds of such examples in our files.

NRLC Materials Have Been Consistent and Accurate

As requested by the committees, we have submitted what we believe to be a complete set of NRLC's press releases, factsheets, media background papers, and letters to Congress on this issue, going back to the introduction of this legislation in June, 1995. Previously, we had submitted a set of these same materials to the journalists associated with PBS's *Media Matters*.

We welcome scrutiny of this material. Such examination will show that, from the beginning, we explicitly emphasized that most partial-birth abortions are performed in the fifth and sixth months and for purely non-medical reasons.

For example, consider the very first NRLC factsheet sent out to the press on this issue, dated June 21, 1995, in which we quoted various items of what we called "misinformation" that had appeared in the press in the days immediately following the bill's introduction on June 15. The very first item of misinformation that we rebutted was the claim that the bill was aimed primarily at "third-trimester" abortions. We explained, "In fact, the partial-birth method is generally used starting at 20 weeks (four and one-half months, or halfway through the second trimester) -- and the bill bans use of the method at any stage of development." [16]

We continued to vigorously challenge the same misconception in innumerable later factsheets, letters, and memos to editors. For example, on May 28, 1996, I sent a memo to a *60 Minutes* producer, Amy Cunningham, who was working on a story on partial-birth abortion, in which I said:

I have noticed that critics of HR 1833 are working overtime to artificially constrict the debate to ~~"third-trimester" abortions, in order to evade discussion of the many partial-birth abortions performed -- mostly for social reasons -- during the late second trimester. (Haskell's 80%, etc.)~~ But a "third-trimester" demarcation, while in some respects convenient for the White House and its allies, is without legal or medical justification. . . . there is no non-ideological basis for focusing only on "third-trimester" partial-birth abortions.

Notwithstanding this objection, *60 Minutes* adopted precisely the "filter" sought by the pro-

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 14

abortion lobby. Many similar communications from NRLC to other news outlets were equally ineffectual. [16]

Another example: in the September 11, 1996 edition of our comprehensive factsheet -- issued before the *Washington Post* and *Bergen Record* published quotes from a number of previously unreported practitioners of the method -- we said:

It appears that the substantial majority of partial-birth abortions are performed late in the *second* trimester -- that is, before the 27-week mark -- but usually after 20 weeks (4½ months). There is compelling evidence that the overwhelming majority of these pre-week-27 partial-birth abortions are performed for purely 'social' reasons. In an attempt to 'filter out' this documentation, many opponents of the bill attempt to narrow the debate to only *third-trimester* partial-birth abortion procedures. . .

The conclusion of the PBS *Media Matters* investigation was that those of us who were in the forefront of the campaign for this bill asserted, *from the beginning*, that partial-birth abortions are performed thousands of times annually, mainly in the second trimester, for non-medical reasons in the great majority of cases, while the pro-abortion groups asserted that it was used only hundreds of times, in the third trimester, only in extreme circumstances. Therefore, it is rather vexing to read statements over the past two weeks, by pro-abortion advocacy groups, and by some journalists, suggesting that the leading supporters of the bill originally framed the issue primarily in terms of third-trimester abortions, and only recently switched the focus. This is revisionist history. It is an effort by the pro-abortion lobby to control damage and salvage credibility. But it is irreconcilable with the documents that NRLC has submitted to these committees, and will make available to others.

It is true that there were some public statements by some lawmakers and other supporters of the bill that spoke of partial-birth abortions as if they were most often performed in the third trimester, and/or that unduly emphasized those abortions that Dr. James McMahon performed even in the eighth and ninth months. When we urged such speakers to place their emphasis on the typical practice rather than exceptional cases, the typical response we received was more or less along the lines of, "But that's what we read in the paper!" And they had read it in the paper because the paper had adopted "the party line" of the abortion lobby that this was a third-trimester issue, over our objections.

Success of Pro-Abortion Disinformation Documented by PBS *Media Matters*

That assessment by NRLC is confirmed by the findings of the investigative report released by *Media Matters*, the quarterly PBS program of media criticism. In an edition released in late January, the *Media Matters* journalists concluded that many journalists "did little original reporting and willingly accepted information from pro-choice sources -- which turned out to

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 15

be inaccurate," said the producers. From the time the Partial-Birth Abortion Ban Act was introduced in June, 1995, until the final votes on President Clinton's veto in September, 1996, most "reporters tended to accept as true the assertions of the abortion-rights side, despite evidence calling into question their claims."

The program focused on three specific disputed issues. From the beginning, correspondent Terry Eastland stated, "Abortion opponents claimed that the procedure was used thousands of times a year, mainly in the second trimester of pregnancy, and mostly on the healthy fetuses of healthy mothers. Countering their campaign, abortion-rights groups said that the procedure was used only several hundred times a year, mainly in the third trimester, and almost always in cases of severe fetal deformity and to protect the health or the life of the mother."

After displaying press releases in which NAF, NARAL, and PPFA made just such claims regarding the number and circumstances of the procedures, the program showed how the pro-abortion side's assertions were adopted as fact by the *Washington Post*, the *Los Angeles Times*, and many others.

A June 2, 1996 *60 Minutes* program on partial-birth abortion received particularly sharp criticism from *Media Matters*. "The piece that *60 Minutes* did really fell into all the traps that this whole debate presented," *Time* magazine's Karen Tumulty said during the program. "They used these incredibly tragic examples, but examples that only portrayed basically one side of the debate."

60 Minutes "made little effort to convey the view of abortion opponents that the procedure is most often used on healthy fetuses in the second trimester," noted *Media Matters*.@

NCAP's Ron Fitzsimmons Blows the Whistle

The abortion industry's disinformation continued to be asserted by prominent voices in the abortion lobby, and accepted by many in the press, until just two weeks ago, when Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers (NCAP), told the press that he lied when he claimed that partial-birth abortions were performed only rarely and in extreme medical circumstances. He knew this was untrue, he said, because when the Partial-Birth Abortion Ban Act was first introduced (in June, 1995), he called doctors who use the method, and "I learned right away that this was being done for the most-part in cases that did not involve those extreme circumstances."

Fitzsimmons now estimates that up to 5,000 partial-birth abortions are performed annually, and that "they're primarily done on healthy women of healthy fetuses." *The New York Times* (Feb. 26) reported, "As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common. . . . In the vast majority of cases, the procedure is

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 16

performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said."

(Curiously, in a March 6 Associated Press dispatch, these statements by Fitzsimmons were translated as, "not all are medically necessary.")

[The 5,000 "ceiling" also may eventually prove to be low, because we still don't know how much of the iceberg we are seeing. The Alan Guttmacher Institute, an affiliate of PPFA, has reported for one year 164,000 abortions performed after the first trimester, and that figure is based on incomplete, voluntary reports. The Centers for Disease Control has reported that in 1993, over 17,000 abortions were performed at 21 weeks and later-- and the CDC acknowledges that the reports that it receives are very incomplete.]

Were the Pro-abortion Groups Confused?

Faced with this whistleblower in their ranks, the leaders of NARAL, PPFA, and NAF have offered as their defense a claim that they were confused. They claim that material put out by NRLC and other prominent supporters of the bill misled them into believing that the bill was aimed at *third-trimester* partial-birth abortions. Therefore, all of their past public statements as to the frequency and circumstances in which the partial-birth method is employed, they say, should be retroactively edited to refer to only those abortions performed in the seventh month and later.

This really won't wash.

First, the Partial-Birth Abortion Ban Act is a short, simple bill. Typewritten, it fits on one page. The bill has never contained any reference to the developmental age of the baby. It simply bans any abortion in which "the person performing the abortion partially vaginally delivers a living fetus before killing the infant and completing the delivery." In a March 5, 1997 memo to editors, NARAL on one page argues that statements by bill supporters caused NARAL to make statements that should now be understood to apply only to third-trimester abortion. But on the very next page of the memo, NARAL acknowledged:

The intent of the legislation has been clear from the beginning. The bill would outlaw the procedure in the second and third trimesters, both before and after fetal viability.

Second, as discussed above, from the beginning the materials disseminated to congressional offices and to the press, by the House Judiciary Constitution Subcommittee, by Congressman Canady's personal office, and by NRLC, have all emphasized that most of the abortions affected by the bill occur in the fifth and sixth months -- specifically, beginning at 20 weeks.

Third, anyone who takes the time to look at the past public statements of the leaders of

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 17

NARAL, NAF, and PFFA, in context, will find that they clearly did *not* confine their sweeping assertions to *third-trimester* partial-birth abortions. Typical of many such claims was the release issued by the Planned Parenthood Federation of America (PPFA) when the bill passed the House on November 1, 1995, which said regarding the method the bill would ban: "The procedure, dilation and extraction (D&X), is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality."

The same claim was made continuously by the National Abortion Federation in materials provided to journalists in print and through that organization's page for journalists on the World Wide Web, even after the publication of the Bergen *Record* and *Washington Post* stories last September. As recently as February 25, 1997, the day before the Ron Fitzsimmons story broke, the NAF page informed journalists and other web visitors, "This particular procedure is used only in about 500 cases per year, *generally after 20 weeks of pregnancy*, and most often when there is a severe fetal anomaly or maternal health problem detected late in pregnancy." [emphasis added] Many, many other such examples are on record.

Most of the members of Congress who voted against the Partial-Birth Abortion Ban Act last year justified their position, at least in part, on the claims that the procedure was extremely rare and done only in cases of dire necessity -- not by citing *Roe v. Wade*. It will be instructive to see how many of those lawmakers support the bill this year, now that these assertions have been discredited, and the truth is laid clearly before them and their constituents.

Why Are Abortions Typically Performed in the Fifth and Sixth Months?

Very few abortions in the fifth and sixth months involve any of the medical circumstances that President Clinton and others have relied on to justify their opposition to the Partial-Birth Abortion Ban Act. The overwhelming majority of partial-birth abortions (like other second-trimester abortions) are purely "elective" procedures -- that is, they are performed for purely non-medical reasons.

On September 15, 1996, the *Record* (Bergen, New Jersey) published a report by staff writer Ruth Padawer, based on separate interviews with two abortionists at a single-abortion clinic in Englewood, who independently told her that they perform over 1,500 partial-birth abortions annually in that facility-- triple the *nationwide* figure given out by pro-abortion advocacy and industry groups. As to *why* they perform these procedures:

"We have an occasional amnio abnormality, but it's a minuscule amount," said one of the doctors at Metropolitan Medical, an assessment confirmed by another doctor there. "Most are Medicaid patients, black and white, and most are for elective, not medical,

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 18

reasons: people who didn't realize, or didn't care, how far along they were. Most are teenagers." [18]

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

Furthermore, in most cases where the procedure is used, the physical health of the woman whose pregnancy is being terminated is not in jeopardy.... Instead, the "typical" patients tend to be young, low-income women, often poorly educated or naive, whose reasons for waiting so long to end their pregnancies are rarely medical. [19]

The *Post's* Brown later explained to *Media Matters*:

Cases in which the mother's life were at risk were extremely rare. . . . Most people who got this procedure were really not very different from most people who got abortions.

Indeed, there is really no evidence that the reasons for which abortions are performed in the fifth and sixth months by the partial-birth abortion method are any different, in general, from the reasons why abortions are performed during that period by other abortion methods -- and it is well established that the great majority of second-trimester abortions do not involve any illness of the mother or the baby. In 1987, the Alan Guttmacher Institute (AGI), an affiliate of the Planned Parenthood Federation of America (PPFA), collected questionnaires from 1,900 women who were at abortion clinics procuring abortions. Of the 1,900, "420 had been pregnant for 16 or more weeks."

These 420 women were asked to choose among a menu of reasons why they had not obtained the abortions earlier in their pregnancies. Only two percent (2%) said "a fetal problem was diagnosed late in pregnancy," compared to 71% who responded "did not recognize that she was pregnant or misjudged gestation," 48% who said "found it hard to make arrangements," and 33% who said "was afraid to tell her partner or parents." The report did not indicate that any of the 420 late abortions were performed because of maternal health problems. ["Why Do Women Have Abortions?," *Family Planning Perspectives*, July/August 1988.]

Also illuminating is an 1993 internal memo by Barbara Radford, then the executive director of the National Abortion Federation:

There are many reasons why women have late abortions: life endangerment, fetal indications, *lack of money or health insurance, social-psychological crises, lack of knowledge about human reproduction, etc.* [emphasis added]

In June, 1995, Dr. James McMahan submitted to the House Judiciary Constitution

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 19

Subcommittee a report on a "series" of more than 2,000 "intact dilation and evacuation" procedures that he had performed. Of these, by Dr. McMahon's own reckoning, only 175 cases (9%) were for "maternal indications," the most common of which was "depression." Another 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders, such as cleft palate and Down Syndrome. (Although this material was published in the official hearing record, when asked at a November 7, 1995 press conference about "arguments. . . that these procedures. . . are given for depression or cleft palate," NARAL's Kate Michelman response, "That is . . . not only a myth, it's a lie.")

In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws" group. She concluded that "most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting." [20]

Over one-third of McMahon's 2,000-abortion "series" involved neither fetal nor maternal health problems, however trivial. This should not be surprising, given McMahon's philosophy on the matter, as he expressed in a 1993 interview with *American Medical News*:

"[A]fter 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.' On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother."

Does the Ban Interfere With "the Practice of Medicine"?

In a March 5, 1997 press release, PPFA avoided discussion of its past misstatements and argued, "Congress should not be telling doctors how to practice medicine." But the killing of these members of the human family is not the practice of "medicine" in the way that term is usually understood. Those who perform these procedures are really cloaking the brutality of what they do behind the aura of respect that we all hold for those who practice true healing arts. Dr. Warren Hern, who performs many third-trimester abortions (although not by the partial-birth method, which he has criticized as risky [21]), has written:

It is in the interest of the abortion service to use the social status of the physician and the legitimate medical activity associated with the physician to overcome community resistance to the abortion service. For the physician, particularly one in solo practice, this can mean establishing, displaying, or maintaining all the substance and appearance

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 20

of a 'normal' professional status to the extent possible and obtaining, by proxy, acceptance of one's activity with regard to abortion. [22]

Our laws require that partial-birth abortion, like other abortion, be performed by licensed medical professionals, but that does not make it medicine in the true sense. It is not a healing art. Partial-birth abortion is the unmerciful killing of a member of the human family who is indeed almost within reach – just a few short weeks, or a few short inches – of the lifespan of varied experiences of any one of us, of anyone viewing this hearing.

Last year, Congress banned the practice of "female genital mutilation" (that is the term adopted by Congress, although the "medical terms" are "infibulation" or "female circumcision"). Some physicians had argued that if they refuse to perform this procedure for immigrants whose cultural norms demand this practice, then the procedure will be performed by those who are less technically proficient. Congress rejected this rationale, and banned the procedure even by physicians, with a five-year prison sentence for violations of the ban. Congress concluded – rightly, I believe – that even if performed by a physician, female genital mutilation is a cruel form of child abuse. So, too, is partial-birth abortion.

Claims of Medical Necessity Refuted

Although it is now coming to be generally accepted that the "vast majority" of partial-birth abortions are performed in the fifth and sixth months on healthy babies of healthy mothers, a small fraction -- no doubt under 10%, probably under 5% since Dr. McMahon's death -- actually are performed in the third trimester. What about them?

First, the repeated assertions by pro-abortion groups that partial-birth abortions that have been performed in the third trimester have been performed only in cases of extreme physical disorders of the mother and/or the baby, are false. In 1995, Dr. McMahon submitted to the House Judiciary Constitution Subcommittee a graph and explanation that explicitly showed that he aborted *healthy* ("not flawed") babies *even in the third trimester (after 26 weeks of pregnancy)*. Dr. McMahon's own graph showed, for example, that at 29 or 30 weeks, *one-fourth* of the aborted babies had no "flaw" however slight. Underneath the graph, Dr. McMahon offered this explanation:

After 26 weeks, those pregnancies that are not flawed are still non-elective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications. [chart and caption reproduced in June 15, 1995 hearing record, page 109, and are attached] [23]

In an interview with Constitution Subcommittee Counsel Keri Harrison, Dr. McMahon

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 21

explained that "pediatric indication" referred to underage mothers, not to any medical condition of the mother or the baby.

Still, it is true that a subset of the third-trimester partial-birth abortions involve babies who have grave disorders that will result in death of the baby soon after birth. These unfortunate babies deserve compassion and the best comfort-care that medical science can offer -- not a scissors in the back of the head. In some such situations there are good medical reasons to deliver such a child early, after which natural death will follow quickly.

These cases have been addressed by the Physicians' Ad Hoc Coalition for Truth (PHACT), a group of physicians, mostly professors or specialists in obstetrics or related disciplines, now numbering more than 400, including former Surgeon General C. Everett Koop. Beginning in newspaper ads last fall, these specialists said that "partial-birth abortion is never medically necessary to protect a mother's health or future fertility. On the contrary, this procedure... can pose a significant threat to both her immediate health and future fertility." [24]

The PHACT specialists have also distributed to congressional offices very specific refutations of claims that partial-birth abortion was necessary or medically advisable in any of the cases cited by President Clinton. For example, at his May 23, 1996, and December 13, 1996, press conferences, President Clinton relied heavily the argument that partial-birth abortion is necessary to prevent serious injury to women whose babies have enlarged heads (hydrocephaly). PHACT commented:

We, and many other doctors across the United States, regularly treat women whose unborn children suffer these and other serious conditions. Never is the partial-birth procedure medically indicated. Rather, such infants are regularly and safely delivered live, vaginally, with no threat to the mother's health or fertility.

It is noteworthy that none of the five women who appeared with President Clinton at his April 10, 1996 veto ceremony required a partial-birth abortion because of danger to her life. As one of the women, Claudia Crown Ades, said in a tape-recorded April 12, 1996, radio interview on WNTM (Mobile, AL):

~~My procedure was elective... That is considered an elective procedure,~~ as were the procedures of Coreen Costello and Tammy Watts and Mary-Dorothy Line and all the other women who were at the White House yesterday. All of our procedures were considered elective. [Complete tape recording available on request from NRLC.]

Ades and one of the other women who appeared with President Clinton had previously said that her condition threatened her life, but they elaborated that the risk would have occurred *if* their babies had died natural deaths within their wombs. But the removal of a baby who dies

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 22

a natural death, whether by foot-first extraction or in any other manner, is not an abortion and has nothing to do with the bill. Professor Watson Bowes, Jr., of the University of North Carolina, co-editor of the *Obstetrical and Gynecological Survey*, has stated that weeks would pass between the baby's natural death and the development of any resulting risk to the mother.

Dr. Harlan Giles, a professor of "high-risk" obstetrics and perinatology at the Medical College of Pennsylvania, performs abortions by a variety of procedures up until "viability." However, in sworn testimony in the U.S. Federal District Court for the Southern District of Ohio (Nov. 13, 1995), Prof. Giles said:

[After 23 weeks] I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent. . . But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt. [transcript, page 240]

Under closer examination, it becomes clear that in some cases, the primary reason for performing the procedure is not concern that the baby will die in utero, but rather, that he/she will be *born alive*, either with disorders incompatible with sustained life outside the womb, or with a *non-lethal* disability. (Again, in Dr. McMahon's table of partial-birth abortions performed for "fetal indications," the largest category was for Down Syndrome.)

Viki Wilson, whose daughter Abigail died at the hands of Dr. McMahon at 38 weeks, said:

I knew that I could go ahead and carry the baby until full term, but knowing, you know, that this was futile, you know, that she was going to die... I felt like I needed to be a little more in control in terms of her life and my life, instead of just sort of leaving it up to nature, because look where nature had gotten me up to this point. [NAF video transcript, page 4.]

Tammy Watts, whose baby was aborted by Dr. McMahon in the 7th month, said:

I had a choice...I could have carried this pregnancy to term, knowing everything that was wrong. [Testimony before Senate Judiciary Committee, Nov. 17, 1995]

In a 1995 letter opposing the ban, one of Dr. McMahon's colleagues at Cedar-Sinai Medical Center, Dr. Jeffrey S. Greenspoon, put it this way:

As a volunteer speaker to the National Spina Bifida Association of America and the Canadian National Spina Bifida Organization, I am familiar with the burden of raising

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 23

a significantly handicapped child. . . . The burden of raising one or two abnormal children is realistically unbearable. [Letter to Rep. Hyde, July 19, 1995]

In many of these cases, therefore, the argument that the mother's "health" requires a partial-birth abortion, upon scrutiny, turns out to be an argument for euthanasia of partly born human beings.

Misconceptions Remain

Even in the light of recent developments, several serious misconceptions remain. It is not true that 41 states ban third-trimester abortions. All but a few of those laws allow the abortionist himself to define what "viability" means (exceptions are New York and Pennsylvania, which specify that restrictions apply after "24 weeks:), and/or contain wide-open exceptions for "health," including emotional "health." These laws do not "ban" or "severely restrict" third-trimester abortions. They amount to a mostly symbolic but unenforceable statement by the state that third-trimester abortions are frowned upon.

As *Washington Post* medical writer David Brown, M.D., concluded in a September 17, 1996 article:

Contrary to a widely held public impression, third-trimester abortion is not outlawed in the United States. The landmark Supreme Court decisions *Roe v. Wade* and *Doe v. Bolton*, decided together in 1973, permit abortion on demand up until the time of fetal "viability." . . . In *Doe v. Bolton* the court ruled that abortion could be performed after fetal viability if the operating physician judged the procedure necessary to protect the life or health of the woman. "Health" was broadly defined. "Medical judgment may be exercised in the light of all factors -- physical, emotional, psychological, familial and the woman's age -- relevant to the well-being of the patient," the court wrote. "All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment." Because of this definition, life-threatening conditions need not exist in order for a woman to get a third-trimester abortion. [25]

I have been involved in full-time pro-life work since 1980. I have often heard NARAL's Kate Michelman say that most states "ban" third-trimester abortions or ban them "except for life and health," but I have never heard her frankly acknowledge that the Supreme Court's definition of "health" includes any purely "emotional" factors "relevant to the well-being of the patient."

I have seen many press accounts that reported, quite erroneously, that most states have banned third-trimester abortions. For example, a March 7 *Boston Globe* story said that "states have the right to ban late-term abortions," and that "Massachusetts and 40 other states have banned late-term abortions, with few exceptions." Such assertions are extremely misleading.

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 24

The Clinton-Daschle "Phony Ban" Scam: Fodder for the Gullible

The March 4 *American Medical News* story in which NCAP's Ron Fitzsimmons blew the whistle on the pro-abortion disinformation campaign also contained the observation that the "abortion rights" side's strategy is "to try to narrow the focus of the debate to third-trimester abortions, which are far fewer in number than those done in the late second trimester and more frequently done for reasons of fetal anomaly."

That diversionary strategy is still being employed by President Clinton and his agents, and by pro-abortion members of Congress led by Senator Tom Daschle (D-SD). Their strategy depends heavily on the continuation of careless and gullible coverage of this issue by elements of the news media. Unfortunately, we are still seeing a good deal of such coverage.

At his televised December 13 press conference, President Clinton (directly or through spokespersons) has told the American people that he would sign "the bill" that he vetoed if an exception were added to cover "serious" health-related circumstances. That was a deceptive, because President Clinton's agents have clearly communicated through other channels that Mr. Clinton will *not* sign "the bill" unless it is also limited to the third trimester.

In policy terms, those two sets of assurances are light-years apart. It is now recognized by all concerned that the vast majority of partial-birth abortions -- surely over 90% -- are performed in the fifth and sixth months, not the third trimester. So, the televised public statement by President Clinton (and Vice-president Gore [26]), that President Clinton will sign "the bill" if the "health exception" is added, are deceptive. In reality, President Clinton is demanding a radically different bill -- a bill that would allow the thousands of partial-birth abortions performed in the fifth and sixth months of pregnancy, on healthy babies of healthy mothers, to continue with no restriction at all.

NBC News' Tim Russert pinned down White House Chief of Staff Leon Panetta on this point on the Dec. 15, 1996 edition of *Meet the Press*. Mr. Panetta confirmed that President Clinton's position is indeed that he will not sign a bill that places limitations on partial-birth abortions performed in the fifth and sixth months. But that confirmation has not been reflected in most subsequent news stories coming out of the White House press corps, which continue to report that President Clinton would sign the ban if a so-called "health" exception were added.

Last week, we finally saw another couple of attempts to flush President Clinton out on this. On March 5, one reporter questioned White House Press Secretary Mike McCurry about whether Clinton would indeed "sign the bill" if the health exception were added, or whether he is also demanding the removal of all of the fifth and sixth-month partial-birth abortions

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 25

from the scope of the bill. Mr. McCurry replied lamely, "The difference between second-trimester ban and third-trimester ban is one I can't address. It may be a little too technical for here."

Then, at President Clinton's March 7 press conference, NBC's Jim Miklaszewski asked the really pertinent question, perfectly directly: "It's since been revealed that there are approximately 5,000 of these so-called partial-birth abortions performed every year -- 90 percent of them in the fifth and sixth month. Would you now support a ban if it included provisions to protect the mother but would ban the procedure also in the fifth and sixth month?" In response, President Clinton launched into a diversionary discourse about the women who, he insists, require the procedure to preserve future childbearing capacity, before concluding, "I can't answer the question that you asked me any clearer than that because I want to see the language of any proposed bill."

President Clinton's response, like McCurry's, was evasive and deceptive. But President Clinton's subordinates have confirmed that Leon Panetta's December 15 statement on *Meet the Press* is still valid. As the *Boston Globe* reported on March 8, "White House spokeswoman Mary Ellen Glynn said Clinton's remarks should be interpreted as an endorsement for a bill banning *third-trimester* abortions . . . with a very narrow exception for health reasons." [emphasis added]

Thus, President Clinton and Senator Daschle are proposing a bill that would explicitly allow *at a minimum* 90% of the partial-birth abortions to continue without *any* limitation -- those performed before the seventh month.

Moreover, their proposal would allow performance of a partial-birth abortion even in the seventh month and later based on an abortionist's mere assertion, however baseless in fact, that this procedure would enhance prospects for future childbearing, or on the basis of his assertion that he did not consider the child to be "viable."

The *Boston Globe* Takes the Bait

Yet, President Clinton, Senator Daschle, and the abortion lobby hope to market this entirely hollow bill as a great "compromise." This marketing plan depends on their expectation of an unskeptical mindset still prevalent among many in the news media.

That expectation was certainly amply fulfilled by a story that appeared on page 1 of the March 7 edition of the *Boston Globe*. This report, titled "President quietly shifts on late-term abortions, compromise would be first U.S. curb," may be the single most gullible piece of reporting we've seen since the partial-birth abortion debate began in mid-1995 -- and that's saying a lot.

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 26

The *Globe* swallowed -- hook, line, and sinker -- the Clinton-Daschle proposal as a great compromise -- indeed, as a historic concession by the pro-abortion forces. The Clinton-Daschle proposal was billed by the *Globe* as "a dramatic shift in the quarter-century political battle over abortion."

The *Globe* even went so far as to predict that "Republicans who oppose abortion might be willing to support the compromise as a way to restrict abortions." Well, nice try. But members of Congress who genuinely "oppose abortion," or who wish to place an authentic ban on partial-birth abortions, will not be as gullible as the *Boston Globe*.

The Clinton-Daschle proposal is entirely hollow. It is a purely political construct, designed to provide political cover for lawmakers who want to maintain high ratings with NARAL while appearing to vote for restrictions on partial-birth abortions. This "phony ban" would allow, without restriction, every one of the roughly 4,000 or more partial-birth abortions that are performed on healthy babies of healthy mothers in the fifth and sixth months of pregnancy -- every single one. And in the seventh month and later, the Clinton-Daschle bill would allow partial-birth abortion at the abortionists' discretion.

Indeed, the Clinton-Daschle is nothing more than a re-packaged version of the unsuccessful amendment offered to the Partial-Birth Abortion Ban Act by Senator Boxer on December 7, 1995 -- an amendment endorsed by the National Abortion and Reproductive Rights Action League (NARAL). The Boxer Amendment said:

The prohibition... shall not apply to any abortion performed prior to the viability of the fetus, or after viability where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or avert serious adverse health consequences to the woman.

What Does "Viability" Mean in the Clinton-Daschle Proposal?

In *medical* terms, "viability" is the point at which a baby born prematurely can be sustained by good medical assistance. Currently, many babies are "viable" a full three weeks before the "third trimester." Therefore, most partial-birth abortions kill babies who are already "viable," or who are at most a few weeks short of "viability," in *medical* terms.

However, it is important to note that when the term "viability" appears in proposals such as the Boxer Amendment or the Clinton-Daschle proposal, the meaning is quite different. First: these formulations invariably fail to define "viability," but rather empower the abortionist himself to decide what "viability" means. This is, by analogy, comparable to a law by which Congress would ban any "assault weapon," while empowering each gun dealer to

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 27

determine what constitutes an "assault weapon." That is not a restriction. Under the Clinton-Daschle proposal, it would be logically impossible for any partial-birth abortion ever to be illegal, because the person who is supposedly being "regulated," the abortionist, would have the sole authority to define the point at which the procedure becomes illegal!

According to a press report, a spokeswoman for Dr. George Tiller of Kansas, who regularly performs third-trimester abortions, defended abortions through 26 weeks "because these fetuses are not capable of surviving outside the womb *without artificial life supports.*" [emphasis added] But the point at which the baby can survive "without artificial life supports" would be *34 weeks or even later*. Under the Clinton-Daschle proposal, Dr. Tiller's idiosyncratic definition would be the only definition that mattered. [27]

Moreover, in 1995, Dr. Martin Haskell testified in court that 24-week babies should not be presumed viable, because "fetal viability outside the womb at 23 to 24 weeks is about 3 percent." According to the landmark 1987-88 NIH study by Heck, et al, the actual figure should be at least 23 percent -- but under Clinton-Daschle, only Haskell's personal opinion is legally pertinent.

Also, if there were hypothetically a criminal law banning abortions after "viability," that term would have to be understood in the context of the standard of proof, which is "beyond a reasonable doubt." Thus, to convict an individual of performing an illegal abortion past "viability," it would not be sufficient to show that the baby had a one-in-three or a one-in-two or even a three-in-four chance of survival. Unless the baby was indeed past the seven-month point, a "reasonable doubt" might remain as to whether that *particular* baby would have survived, but for being killed by the partial-birth abortion. **Thus, in the context of such a criminal law, the term "viability" really does mean "third trimester," if it means anything at all.**

This particular difficulty is avoided by drawing a firm "time line" in the statute, as New York and Pennsylvania have done at 24 weeks. But such bright-line laws are invariably opposed by the abortion lobby, since they go beyond symbolism and might actually prevent an abortion.

By the way, the Arkansas law to which President Clinton has often referred does not actually "ban" third-trimester abortions," as he claims. Rather, it allows abortion without restriction until "viability," ~~which is explicitly presumed not to have occurred~~ "prior to the end of the 25th week of the pregnancy," and then allows abortions after that point for unlimited "health" reasons.

The Bill Poses a New Question for the Supreme Court

The Supreme Court has never said that there is a constitutional right to kill human beings who are mostly born. In its official 1995 report on the bill, the House Judiciary Committee makes

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 28

the very plausible argument that the Partial-Birth Abortion Ban Act could be upheld by the Supreme Court without disturbing *Roe*.

In *Roe*, the Supreme Court said that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." But a partial-birth abortion does not involve an "unborn fetus." A partial-birth abortion, by the very definition in the bill, kills a human being who is partly born. Indeed, a partial-birth abortion kills a human being who is four-fifths across the 'line-of-personhood' established by the Supreme Court.

Moreover, in *Roe v. Wade* itself, the Supreme Court took note of a Texas law that made it a felony to kill a baby "in a state of being born and before actual birth," and the Court did not disturb that law. [28]

Thus, the Supreme Court could very well decide that the killing of a mostly born baby, even if done by a physician, is not protected by *Roe v. Wade*.

I again thank the Chairmen and the members for this opportunity. The National Right to Life Committee would welcome the opportunity to provide further documentation on any substantive issue on which I have touched in my testimony.

NOTES

[1] HR 929/S. 6 permits performance of a partial-birth abortion "that is necessary to save the life of a mother because her life is endangered by a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, if no other medical procedure would suffice for that purpose." Yet some press accounts continue to imply that the bill contains no such exception. For example, on March 5, 1997, *CBS Evening News With Dan Rather* reported, "President Clinton says . . . he will again veto any ban that does not make exceptions where the mother's life or health is in danger"-- ignoring both the fact that the bill already contains a life-of-mother exception, and the President's additional demand that all pre-seventh-month abortions be dropped from the ban.

[2] *Media Matters* describes itself as "a series that looks critically at news media performance." The program is hosted by executive editor Alex Jones, a Pulitzer Prize-winning journalist who also hosts National Public Radio's weekly show *On the Media*. The investigation of partial-birth abortion coverage was reported by Terry Eastland, editor of *Forbes MediaCritic Online*, and produced by two-time Emmy documentary nominee Joseph Dorman.

[3] "Abortion Rights Leader Urges End to 'Half Truths'," by Diane M. Gianelli, *American Medical News*, March 3, 1993. See also "Pro-Choice Advocates Admit to Deception," by Ruth Padawer, February 27, 1997 *Record*, and "An Abortion Advocate Says He Lied About

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 29

Procedure," by David Stout, *The New York Times*, February 26, 1997.

[4] "Shock-tactic Ads Target Late-Term Abortion Procedure," by Diane M. Gianelli, *American Medical News*, July 5, 1993. Also, "Second Trimester Abortion: An Interview with W. Martin Haskell, M.D.," *Cincinnati Medicine*, Fall, 1993.

[5] "Dilation and Extraction for Late Second Trimester Abortion," by Martin Haskell, M.D., National Abortion Federation, 1992.

[6] Transcript submitted with letter from Barbara Bolen, editor of *American Medical News*, to House Judiciary Committee Subcommittee on the Constitution, July 11, 1995.

[7] "Late Abortion Pushes Medicine to the Edge: Accounts Differ in Kettering Case," by Dave Daley, *Dayton Daily News*, December 10, 1989, reproduced in House Judiciary Committee Hearing Before the Subcommittee on the Constitution, June 15, 1996, Serial No. 31.

[8] See "Effects of Anesthesia During a Partial-Birth Abortion," Hearing Before the Subcommittee on the Constitution of the House Judiciary Committee, March 21, 1996, Serial No. 73.

[9] "H.R. 1833: Medical Questions and Answers," "Fact Sheet Prepared by Mary Campbell, M.D., Medical Director, Planned Parenthood of Metropolitan Washington," October, 1995.

[10] See "Anesthesiologists Question Claims in Abortion Debate," by Diane M. Gianelli, *American Medical News*, January 1, 1996.

[11] Senate Judiciary Committee hearing record J-104-54, Nov. 17, 1995, page 153.

[12] Senate Judiciary Committee, Nov. 17, 1995 hearing record, page 226.

[13] Dr. McMahon's submission of June 8, 1995, is reproduced in "Hearing Before the Subcommittee on the Constitution of the Committee on the Judiciary," 104th Congress, First Session.

[14] "The First Crack in the Wall," by John Leo, *U.S. News & World Report*, March 10, 1997.

[15] "Late-Term Abortion Ban Vetoed," by Ann Devroy, *Washington Post*, April 11, 1996.

[16] "Partial-Birth Abortions: Misinformation and Rebuttal," NRLC factsheet, June 21, 1995. This factsheet is reproduced in "Hearing Before the Subcommittee on the Constitution

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 30

of the Committee on the Judiciary," 104th Congress, First Session, Serial No. 31, pages 122-127.

[17] See "CBS 60 Minutes on Partial-Birth Abortions: A Critique," NRLC, June 10, 1996. Available on NRLC Homepage, www.nrlc.org.

[18] "The Facts on Partial-Birth Abortion," by Ruth Padawer, *The Sunday Record* (Bergen, N.J.), September 15, 1996. On *CNN Crossfire* (Sept. 26, 1996), NARAL's Kate Michelman said, "the reporter got it completely wrong...the 1,500 is a lie." But on October 2, 1996, the *Record* published a convincing rebuttal to such attacks on the accuracy of the original story. The clinic has said that all of the abortions it performs on Medicaid-eligible patients are "medically necessary," but it is well established that in Medicaid law, the term "medically necessary" merely means that the abortion was performed by a licensed physician. See "The Editor Replies," Oct. 2, 1996 *Record*.

[19] "Discomfiting Details of Late-Term Abortions Intensify Dispute," by Barbara Vobejda and David Brown, and "Late Term Abortions: Who Gets Them and Why," *Washington Post*, September 17, 1996.

[20] "What Constitutes A Quality Life?," by Katherine Dowling, M.D., *Los Angeles Times*, Aug. 28, 1996.

[21] Late-term abortion specialist Warren Hern told *American Medical News*, "I have very serious reservations about this procedure. . . You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it." See "Outlawing Abortion Method," by Diane M. Gianelli, *American Medical News*, November 20, 1995.

[22] *Abortion Practice*, by Warren M. Hern, M.D.. (J.B. Lippincott Company, 1984). Page 318.

[23] Dr. McMahon's submission of June 8, 1995, is reproduced in "Hearing Before the Subcommittee on the Constitution of the Committee on the Judiciary," 104th Congress, First Session.

[24] In an interview published in the August 19, 1996, edition of *American Medical News*, former Surgeon General C. Everett Koop said, "I believe that Mr. Clinton was misled by his medical advisors on what is fact and what is fiction in reference to late-term abortions. Because in no way can I twist my mind to see that the late-term abortions as described-- you know, partial birth, and then destruction of the unborn child before the head is born-- is a medical necessity for the mother. It certainly can't be a necessity for the baby." Dr. Koop also authored an op ed piece in *The New York Times* titled "Why Defend Partial-Birth

NATIONAL RIGHT TO LIFE COMMITTEE, PAGE 31

Abortion" (Sept. 26, 1996), and his photo appeared in full-page newspaper ads produced by the Physicians' Ad Hoc Coalition for Truth (PHACT). Curiously, however, Dr. Koop's forthright challenges to President Clinton's medical claims regarding partial-birth abortion went almost entirely unreported in news columns and broadcasts -- in striking contrast to the big play given to his challenge to a statement made by Republican presidential candidate Bob Dole regarding the addictiveness of nicotine.

[25] "Viability and the Law," by David Brown, *Washington Post*, September 17, 1996.

[26] In his October 9, 1996 debate with Jack Kemp, Vice-president Gore said, "President Clinton has made it clear that *he will sign legislation outlawing procedures such as this* if there is an exception to protect the health of the mother where serious health consequences, such as the inability to have any further children, are involved and her doctor advises her so." [emphasis added]

[27] *Kansas City Star*, August 26, 1991. Dr. George Tiller was a guest at one of the White House's now renowned fundraising coffees, on June 17, 1996. Apparently President Clinton's "opposition" to "late-term" abortions does not extend to opposition to accepting the proceeds thereof. See *The Hill*, February 26, 1997, page 21.

[28] "Partial-Birth Abortion Ban Act of 1995," House Judiciary Committee report 104-267, 104th Congress, 1st Session. See also testimony of Douglas Kmiec, professor of constitutional law, University of Notre Dame, Senate hearing record (Nov. 17, 1995).

The Testimony of Gianna Jessen

"I am the person she aborted. I lived instead of died."

On April 22, the U.S. House Judiciary Subcommittee on the Constitution held a hearing on "The Origins and Scope of Roe v. Wade," which focused in part on the little-understood fact that the Supreme Court has legalized abortion during the final months of pregnancy. Among the witnesses who testified before the subcommittee were Gianna Jessen, who in 1977 survived an attempted saline abortion at 7½ months. Her testimony appears below.

A unusual hush fell - - even at the press tables and among the pro-abortion lobbyists - - as Gianna's riveting words echoed through the high-ceiling hearing room. Afterwards, Congressman Henry Hyde said, "I mark Gianna Jessen's testimony as one of the high points of my life. I have seen somebody come back from the jaws of hell... and I say, God love you, I am honored to be in the same room with you."

My name is Gianna Jessen. I am 19 years of age. I am originally from California, but now reside in Franklin, Tennessee.

I am adopted. I have cerebral palsy. My biological mother was seventeen years old and seven-and-one-half months pregnant when she made the decision to have a saline abortion. I am the person she aborted. I lived instead of died.

Fortunately for me the abortionist was not in the clinic when I arrived alive, instead of dead, at 6:30 a.m. on the morning of April 6, 1977. I was early, my death was not expected to be seen until about 9 a.m., when he would probably be arriving for his office hours. I am sure I would not be here today if the abortionist would have been in the clinic, as his job is to take life, not sustain life. Some have said I am a "botched abortion." A result of a job not well done.

There were many witnesses to my entry into this world. My biological mother and other young girls in the clinic, who also awaited the death of their babies, were the first to greet me. I am told this was a hysterical moment. Next was a staff nurse who apparently called emergency medical services and had me transferred to a hospital.

I remained in the hospital for almost three months. There was not much hope for me in the beginning. I weighed only two pounds. Today

babies smaller than I was have survived.

A doctor once said I had a great will to live and that I fought for my life. I eventually was able to leave the hospital and be placed in foster care. I was diagnosed with cerebral palsy as a result of the abortion.

My foster mother was told that it was doubtful that I would ever crawl or walk. I could not sit up independently. Through the prayers and dedication of my foster mother, and later many other people, I eventually learned to sit up, crawl, then stand. I walked with leg braces and a walker shortly before I turned age four.

I was legally adopted by my foster mother's daughter, Diana De Paul, a few months after I began to walk. The Department of Social Services would not release me any earlier for adoption.

I have continued in physical therapy for my disability, and after a total of four surgeries, I can now walk without assistance. It is not always easy. Sometimes I fall, but I have learned how to fall gracefully after falling for 19 years.

I am happy to be alive. I almost died. Everyday I thank God for life. I do not consider myself a by-product of conception, a clump of tissue, or any other of the titles given to a child in the womb. I do not consider any person conceived, to be any of those things.

I have met other survivors of abortion. They are all thankful for life. Only a few months ago I met another saline abortion survivor. Her name is Sarah. She is two years old. Sarah also has cerebral palsy, but her diagnosis is not good. She is blind and has severe seizures. The abortionist, besides injecting the mother with saline, also injects the baby victims. Sarah was injected in the head. I saw the place on her head where this was done.

When I speak, I speak not only for myself, but for the other survivors, like Sarah, and also for those who cannot yet speak.

Abortion is not the solution people say it is. It is no solution. It is murder. Abortion violates the right to life. I was just as much a person when I was aborted as I am today. You will have a hard time convincing me otherwise. You will have a hard time convincing me that



Gianna Jessen, 19, of Tenn., testifies on Capitol Hill Monday, April 22, 1996, before the House Constitution subcommittee's abortion hearing, "The Origins and Scope of Roe v. Wade." Jessen discussed her life as she told the subcommittee she was aborted by her mother but lived. (AP Photo/John Duricka)

abortion helps women when I meet all around our nation telling of their disappointment in our society in America. They have no respect for a government which allows life to be thrown away. They see leadership in our country fighting over our most important asset... life.

The best thing I can show you to defend life is my life. It has been a great gift. Killing is not the answer to any question or situation. Show me how it is an answer.

There is a quote which is etched into the high ceilings of one of our state's capitol buildings. The quote says, "Whatever is morally wrong, is not politically correct." Abortion is morally wrong. Our country is shedding the blood of the innocent. America is killing her future.

All life is valuable. All life is a gift from our Creator. We must receive and cherish the gifts we are given. We must honor the right to life.

Youth today are seeing their siblings killed through abortion. This devalues life. Teens are disappointed. I have files of letters written to me by young people from

C · R · L · P

THE CENTER FOR REPRODUCTIVE LAW AND POLICY

120 WALL STREET
NEW YORK
NEW YORK 10005
USA
917/637-3600
917/637-3666 fax

July 11, 2002

The Honorable J. Randy Forbes
United States House of Representatives
Washington DC 20515

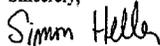
1146 19TH STREET, NW
WASHINGTON, DC 20036
USA
202/530-2975
202/530-2976 fax

[HTTP://WWW.CRLP.ORG](http://www.crlp.org)

Dear Representative Forbes:

I wanted to follow up on your invitation to submit additional materials pertaining to your questions. With regard to the issue of the relative safety of the D&E and D&X procedures, in addition to referring you to the ACOG statement submitted into the record and the statement submitted by Vanessa Cullins, Vice President of Medical Affairs of Planned Parenthood Federation of America, I refer you to the enclosed excerpt from the Board of Trustees of the American Medical Association which was received in evidence by the United States District Court for the District of Nebraska in the *Carhart* case as Exhibit 7. It establishes the overall safety of the D&E abortion method (pages 9-11), that the D&X technique is a form of D&E (page 8), and that the D&X technique offers several safety advantages over other forms of D&E (page 8).

Sincerely,


Simon Heller
Consulting Attorney

cc: Chairman Chabot
Ranking Member Nadler

Encl.

PREVALENCE OF AND REASONS FOR INDUCED ABORTION

The Centers for Disease Control and Prevention (CDC) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."²⁴ A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention are not regarded as an induced abortion.

The most scientifically reliable, national data on the incidence of abortion and characteristics of women who have abortions in the United States come from the Centers for Disease Control and Prevention and the Alan Guttmacher Institute (AGI). The Alan Guttmacher Institute is an independent, nonprofit corporation for research, policy analysis, and public education. Because the prevalence of late-term abortion procedures has been questioned in the popular press, it is worth describing the type of national abortion statistics which are collected in the United States as well as methods of data collection.

Both the CDC and the AGI collect data on the total number of abortions in the United States. The CDC data are derived primarily from reports by state health departments, whereas the AGI collects data directly from abortion providers. For many years AGI estimates of the number of abortions performed in the United States each year have been higher and considered to be more accurate than those reported by the CDC.^{25,26} However, AGI does not collect data on gestational age. Instead, it uses CDC data on the number of abortions performed at various gestational ages and makes statistical adjustments for discrepancies between AGI and CDC data when publishing its estimates.

Although the CDC collects annual data on abortion, the data have limitations. First, all states do not provide abortion-related information to the CDC. As recently as 1992, Alaska, California, Iowa, New Hampshire and Oklahoma did not collect data on abortion. For these states the CDC conducted limited surveys of abortion providers or estimated the number of abortions.²⁵⁻²⁷ Second, information from state health departments on abortion is often incomplete, with some states lacking information on as many as 40% to 50% of the abortions performed in the states.^{26,27} Third, the categories used by the CDC to report the method of abortion differentiate between D&E, labor induction procedures, and hysterotomy/hysterectomy, but they do not have a separate category for D&X. Fourth, states vary in their method of

recording gestational age. Some use the number of weeks since the first day of the woman's last menstrual period, and others record the physician's estimate of gestational age. Finally, although the CDC is the only organization which collects national data on abortion by weeks of gestation, it does not provide a detailed breakdown of abortions performed at 21 weeks and beyond.

Despite these limitations, the CDC and AGI remain the most reliable sources of national data on abortions. As shown in Table 1, the vast majority (95%) of induced abortions are done at or before 15 weeks' gestation, in the first or very early second-trimester.²⁷

Table 1: Induced Abortion: 1992

<u>Gestational Age</u>	<u>Number</u>	<u>Percent of procedures</u>
≤ 8 weeks	798,850	52%
9-10 weeks	377,570	25%
11-12 weeks	181,960	12%
13-15 weeks	94,060	6%
16-20 weeks	60,040	4%
21 weeks or more	16,450	1%
TOTAL	1,528,930	100%

A more detailed, estimated breakdown of the number of induced abortions at 21 weeks or more appears in Table 2.²⁷ The estimate is based on data from the CDC abortion surveillance reports, data collected by the National Center for Health Statistics (NCHS) from 14 states, and AGI survey data; estimates were calculated by the AGI. However, these estimates must be viewed cautiously. First, they are based on a limited number of states which may not be representative of the nation as a whole, and reporting by these states may be incomplete. Second, assuming that the number of providers who perform late-term abortions is relatively small,²⁷ they may have relatively large caseloads. The number of late-term abortions would be underestimated if these providers were not in the NCHS sample. Third, random errors in coding gestational age could substantially inflate the estimated number of abortions performed beyond 26 weeks, because these procedures constitute such a small proportion of abortions overall. Fourth, clinician errors in estimating gestational age could bias the data in unknown ways. Finally, natural fetal deaths beyond 20 weeks of gestation reported to the NCHS may be mistakenly counted as abortions if the fetus were removed using procedures commonly used to induce abortion.²⁷

Table 2: Estimated Number of Late-Second- and Third-Trimester Induced Abortions

<u>Gestational Age</u>	<u>Number</u>	<u>Percent of procedures at 21 weeks or later</u>
21-22 weeks	10,340	63%
23-24 weeks	4,940	30%
25-26 weeks	850	5%
>26 weeks	320	2%
TOTAL	16,450	100%

According to these estimates, two-thirds of abortions beyond 20 weeks are performed between 21 and 22 weeks. After 26 weeks, the number of abortions nationwide is estimated as being between 320 and 600. While it is not possible to quantify the type of D&E procedure used in these circumstances, it is estimated that 86% of all abortions performed past 20 weeks of gestation are performed by dilation and evacuation (D&E), and most of the remainder by inducing labor.²⁷

In 1992, teenagers were more likely than older women to have an abortion at 16 weeks of gestation or later.²⁵ Approximately 9% of women 19 years of age and younger who had an abortion in 1992, had the procedure performed at 13 weeks of gestation or later, compared to 5% of women 20 years of age and older.²⁵ Seven percent of women who were black or of other races who had an abortion in 1992 had the procedure performed during the second- or third-trimester, compared to 5% of white women. Differences between Hispanic and non-Hispanic women were minimal (6.5% and 6.3%, respectively).²⁵

Little research has been done on reasons for induced abortion in the second-trimester. In 1987, AGI conducted a survey of patients in 30 abortion facilities in which at least 400 abortions were performed annually and which performed abortions at 16 or more weeks of gestation.²⁸ The 30 providers represented each of the four regions of the country and the average patient response rate was 80 percent. Of the 1,900 women in the survey, 420 had been pregnant for 16 or more weeks and they were asked to report the most important reasons for their delay in having an abortion. Seventy-one percent reported that they did not recognize that they were pregnant or misjudged gestation. Forty-eight percent reported having difficulty making arrangements for an abortion (particularly raising enough money for the procedure), 33% were afraid to tell their parents or partner, and 24% reported having had great difficulty with the decision to have an abortion. Women having a later abortion were more likely than other women to cite personal health problems, possible fetal health problems, or rape or incest as having caused the pregnancy.

Medical reasons for second-trimester abortions can include maternal indications, such as those which threaten her health or life. For some women the condition may have existed prior to the pregnancy, for others a condition may have occurred during the pregnancy, and for others, the condition could have resulted from the pregnancy itself.

Some serious fetal abnormalities are not diagnosed until the second-trimester and the discovery of such anomalies prompt some women to decide to terminate the pregnancy by inducing abortion. Amniocentesis is usually performed between the 14th and 18th weeks of pregnancy, and the results usually are not available for another two to three weeks. Chorionic villus sampling (CVS) can be performed earlier, between the 10th and 12th weeks of pregnancy. Preliminary results are usually available within 48 hours and confirmatory, final results typically take a maximum of 7 to 10 days. However, the timing of an induced abortion prompted by the discovery of fetal anomalies through CVS or amniocentesis is almost certain to occur after the first trimester.

PROCEDURES USED TO INDUCE ABORTION

The procedure used to induce abortion depends, in part, on gestational age, commonly defined as the number of weeks since the first day of the last menstrual period, based on a 28-day menstrual cycle.²⁹ The percentage of reported legal abortions by weeks of gestation and type of procedure appears in Table 3.²⁵ As can be seen, suction or sharp curettage and dilatation and evacuation are the most common procedures used to induce abortion in the United States (99%). However, by 16 weeks of gestation and beyond, approximately 9% of induced abortions are performed using labor induction techniques. Hysterotomy and hysterectomy are used very rarely, regardless of gestational age.

Table 3: Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure—United States, 1992

<u>Type of procedure</u>	<u>Weeks of gestation</u>				<u>Total</u>
	<u><8-12 weeks</u>	<u>13-15 weeks</u>	<u>16-20 weeks</u>	<u>≥21 weeks</u>	
Curettage (suction or sharp) ^a	99.9%	98.2%	86.0%	86.4%	99.0%
Labor induction ^b	0.0% ^c	1.0%	8.8%	9.1%	0.6%
Hysterotomy Hysterectomy	0.0% ^c	0.0% ^c	0.0% ^c	0.1%	0.0% ^c
Other ^d	0.09%	0.8%	5.1%	4.4%	0.4%
Total ^e	100%	100%	100%	100%	100%

^aIncludes dilatation and evacuation^bIncludes intrauterine saline instillation and intrauterine prostaglandin instillation^c<0.05%^dIncludes instillation procedures not reported as a specific category^eReported by 35 states and New York City

First Trimester Procedures to Induce Abortion

Since the 1970s, vacuum aspiration, also referred to as suction curettage, has been the most common procedure used to induce abortion in the first trimester (i.e., from the 6th through 12th week of gestation).²⁴ Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator).³⁰ Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue.^{30,31} These procedures are typically performed on an outpatient basis.

Menstrual regulation, also known as menstrual extraction, is a type of early suction curettage. After inserting the cannula, the clinician attaches the syringe, releases the pinch valve, and suctions blood and tissue into the syringe. The procedure can be performed no later than 42 to 50 days from the last menstrual period.³² Neither anesthesia nor dilation are usually necessary.

In the last several years, pharmaceutical agents have also been used to induce abortion in the first trimester. These include mifepristone (RU-486), a synthetic hormone, which can be used within 9 weeks of the last menstrual period.³¹ Mifepristone causes the lining of the uterus to shed by blocking progesterone, thereby terminating the pregnancy. To induce abortion, the woman takes one oral dose of mifepristone followed a few days later by misoprostol, to stimulate uterine contractions and expel the embryo.³¹ Methotrexate used in conjunction with misoprostol represents a second pharmaceutical approach.³³

Early-Second-trimester Procedures to Induce Abortion

During the second-trimester the most common procedure used to induce abortion is dilation and evacuation (also referred to as dilatation and evacuation or D&E), which refers generically to transcervical procedures performed at 13 weeks gestation or later.²⁴⁻²⁶ Labor induction techniques can also be used during the second-trimester though they are more common in the late-second and third-trimesters. These procedures are described below.

Dilation and evacuation procedures are usually performed early in the second-trimester, that is, in the 13th through 15th week of gestation.^{25, 26} Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D&E procedure.^{32, 37-39} D&E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains. In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.²⁰⁻²²

Mid-Second-Trimester and Third-Trimester Procedures to Induce Abortion

By the 16th to 24th week of gestation there are several alternative procedures that can be used to induce abortion, though some are more common than others. These include dilation and evacuation (which may or may not be preceded by induced fetal demise), dilation and extraction (D&X), labor induction, hysterotomy and hysterectomy.

By the 16th week of gestation, ultrasonography should be used to verify gestational age. Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopressin is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage.^{32, 36} Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation.³⁰

To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction (D&X). According to the American College of Obstetricians and Gynecologists, intact D&X is comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.¹⁹ This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb.

As gestational age increases, particularly during the 16th to 24th week, labor induction techniques are more commonly used to induce abortion.²⁸ Labor induction techniques can be subdivided by the type of abortifacient used (hypertonic solutions such as urea or saline), and prostaglandin inductions (e.g., prostaglandin E₂ suppositories).^{31,39} The use of hypertonic solutions typically produce fetal death from osmotic insult, and labor then usually follows. In a saline abortion, a needle is inserted through the abdomen and the amniotic sac is injected with a concentrated salt solution. This results in fetal demise and induces contractions of the uterus. Over several hours, the contractions cause the cervix to dilate and the contents of the uterus to be expelled. Alternatively, urea, a nitrogen-based solution that causes fetal demise when injected into the amniotic sac, typically is used in conjunction with subsequent administration of prostaglandins, to induce contractions of the uterus and to expel its contents.³¹ Unlike saline instillation, the use of urea does not cause maceration of the fetal tissues and thereby interfere with the histologic diagnosis of some types of fetal abnormalities.⁴⁰

Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion.^{28,34,41,42} Hysterotomy involves the surgical delivery of the fetus through an incision in the uterine wall and the abdomen. Anesthesia is administered through an epidural, a spinal, or through general anesthesia. After removing the fetus the umbilical cord is cut and placenta removed. Hysterotomy involves major surgery and must be done in a hospital setting. It typically lengthens a woman's hospital stay and recovery.³¹ Hysterectomy is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix.³²

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Maternal Mortality

Maternal mortality is the most serious complication resulting from induced abortion, and the risk of maternal death increases with gestational age. In 1991, the overall rate of maternal mortality was one per 167,000 abortions.⁴³ The risk of maternal death from induced abortion at 8 weeks gestation or less was one in 600,000 procedures, but by 16-20 weeks increased to one in 17,000 procedures. At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries, though the difference was not statistically significant.⁴³

Maternal mortality rates comparing dilation and evacuation, labor induction, and hysterectomy/hysterotomy at 13 weeks gestation or later are shown in Table 4.⁴⁴ For all types of procedures maternal mortality rates increase with gestational age, but they are significantly greater for hysterectomy and hysterotomy, regardless of gestational age. Maternal mortality rates, overall, are higher for labor induction than D&E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D&E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3).

Table 4: Maternal Mortality Rates* for Induced Abortion Procedures at 13 Weeks' Gestation or Later, United States, 1974-1987

Type of procedure	Weeks of gestation			Total
	13-15 weeks	16-20 weeks	≥21 weeks	
Dilation and evacuation	2.0	6.5	11.9	3.7
Labor induction	3.8	7.9	10.3	7.1
Hysterectomy/ hysterotomy	28.1	103.4	274.3	51.6

*Per 100,000 abortions

Maternal Morbidity

It is difficult to estimate abortion-related morbidity because definitions of what constitutes a complication vary widely, and because in the United States national data on abortion-related morbidity have not been collected on a systematic, ongoing basis. The best available national data on complications was collected during the 1970s by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council (New York, NY) and the CDC.⁴⁵ JPSA consisted of three prospective studies of abortion between 1971 and 1978, and involved a sample of hospitals and clinics throughout the United States. Between 73,000 and 84,000 women were involved in each phase of the research program.

The most commonly used indicator of abortion-related morbidity is admission to a hospital. This excludes minor physical sequelae but captures fairly accurately the more serious maternal aftereffects of induced abortion. The CDC defines major complications from induced abortion as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0°C (100.4°F) that lasts for 3 or more days.⁴⁶

Between 1970 and 1990 the overall risk of major complications from abortion-related procedures declined dramatically. From 1970 to 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.⁴⁷ Between 1975 and 1978 the rate dropped to five major complications per 1000 abortions,⁴⁶ and by 1990, the National Abortion Federation (Washington, DC) estimated that there was one complication per 1000 abortions.⁴⁴ The overall decline in complication rates can probably be attributed to an increased proportion of procedures being performed earlier in the pregnancy, improvements in medical technology, and improvements in medical training.

The risk of complications is related to the abortion method used. Between 1975 and 1978, the last years of the Joint Program for the Study of Abortion, the complication rate associated with vacuum aspiration was two per 1000 procedures, while dilation and evacuation had a complication rate of seven per 1000 procedures. Procedures that induced labor (saline or prostaglandin instillation) had a higher rate (21 and 25 per 1000 procedures, respectively), and those involving major surgery had the highest rate of complications.⁴⁷

The risk of complications and complication rates from induced abortion are also related to gestational age. From 1975 to 1978 there were between 1 and 4 major complications per 1000 procedures performed through the 12th week of gestation.³² There were 6 major complications per 1000 procedures performed in weeks 13 to 14, 13 per 1000 in weeks 15 to 16, and 19 per 1000 in weeks 17 through 20.³²

More recent, international data have also shown that complication rates increase with gestational age. Direct comparisons on abortion-related complication rates between countries must be made with caution because of differences in the definition and measurement of complications. Nonetheless data from 1988 for Denmark, West Germany, and New York State, and from 1987 for Canada, England and Wales, showed complication rates ranging from 0.4% to 3.4% for first-trimester abortions, and from 1.1% to 8.7% for second-trimester abortions.⁴⁹ However, more research on major complication rates associated with various procedures and by gestational age is needed before any firm conclusions about the relative safety of procedures can be made.

Cervical incompetence and compromised subsequent pregnancies are important but unresolved concerns related to abortions performed in the second- or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X), or from labor induction techniques. Some physicians prefer D&E over labor induction methods for second-trimester abortions because, they argue, it has a lower mortality rate, it takes less time, it is less expensive, it can be done on an outpatient basis, and it takes less of a psychological toll on some women because it does not imitate labor.^{33,50,51} Other physicians prefer to induce labor because they find it a less distasteful procedure.⁵⁰ Still others prefer it because they feel that it is less likely to interfere with the diagnosis of cytogenetic, anatomical, or DNA abnormalities in the fetus, particularly if saline instillation is avoided.⁵² However, one research study involving 60 patients who underwent D&E at 14-22 weeks of gestation after fetal abnormalities were detected, found that D&E successfully and consistently confirmed abnormal prenatal diagnoses.⁴⁰

In summary, maternal mortality during second-trimester abortions is lower for dilation and evacuation procedures than for labor induction methods. However, for procedures performed at 20 weeks' gestation and beyond, the rates are similar. More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond.

24. Centers for Disease Control. *Abortion Surveillance, 1981*. Atlanta, Ga: Centers for Disease Control; 1985.
25. Koonin LM, Smith JC, Ramick M, Green CA. *Abortion Surveillance—United States, 1992*. *MMWR*. 1996;45SS-3:1-36.
26. Atrash HK, Lawson HW, Smith JC. Legal abortion in the US: trends and mortality. *Contemp OB/GYN*. 1990;35:58-69.
27. The Alan Guttmacher Institute. *Issues in brief: The limitations of US statistics on abortion*. New York, NY: The Alan Guttmacher Institute. 1997. (NOTE: The Centers for Disease Control and Prevention plans to publish abortion surveillance data from 1993 and 1994 by June, 1997. The updated information will be included in the report when it becomes available.)
28. Torres A, Forrest JD. Why do women have abortions?" *Fam Plann Persp*. 1988;20:169-176.
29. Santee B, Henshaw SK. The abortion debate: Measuring gestational age. *Fam Plann Persp*. 1992;24:172-173.
30. Policar MJ, Pollack AE (eds.) *Clinical Training Curriculum in Abortion Practice*. Washington, DC: National Abortion Federation; 1995.
31. Slupik RJ, ed. *American Medical Association Complete Guide to Women's Health*. New York, NY: Random House; 1996.
32. Grimes D. Management of abortion. In: Rock JA, Thompson JD, eds. *Te Linde's Operative Gynecology*. 8th ed. Philadelphia, Pa: Lippincott-Raven. 1997; chap 23.
33. Shulman LP, Grimes DA, Stubblefield PG. Abortion. *ACOG Update*. 1997;22;7:1-9.

34. Koonin LM, Smith JC Ramick M. Abortion Surveillance—United States, 1991. *MMWR*. 1995;44SS-2:23-53.
35. Centers for Disease Control. *Abortion Surveillance, 1978*. Atlanta, Ga: Centers for Disease Control. 1980.
36. Cates W Jr, Schulz KF, Grimes DA. et al. Dilatation and evacuation procedures and second-trimester abortions: the role of physician skill and hospital setting. *JAMA*. 1982;248:559-563.
37. Sabbagha R. Ultrasonic evaluation. In: Berger GS, Breuner WE, Deith LG, eds. *Second-Trimester Abortion*. Boston, Ma: John Wright/PSG. 1981:57-67.
38. Cates W Jr, Grimes DA. Deaths from second-trimester abortion by dilatation and evacuation: Causes, prevention, facilities. *Obstet Gynecol*. 58;1981:401-408.
39. Grimes DA, Schulz KF. Morbidity and mortality from second-trimester abortions. *J Reprod Med*. 1985;30:505-514.
40. Shulman LP, Ling FW, Meyers CM, Shanklin DR, Simpson JL, Elias S. Dilatation and evacuation for second-trimester genetic pregnancy termination. *Obstet Gynecol*. 1990;75:1037-1040.
41. Grimes DA. Second-trimester abortions in the United States. *Fam Plann Persp*. 1984;16:260-266.
42. Atrash HK, Peterson B, Cates W Jr, Grimes DA. The risk of death from combined abortion-sterilization procedures: Can hysterotomy or hysterectomy be justified? *Am J Obstet Gynecol*. 1982;142:269.
43. The Alan Guttmacher Institute. *Facts in brief: induced abortion*. New York, NY: The Alan Guttmacher Institute. 1996.
44. Lawson HW, Frye A, Atrash HK et al. Abortion mortality, United States, 1972 through 1987. *Am J Obstet Gynecol*. 1994;171:1365.
45. Binkin N. Trends in induced legal abortion morbidity and mortality. *Clin Obstet Gynecol*. 1986;13:83-93.
46. Cates W Jr, Grimes DA. Morbidity and mortality of abortion in the United States. In: Hodgson JE, ed. *Abortion and Sterilization: Medical and Social Aspects*. New York, NY: Academic Press, Inc; 1981:155-180.
47. Tietze C, Henshaw SK. *Induced Abortion: A World View*, 1986. New York, NY: The Alan Guttmacher Institute; 1986.
48. Council on Scientific Affairs, American Medical Association. Induced termination of pregnancy before and after Roe v Wade: Trends in the mortality and morbidity of women. *JAMA*. 1992;268:3231-3239.
49. Henshaw SK. Induced abortion: A world view, 1990. *Fam Plann Persp*. 1990;22:76-89.

50. Kaltreider NB, Goldsmith S, Margolis AJ. The impact of midtrimester abortion techniques on patients and staff. *Am J Obstet Gynecol.* 1979;135:235-238.
51. Crist T, Williams P, Lee SH, Hulka JF. Midtrimester pregnancy termination: A study of the cost effectiveness of dilatation and evacuation in a free standing facility. *North Caroline Med J.* 1983;44:549-551.
52. Rhoads GG, Jackson LG, Schlesselman SE, et al. The safety and efficacy of chorionic villus sampling for early prenatal diagnosis of cytogenetic abnormalities. *N Engl J Med.* 1989;320:609-616.

Material Submitted by Dr. Kathi Aultman

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

I. AMA and ACOG stances

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

The AMA's position: On May 19, 1997 John Seward, MD Executive Vice President of the AMA, wrote a letter supporting HR 1122, "The Partial Birth Abortion Ban Act of 1997" as amended. The AMA's support was based on three specific principles. "First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding." (Letter to The Honorable Rick Santorum from P. John Seward, MD on May 19, 1997) Nancy W. Dickey, MD, Chair of the AMA Board of Trustees released a statement in support of HR 1122. She stated, "Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, HR 1122 now narrowly defines the procedure to be restricted - a procedure for which AMA's expert panel could not find 'any identified situation' in which it was 'the only appropriate procedure to induce abortion' - and it broadens the exceptions. As amended, HR 1122 is now a bill which impacts only a particular and broadly disfavored - both by experts and the public - abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with Roe v Wade. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb." (Statement released by the AMA "AMA Supports HR 1122 As Amended" attributable to Nancy W. Dickey, MD) The AMA elaborated further on this issue in the "Board of Trustees Report 26 - A 97."

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

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

II. Comments

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

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

PHACT

Physicians' Ad Hoc Coalition for Truth

September 18, 1996

FOUNDING MEMBERS

Hon. Tom A. Coburn, M.D.
Family Practitioner, Obstetrician
Member, U.S. House of
Representatives (OK-2)

Nancy Romer, M.D.
Fellow, American College of
Obstetricians & Gynecologists
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn,
Miami Valley Hospital, OH

Fanella Smith, M.D.
Director of Medical Education
Dept. of Obstetrics & Gynecology
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

Janet Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Butterworth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Stalter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

Bernard Nathanson, M.D.
Visiting Scholar
Center for Clinical &
Research Ethics
Vanderbilt University

1150 South Washington Street
Suite 230
Alexandria, VA 22314
(703) 693-5054

Communications Contact:
Gestii Tanna, Michelle Powers

Dear Member of Congress:

We write to you as founding members of the Physicians' Ad-hoc Coalition for Truth (PHACT), an organization of over three hundred members drawn from the medical community nationwide -- most ob/gyns, perinatologist and pediatricians -- concerned and disturbed over the medical misinformation driving the partial-birth abortion debate. As doctors, we cannot remember another issue of public policy so directly related to the medical community that has been subject to such distortions and outright falsehoods.

The most damaging piece of medical disinformation that seems to be driving this debate is that the partial-birth abortion procedure may be necessary to protect the lives, health and future fertility of women. You have heard this claim most dramatically not from doctors, but from a handful of women who chose to have a partial-birth abortion when their children were diagnosed with some form of fetal abnormality.

As physicians who specialize in the care of pregnant women and their children, we have all treated women confronting the same tragic circumstances as the women who have publicly shared their experiences to justify this abortion procedure. So as doctors intimately familiar with such cases, let us be very clear: *the partial-birth abortion procedure, as described by Dr. Martin Haskell (the nation's leading practitioner of the procedure) and defined in the Partial-Birth Abortion Ban Act, is never medically indicated and can itself pose serious risks to the health and future fertility of women.*

There are simply no obstetrical situations encountered in this country which require a partially-delivered human fetus to be destroyed to preserve the life, health or future fertility of the mother. Not for hydrocephaly (excessive cerebrospinal fluid in the head); not for polyhydramnios (an excess of amniotic fluid collecting in the woman); and not for trisomy (genetic abnormalities characterized by an extra chromosome).

Our members concur with former Surgeon General C. Everett Koop's recent statement that "in no way can I twist my mind to see that [partial-birth abortion] is a medical necessity for the mother."

As case in point would be that of Ms. Correen Costello, who has appeared several times before Congress to recount her personal experience in defense of this procedure. Her unborn child suffered from at least two conditions: "polyhydramnios secondary to abnormal fetal swallowing," which causes amniotic fluid to collect in the uterus, and "hydrocephalus", a condition that causes an excessive amount of fluid to accumulate in the fetal head.

The usual treatment for removing the large amount of fluid in the uterus is a procedure called amniocentesis. The usual treatment for draining excess fluid from the fetal head is a procedure called cephalocentesis. In both cases the excess fluid is drained by using a thin needle that can be placed inside the womb through the abdomen ("transabdominally"--the preferred route) or through the vagina ("transvaginally.") The transvaginal approach however, as performed by Dr. McMahon on Ms. Costello, puts the woman at an increased risk of infection because of the non-sterile environment of

the vagina. Dr. McMahon used this approach most likely because he had no significant expertise in obstetrics and gynecology. After the fluid has been drained, and the head decreased in size, labor would be induced and attempts made to deliver the child vaginally. Given these medical realities, the partial-birth abortion procedure can in no way be considered the standard, medically necessary or appropriate procedure appropriate to address the medical complications described by Ms. Costello or any of the other women who were tragically misled into believing they had no other options.

Indeed, the partial-birth abortion procedure *itself* can pose both an immediate and significant risk to a woman's health and future fertility. To take just one example, to forcibly dilate a woman's cervix over the course of several days, as this procedure requires, risks creating an "incompetent cervix," a leading cause of future premature deliveries. It seems to have escaped anyone's attention that one of the five women who appeared at President Clinton's veto ceremony who had a partial-birth abortion subsequently had five miscarriages.

The medical evidence is clear and argues overwhelmingly against the partial-birth abortion procedure. Given the medical realities, a truly pro-woman vote would be to end the availability of a procedure that is so potentially dangerous to women. The health status of women and children in this country can only be enhanced by your unequivocal support of H.R. 1833.

Thank you for your consideration.

Sincerely,

Nancy G. Romer M.D.

Nancy G. Romer, M.D.
FACOG
Clinical Professor
Department of Obstetrics and Gynecology
Wright State University,
Chairman, Dept. of Ob/Gyn
Miami Valley Hospital, OH

Curtis R. Cook M.D.

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Butterworth Hospital
Michigan State College of Human
Medicine

Pamela E. Smith, M.D.

Pamela E. Smith, M.D.
Director of Medical Education
Dept. of Obstetrics and Gynecology
Mt. Sinai Medical Center
Chicago, IL;
Member, Association of Professors of Ob/Gyn

Joseph L. DeCook M.D.

Joseph L. DeCook, M.D.
FACOG
Holland, MI

American Medical Association

Physicians dedicated to the health of America



Statement

AMA Supports HR 1122 As Amended

Statement attributable to: Nancy W. Dickey, MD
Chair

The American Medical Association Board of Trustees has determined to support HR 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation. (The document containing that criteria, made public and forwarded to our House of Delegates early last week, is attached.)

Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, HR 1122 now narrowly defines the procedure to be restricted — a procedure for which AMA's expert panel could not find "any identified situation" in which it was "the only appropriate procedure to induce abortion" — and it broadens the exceptions.

The changed language in the bill now: (a) makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation (also referred to as "D&E") is not covered by the bill, (b) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (c) does not restrict use of the procedure for physicians intending a delivery at the outset, i.e., it can be done as necessary in their best medical judgment.

In addition, as also required by our legislative criteria letter, a physician will be entitled to stay any criminal proceeding in order to obtain expert review by the state medical board of any questioned conduct under the bill for use at trial.

As amended, HR 1122 is now a bill which impacts only a particular and broadly disfavored — both by experts and the public — abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with *Roe v. Wade*. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb.

HR 1122 is serving as a model for many state legislatures and it is vitally important that the improvements which have been made become a part of the broader legislative process.

For more information, please contact:

James Stacey 202/789-7419
Brenda Craine 202/789-7447

1101 Vermont Avenue, NW
Washington, DC 20006
202 789-7400

For Response Only

April 5, 2000

"The House today is considering a bill that would ban intact dilatation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure."

"The AMA has asked that the criminal sanctions be removed from this bill, but such a change has not been made. For this reason we do not support the bill."

American Medical Association

Physicians dedicated to the health of America



P. John Seward, MD 516 North State Street 312 464-5000
Executive Vice President Chicago, Illinois 60610 312 464 4184 Fax
May 19, 1997

The Honorable Rick Santorum
United States Senate
120 Russell Senate Office Bldg.
Washington, DC 20510

Dear Senator Santorum:

The American Medical Association (AMA) is writing to support HR 1122, "The Partial-Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122 now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,

A handwritten signature in cursive script that reads "P. John Seward, MD".

P. John Seward, MD

150 *Years of Caring for the Country*
1847 • 1997

ENTIRE REPORT SUBJECT TO
AMA House of Delegates Review in June
1997

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26 - A-97

Subject: Late-Term Pregnancy Termination Techniques

Presented by: Nancy W. Dickey, MD, Chair

Referred to: Reference Committee B
(Mark A. Levine, MD, Chair)

Induced abortion through the first trimester was legal under common law in the United States until the middle of the 19th century.¹ By 1900, it was prohibited by law unless two or more physicians agreed that the procedure was necessary to preserve the life of the pregnant woman.² During the late 1960s, state legislatures began to reconsider the legalization of abortion, and in January, 1973, abortion became legal on a national basis as a result of the U.S. Supreme Court decisions in Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973).

In Roe v. Wade and Doe v. Bolton the U.S. Supreme Court held that states could not interfere with the physician-patient decision about abortion during the first trimester of pregnancy. After the first trimester, and prior to viability, the State could promote its interest in the health of the mother by regulating the abortion procedure in ways that are reasonably related to maternal health. Maternal health included physical, emotional, psychological well-being, familial factors, as well as the woman's age.³

In Roe v. Wade, the Supreme Court noted that the timing of viability can be difficult to establish precisely. The Court defined viability as "the capacity for meaningful life outside the mother's womb, albeit with artificial aid," and not just momentary survival. The Court noted that viability usually occurred at approximately 28 weeks but could occur as early as 24 weeks.⁴ The Court stated that it is the professional responsibility of the physician to determine whether the fetus has the capacity for meaningful life, and not merely temporary survival.

For the stage subsequent to viability, the Court determined that the State, in promoting its interest in the potentiality of human life, could regulate and even proscribe abortion unless it was deemed by medical judgment to be necessary to preserve the life or health of the pregnant woman.⁵ To identify the points at which the state's interest in maternal health and potential life become "compelling," the Court established the trimester framework for state regulation.⁶

In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), the Court stated that "[t]he time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."⁷ The Court rejected the argument that state legislation should specify a number of weeks as the point of viability, reaffirming that the onset of viability was essentially a medical concept, not an issue for legislative determination.⁸

In Webster v. Reproductive Health Services, 492 U.S. 490 (1989) the Supreme Court did, however, uphold a provision in a state statute that created "what is essentially a presumption of viability at 20

weeks, which the physician must rebut with tests indicating that the fetus is not viable prior to performing an abortion.⁹ In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the Court acknowledged that advances in neonatal care moved viability to a point somewhat earlier than when *Roe v. Wade* was decided. The Court went on to state that this fact had “no bearing on the validity of *Roe*’s central holding, that viability marks the earliest point at which the State’s interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions.”¹⁰

Abortion at any stage of gestation has long been controversial in the United States, but in recent years, public debate about abortion, particularly during the second and third trimesters, has increased, as have concerns about the medical and surgical procedures used for second- and third-trimester abortion. This was most clearly demonstrated through recently proposed federal legislation, HR 1833, the “Partial Birth Abortion Act of 1995.”¹¹ The bill would modify the U.S. Criminal Code to make it a federal crime for a physician or other individual legally authorized by the State to perform an abortion that would “partially vaginally deliver a living fetus before killing the fetus and completing the delivery,”¹² unless the procedure was performed to save the life of the woman and there were no other alternative methods available. The physician would also be liable for monetary and statutory damages to the father of the fetus or the maternal grandparents of the fetus if the mother were under 18 years of age.

From a medical perspective, the language used in the proposed legislation—“partially vaginally deliver a living fetus before killing the fetus and completing the delivery”—does not refer to a specific obstetrical/surgical technique, nor does it refer to a specific stage of gestation (i.e., pre- or post-viability). In fact, the description in the proposed legislation could be interpreted to include many recognized abortion and obstetric techniques (such as those used during dilation and evacuation (D&E)), or other procedures used to induce abortion. (A definition of D&E appears on pages 7 and 8.)

Although the language in HR1833 was vague from a medical perspective, a description of “partial birth abortion” emerged during Congressional testimony in November, 1995. In the hearings, the term “partial birth abortion” was used to describe a procedure in which the fetus is converted to a footling breech position and there is a breech extraction of the body excepting the head. A partial evacuation of the intracranial contents of a living fetus is performed to effect vaginal delivery of a dead but otherwise intact fetus.¹³ This procedure was first described by an Ohio physician as intact dilatation and extraction (D&X), at a meeting of the National Abortion Federation in September, 1992.¹⁴ (A definition of intact D&X by the American College of Obstetricians and Gynecologists (ACOG) appears on page 8.)

Supporters of the “Partial Birth Abortion Ban Act” inside and outside of organized medicine have argued that this method of induced abortion is abhorrent and never the only or best procedure to use.^{15, 16, 17, 18} Opponents of the bill expressed their concern about the intrusion of legislative bodies into medical decision-making, the vagueness of the language used to describe the procedure, the lack of specific guidelines about gestational age, the absence of exceptions for cases in which the banned procedures would be necessary to preserve a woman’s health, and that the life exception was too narrow.^{19, 20, 21, 22}

HR1833 was vetoed by President Clinton in April, 1996. In March, 1997, an identical version of the “Partial Birth Abortion Ban Act,” HR1122, was reintroduced into the House of Representatives and passed by a vote of 295-136.²³

At the 1996 Interim Meeting, the American Medical Association (AMA) House of Delegates passed Substitute Resolution 208 (I-96), which addressed late-term pregnancy termination techniques. The resolution was adopted in lieu of Resolutions 208 (I-96) and 225 (I-96), and required: 1) that the AMA

reaffirm current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995; 2) that the AMA Board of Trustees, in consultation with pertinent AMA Councils and medical specialty societies, undertake a study of which late-term pregnancy termination techniques and circumstances conform to the "standards of good medical practice" as required by policies 5.993 and 5.995; and 3) that the AMA work with pertinent medical specialty organizations to develop appropriate clinical practice guidelines for late term pregnancy termination.

AMA policy 5.990 states that "the issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures (Amended Res. 158, A-90)."

AMA policy 5.993 states that "the AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities (Res. 49, I-89)."

AMA policy 5.995 states that "the AMA reaffirms that (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Substitute Resolution 208, I-96)."

In response to Substitute Resolution 208 (I-96), the AMA convened a study group comprised of one representative from each of the following groups: the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the AMA Council on Scientific Affairs, the AMA Council on Legislation, the AMA Council on Medical Education, and the AMA Council on Ethical and Judicial Affairs. A representative from the Illinois State Medical Society which introduced the original Resolution 225, and from the Pennsylvania Medical Society which introduced the original Resolution 208, also participated in the study group. Representatives were invited to comment on late term pregnancy termination techniques and circumstances that would conform to the "standards of good medical practice," and about the development of clinical practice guidelines for late-term abortion.

Substitute Resolution 208 left undefined the phrase "late-term pregnancy termination techniques" and, in particular, whether these procedures would apply only to third trimester procedures, or whether they would include all post-viability procedures (which may occur during the second-trimester). Some of the medical procedures used to induce abortion prior to viability are the same or very similar to procedures used in post-viability abortions, and therefore there is no clear distinction between some later-term pregnancy termination techniques and those which are used earlier to end the pregnancy. In this report,

viability is presumed to exist after 27 weeks of gestation (assuming an otherwise healthy fetus), and is presumed not to exist prior to 20 weeks. The time period between 20 and 27 weeks is a "gray zone" in which some fetuses may be viable while others are not. As used here, late-second-trimester abortion refers to a procedure performed between the 20th and 27th weeks of gestation, and a late-term abortion refers to a procedure performed during the third-trimester, defined at 27 weeks or more. It is also worth noting that Substitute Resolution 208 refers broadly to "pregnancy termination techniques." In this report, the techniques to be studied are those intended to induce abortion and not those intended to deliver a living fetus.

This report provides background information on late-term abortion that can be used to address Substitute Resolution 208. The report is divided into six sections. The first section describes the prevalence of induced abortion and limitations of data on later-term abortions. Procedures used to induce abortion at earlier and later stages of pregnancy are described in the second section, and a review of complications and sequelae related to abortion are described in the third section. A discussion of the legal context of medical decision-making regarding abortion appears in the fourth section, and a more detailed summary of United States Supreme Court decisions regarding abortion appears in Appendix A. The fifth section of the report describes the policies of major medical societies on late-term abortion. An overview of ethical considerations related to abortion in general and with respect to gestational age appears in Appendix B. The report concludes with a set of proposed policy statements for consideration by the AMA House of Delegates.

PREVALENCE OF AND REASONS FOR INDUCED ABORTION

The Centers for Disease Control and Prevention (CDC) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."²⁴ A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention are not regarded as an induced abortion.

The most scientifically reliable, national data on the incidence of abortion and characteristics of women who have abortions in the United States come from the Centers for Disease Control and Prevention and the Alan Guttmacher Institute (AGI). The Alan Guttmacher Institute is an independent, nonprofit corporation for research, policy analysis, and public education. Because the prevalence of late-term abortion procedures has been questioned in the popular press, it is worth describing the type of national abortion statistics which are collected in the United States as well as methods of data collection.

Both the CDC and the AGI collect data on the total number of abortions in the United States. The CDC data are derived primarily from reports by state health departments, whereas the AGI collects data directly from abortion providers. For many years AGI estimates of the number of abortions performed in the United States each year have been higher and considered to be more accurate than those reported by the CDC.^{25, 26} However, AGI does not collect data on gestational age. Instead, it uses CDC data on the number of abortions performed at various gestational ages and makes statistical adjustments for discrepancies between AGI and CDC data when publishing its estimates.

Although the CDC collects annual data on abortion, the data have limitations. First, all states do not provide abortion-related information to the CDC. As recently as 1992, Alaska, California, Iowa, New Hampshire and Oklahoma did not collect data on abortion. For these states the CDC conducted limited surveys of abortion providers or estimated the number of abortions.²⁵⁻²⁷ Second, information from state health departments on abortion is often incomplete, with some states lacking information on as many as

40% to 50% of the abortions performed in the states.^{26, 27} Third, the categories used by the CDC to report the method of abortion differentiate between D&E, labor induction procedures, and hysterotomy/hysterectomy, but they do not have a separate category for D&X. Fourth, states vary in their method of recording gestational age. Some use the number of weeks since the first day of the woman's last menstrual period, and others record the physician's estimate of gestational age. Finally, although the CDC is the only organization which collects national data on abortion by weeks of gestation, it does not provide a detailed breakdown of abortions performed at 21 weeks and beyond.

Despite these limitations, the CDC and AGI remain the most reliable sources of national data on abortions. As shown in Table 1, the vast majority (95%) of induced abortions are done at or before 15 weeks' gestation, in the first or very early second-trimester.²⁷

Table 1: Induced Abortion: 1992

<u>Gestational Age</u>	<u>Number</u>	<u>Percent of procedures</u>
≤ 8 weeks	798,850	52%
9-10 weeks	377,570	25%
11-12 weeks	181,960	12%
13-15 weeks	94,060	6%
16-20 weeks	60,040	4%
21 weeks or more	16,450	1%
TOTAL	1,528,930	100%

A more detailed, estimated breakdown of the number of induced abortions at 21 weeks or more appears in Table 2.²⁷ The estimate is based on data from the CDC abortion surveillance reports, data collected by the National Center for Health Statistics (NCHS) from 14 states, and AGI survey data; estimates were calculated by the AGI. However, these estimates must be viewed cautiously. First, they are based on a limited number of states which may not be representative of the nation as a whole, and reporting by these states may be incomplete. Second, assuming that the number of providers who perform late-term abortions is relatively small,²⁷ they may have relatively large caseloads. The number of late-term abortions would be underestimated if these providers were not in the NCHS sample. Third, random errors in coding gestational age could substantially inflate the estimated number of abortions performed beyond 26 weeks, because these procedures constitute such a small proportion of abortions overall. Fourth, clinician errors in estimating gestational age could bias the data in unknown ways. Finally, natural fetal deaths beyond 20 weeks of gestation reported to the NCHS may be mistakenly counted as abortions if the fetus were removed using procedures commonly used to induce abortion.²⁷

Table 2: Estimated Number of Late-Second- and Third-Trimester Induced Abortions

<u>Gestational Age</u>	<u>Number</u>	<u>Percent of procedures at 21 weeks or later</u>
21-22 weeks	10,340	63%
23-24 weeks	4,940	30%
25-26 weeks	850	5%
>26 weeks	320	2%
TOTAL	16,450	100%

According to these estimates, two-thirds of abortions beyond 20 weeks are performed between 21 and 22 weeks. After 26 weeks, the number of abortions nationwide is estimated as being between 320 and 600. While it is not possible to quantify the type of D&E procedure used in these circumstances, it is estimated that 86% of all abortions performed past 20 weeks of gestation are performed by dilation and evacuation (D&E), and most of the remainder by inducing labor.²⁷

In 1992, teenagers were more likely than older women to have an abortion at 16 weeks of gestation or later.²⁵ Approximately 9% of women 19 years of age and younger who had an abortion in 1992, had the procedure performed at 13 weeks of gestation or later, compared to 5% of women 20 years of age and older.²⁵ Seven percent of women who were black or of other races who had an abortion in 1992 had the procedure performed during the second- or third-trimester, compared to 5% of white women. Differences between Hispanic and non-Hispanic women were minimal (6.5% and 6.3%, respectively).²⁵

Little research has been done on reasons for induced abortion in the second-trimester. In 1987, AGI conducted a survey of patients in 30 abortion facilities in which at least 400 abortions were performed annually and which performed abortions at 16 or more weeks of gestation.²⁸ The 30 providers represented each of the four regions of the country and the average patient response rate was 80 percent. Of the 1,900 women in the survey, 420 had been pregnant for 16 or more weeks and they were asked to report the most important reasons for their delay in having an abortion. Seventy-one percent reported that they did not recognize that they were pregnant or misjudged gestation. Forty-eight percent reported having difficulty making arrangements for an abortion (particularly raising enough money for the procedure), 33% were afraid to tell their parents or partner, and 24% reported having had great difficulty with the decision to have an abortion. Women having a later abortion were more likely than other women to cite personal health problems, possible fetal health problems, or rape or incest as having caused the pregnancy.

Medical reasons for second-trimester abortions can include maternal indications, such as those which threaten her health or life. For some women the condition may have existed prior to the pregnancy, for others a condition may have occurred during the pregnancy, and for others, the condition could have resulted from the pregnancy itself.

Some serious fetal abnormalities are not diagnosed until the second-trimester and the discovery of such anomalies prompt some women to decide to terminate the pregnancy by inducing abortion. Amniocentesis is usually performed between the 14th and 18th weeks of pregnancy, and the results usually are not available for another two to three weeks. Chorionic villus sampling (CVS) can be performed earlier, between the 10th and 12th weeks of pregnancy. Preliminary results are usually available within 48 hours and confirmatory, final results typically take a maximum of 7 to 10 days. However, the timing of an induced abortion prompted by the discovery of fetal anomalies through CVS or amniocentesis is almost certain to occur after the first trimester.

PROCEDURES USED TO INDUCE ABORTION

The procedure used to induce abortion depends, in part, on gestational age, commonly defined as the number of weeks since the first day of the last menstrual period, based on a 28-day menstrual cycle.²⁹ The percentage of reported legal abortions by weeks of gestation and type of procedure appears in Table 3.25 As can be seen, suction or sharp curettage and dilatation and evacuation are the most common procedures used to induce abortion in the United States (99%). However, by 16 weeks of gestation and beyond, approximately 9% of induced abortions are performed using labor induction techniques.

Hysterotomy and hysterectomy are used very rarely, regardless of gestational age.

Table 3. Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure--United States, 1992

Type of procedure	Weeks of gestation				Total
	<8-12 weeks	13-15 weeks	16-20 weeks	≥21 weeks	
Curettage (suction or sharp) ^a	99.9%	98.2%	86.0%	86.4%	99.0%
Labor induction ^b	0.0% ^c	1.0%	8.8%	9.1%	0.6%
Hysterotomy Hysterectomy	0.0% ^c	0.0% ^c	0.0% ^c	0.1%	0.0% ^c
Other ^d	0.09%	0.8%	5.1%	4.4%	0.4%
Total ^e	100%	100%	100%	100%	100%

^aIncludes dilatation and evacuation

^bIncludes intrauterine saline instillation and intrauterine prostaglandin instillation

^c<0.05%

^dIncludes instillation procedures not reported as a specific category

^eReported by 35 states and New York City

First Trimester Procedures to Induce Abortion

Since the 1970s, vacuum aspiration, also referred to as suction curettage, has been the most common procedure used to induce abortion in the first trimester (i.e., from the 6th through 12th week of gestation).²⁴⁻²⁶ Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator)³⁰ Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue.^{30, 31} These procedures are typically performed on an outpatient basis.

Menstrual regulation, also known as menstrual extraction, is a type of early suction curettage. After inserting the cannula, the clinician attaches the syringe, releases the pinch valve, and suctions blood and tissue into the syringe. The procedure can be performed no later than 42 to 50 days from the last menstrual period.³² Neither anesthesia nor dilation are usually necessary.

In the last several years, pharmaceutical agents have also been used to induce abortion in the first trimester. These include mifepristone (RU-486), a synthetic hormone, which can be used within 9 weeks of the last menstrual period.³¹ Mifepristone causes the lining of the uterus to shed by blocking progesterone, thereby terminating the pregnancy. To induce abortion, the woman takes one oral dose of mifepristone followed a few days later by misoprostol, to stimulate uterine contractions and expel the

embryo.³¹ Methotrexate used in conjunction with misoprostol represents a second pharmaceutical approach.³³

Early-Second-trimester Procedures to Induce Abortion

During the second-trimester the most common procedure used to induce abortion is dilation and evacuation (also referred to dilatation and evacuation or D&E), which refers generically to transcervical procedures performed at 13 weeks gestation or later.³⁴⁻³⁶ Labor induction techniques can also be used during the second-trimester though they are more common in the late-second and third-trimesters. These procedures are described below.

Dilation and evacuation procedures are usually performed early in the second-trimester, that is, in the 13th through 15th week of gestation.^{25, 36} Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D&E procedure.^{32, 37-39} D&E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains. In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.³⁰⁻³²

Mid-Second-Trimester and Third-Trimester Procedures to Induce Abortion

By the 16th to 24th week of gestation there are several alternative procedures that can be used to induce abortion, though some are more common than others. These include dilation and evacuation (which may or may not be preceded by induced fetal demise), dilation and extraction (D&X), labor induction, hysterotomy and hysterectomy.

By the 16th week of gestation, ultrasonography should be used to verify gestational age. Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopression is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage.^{32, 36} Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation.³⁰

To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction (D&X). According to the American College of Obstetricians and Gynecologists, intact D&X is comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.¹⁹ This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some

physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb. ↩

As gestational age increases, particularly during the 16th to 24th week, labor induction techniques are more commonly used to induce abortion.²⁵ Labor induction techniques can be subdivided by the type of abortifacient used (hypertonic solutions such as urea or saline), and prostaglandin inductions (e.g., prostaglandin E2 suppositories).^{32, 39} The use of hypertonic solutions typically produce fetal death from osmotic insult, and labor then usually follows. In a saline abortion, a needle is inserted through the abdomen and the amniotic sac is injected with a concentrated salt solution. This results in fetal demise and induces contractions of the uterus. Over several hours, the contractions cause the cervix to dilate and the contents of the uterus to be expelled. Alternatively, urea, a nitrogen-based solution that causes fetal demise when injected into the amniotic sac, typically is used in conjunction with subsequent administration of prostaglandins, to induce contractions of the uterus and to expel its contents.³¹ Unlike saline instillation, the use of urea does not cause maceration of the fetal tissues and thereby interfere with the histologic diagnosis of some types of fetal abnormalities.⁴⁰

Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion.^{26, 34, 41, 42} Hysterotomy involves the surgical delivery of the fetus through an incision in the uterine wall and the abdomen. Anesthesia is administered through an epidural, a spinal, or through general anesthesia. After removing the fetus the umbilical cord is cut and placenta removed. Hysterotomy involves major surgery and must be done in a hospital setting. It typically lengthens a woman's hospital stay and recovery.³¹ Hysterectomy is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix.³² ↗

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Maternal Mortality

Maternal mortality is the most serious complication resulting from induced abortion, and the risk of maternal death increases with gestational age. In 1991, the overall rate of maternal mortality was one per 167,000 abortions.⁴³ The risk of maternal death from induced abortion at 8 weeks gestation or less was one in 600,000 procedures, but by 16-20 weeks increased to one in 17,000 procedures. At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries, though the difference was not statistically significant.⁴³ ↩

Maternal mortality rates comparing dilation and evacuation, labor induction, and hysterectomy/hysterotomy at 13 weeks gestation or later are shown in Table 4.44 For all types of procedures maternal mortality rates increase with gestational age, but they are significantly greater for hysterectomy and hysterotomy, regardless of gestational age. Maternal mortality rates, overall, are higher for labor induction than D&E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D&E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3).

Table 4: Maternal Mortality Rates* for Induced Abortion Procedures at 13 Weeks' Gestation or Later, United States, 1974-1987

<u>Type of procedure</u>	<u>Weeks of gestation</u>			<u>Total</u>
	<u>13-15 weeks</u>	<u>16-20 weeks</u>	<u>≥21 weeks</u>	
Dilation and evacuation	2.0	6.5	11.9	3.7
Labor induction	3.8	7.9	10.3	7.1
Hysterectomy/ hysterotomy	28.1	103.4	274.3	51.6

*Per 100,000 abortions

Maternal Morbidity

It is difficult to estimate abortion-related morbidity because definitions of what constitutes a complication vary widely, and because in the United States national data on abortion-related morbidity have not been collected on a systematic, ongoing basis. The best available national data on complications was collected during the 1970s by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council (New York, NY) and the CDC.⁴⁵ JPSA consisted of three prospective studies of abortion between 1971 and 1978, and involved a sample of hospitals and clinics throughout the United States. Between 73,000 and 84,000 women were involved in each phase of the research program.

The most commonly used indicator of abortion-related morbidity is admission to a hospital. This excludes minor physical sequelae but captures fairly accurately the more serious maternal aftereffects of induced abortion. The CDC defines major complications from induced abortion as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0°C (100.4°F) that lasts for 3 or more days.⁴⁶

Between 1970 and 1990 the overall risk of major complications from abortion-related procedures declined dramatically. From 1970 to 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.⁴⁷ Between 1975 and 1978 the rate dropped to five major complications per 1000 abortions,⁴⁶ and by 1990, the National Abortion Federation (Washington, DC) estimated that there was one complication per 1000 abortions.⁴⁸ The overall decline in complication rates can probably be attributed to an increased proportion of procedures being performed earlier in the pregnancy, improvements in medical technology, and improvements in medical training.

The risk of complications is related to the abortion method used. Between 1975 and 1978, the last years of the Joint Program for the Study of Abortion, the complication rate associated with vacuum aspiration was two per 1000 procedures, while dilation and evacuation had a complication rate of seven per 1000 procedures. Procedures that induced labor (saline or prostaglandin instillation) had a higher rate (21 and 25 per 1000 procedures, respectively), and those involving major surgery had the highest rate of complications.⁴⁷

The risk of complications and complication rates from induced abortion are also related to gestational age. From 1975 to 1978 there were between 1 and 4 major complications per 1000 procedures performed through the 12th week of gestation.³² There were 6 major complications per 1000 procedures performed in weeks 13 to 14, 13 per 1000 in weeks 15 to 16, and 19 per 1000 in weeks 17 through 20.³²

More recent, international data have also shown that complication rates increase with gestational age. Direct comparisons on abortion-related complication rates between countries must be made with caution because of differences in the definition and measurement of complications. Nonetheless data from 1988 for Denmark, West Germany, and New York State, and from 1987 for Canada, England and Wales, showed complication rates ranging from 0.4% to 3.4% for first-trimester abortions, and from 1.1% to 8.7% for second-trimester abortions.⁴⁹ However, more research on major complication rates associated with various procedures and by gestational age is needed before any firm conclusions about the relative safety of procedures can be made.

Cervical incompetence and compromised subsequent pregnancies are important but unresolved concerns related to abortions performed in the second- or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X), or from labor induction techniques. Some physicians prefer D&E over labor induction methods for second-trimester abortions because, they argue, it has a lower mortality rate, it takes less time, it is less expensive, it can be done on an outpatient basis, and it takes less of a psychological toll on some women because it does not imitate labor.^{33, 50, 51} Other physicians prefer to induce labor because they find it a less distasteful procedure.⁵⁰ Still others prefer it because they feel that it is less likely to interfere with the diagnosis of cytogenetic, anatomical, or DNA abnormalities in the fetus, particularly if saline instillation is avoided.⁵² However, one research study involving 60 patients who underwent D&E at 14-22 weeks of gestation after fetal abnormalities were detected, found that D&E successfully and consistently confirmed abnormal prenatal diagnoses.⁴⁰

In summary, maternal mortality during second-trimester abortions is lower for dilation and evacuation procedures than for labor induction methods. However, for procedures performed at 20 weeks' gestation and beyond, the rates are similar. More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond.

THE LEGAL CONTEXT OF MEDICAL DECISION-MAKING REGARDING ABORTION

In light of changes in the composition of the United States Supreme Court, it is impossible to predict with certainty the Court's actions with respect to any law regulating abortions and abortion procedures. Since its 1973 decision in Roe v. Wade, 410 U.S. 113 (1973), the Supreme Court has consistently affirmed that prior to viability (which the Supreme Court defined as the capacity for meaningful life outside the womb), a woman has a constitutionally protected right to choose to have an abortion, and that after viability is achieved, the State may restrict abortions, if the law contains exceptions for pregnancies which endanger a woman's life or health. The Supreme Court has acknowledged that the time when viability is achieved may vary with each pregnancy and has recognized that the determination of whether a particular fetus is viable is a matter for the judgment of the responsible attending physician (Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)). However, in Webster v. Reproductive Health Services, 492 U.S. 490 (1989), the Supreme Court upheld a Missouri statute which created a rebuttable presumption of viability at 20 weeks.

In Roe v. Wade, the Court established guidelines for state regulation of abortion based on gestational stage and viability. For the stage prior to approximately the end of the first trimester, the Court held that the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician. For the stage subsequent to approximately the end of the first trimester, the Court held that the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life, may, if it chooses, regulate and even proscribe abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

Subsequent to Roe v. Wade, the Supreme Court has rendered a number of decisions on the constitutionality of state abortion regulations, including several which impact the medical decision-making process. For example, the Supreme Court has invalidated provisions of state statutes that require a woman to secure the approval of three physicians and a hospital committee before obtaining an abortion (Doe v. Bolton, 410 U.S. 179 (1973)); require a physician to preserve the life and health of the fetus at every stage of pregnancy (Planned Parenthood of Central Missouri v. Danforth); prohibit the use of saline amniocentesis as a method of abortion (Id.); and require physicians to give their patients information regarding the abortion procedure, the attendant health risks and those of childbirth and the probable gestational age of the fetus (City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) and Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986)).

In Colautti v. Franklin, 439 U.S. 379 (1979), the Supreme Court struck down a Pennsylvania statutory provision that subjected a physician who performed an abortion to potential criminal liability if he or she failed to exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus, when the fetus was viable or when there was sufficient reason to believe that the fetus might be viable. The Court expressed uncertainty as to whether the Pennsylvania statute permitted physicians to consider their duty to the patient to be paramount over their duty to the fetus, or whether it required physicians to make a "trade-off" between the woman's health and additional percentage points of fetal survival. (Id. at 400). The Court held that where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions. (Id.).

In Colautti, the Supreme Court also reaffirmed previous decisions that the determination of whether a fetus is viable must be a matter for the judgment of the responsible attending physician. State regulation that impinges on this determination, if it is to be constitutional, must allow the attending physician "the room he needs to make his best medical judgment." (Id. at 396, citing Doe v. Bolton, 410 U.S. at 192.)

The Court also addressed the issue of balancing maternal and fetal interests in Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986). Specifically, the Supreme Court considered a provision of a Pennsylvania statute that set forth two requirements for a post-viability abortion: 1) every person who performs an abortion post viability exercise that degree of care which would be required in order to preserve the life and health of any unborn child intended to be born and not aborted, and 2) that the abortion technique employed be that which would provide the best opportunity for the unborn child to be aborted alive unless, in the good faith judgment of the physician, that method or technique would present a significantly greater medical risk to the life or health of the pregnant woman than would another available method or technique. The Supreme Court found the statute to be unconstitutional, reasoning that the language of the statute could be construed to require the mother to bear an increased medical risk in order to save her viable fetus.

In Planned Parenthood Association of Kansas City, Missouri v. Ashcroft, 462 U.S. 476 (1983), the Supreme Court upheld a provision in a Missouri statute that required the attendance of a second physician at the abortion of a viable fetus. The statute also required the second physician to take all reasonable steps in keeping with good medical practice to preserve the life and health of the viable fetus, provided that such steps did not pose an increased risk to the life or health of the woman. The Court found that the second-physician requirement reasonably furthered the State's compelling interest in protecting the lives of viable fetuses. However, in Thornburgh, the Court struck down a similar provision in a statute that required the presence of a second physician during an abortion performed when viability was possible. In holding the provision unconstitutional, the Court was persuaded that the statute provided no exception for an emergency situation when the mother's health would be endangered by the delayed arrival of the second physician.

The Supreme Court, in Webster v. Reproductive Health Services, upheld a provision in a state statute that required a physician, before performing an abortion on a woman he or she has reason to believe is carrying a fetus of 20 or more weeks gestational age, to first determine if the fetus is viable by using the degree of care, skill, and proficiency commonly exercised by a prudent physician in similar practice under similar conditions. In making this determination of viability, the statute provided that the physician perform or cause to be performed medical examinations and tests necessary to determine the gestational age, weight, and lung maturity of the fetus. In its ruling, the Supreme Court construed the provision to require a physician to perform only those tests that are useful to making subsidiary findings as to viability. *Id.* at 513. The Court recognized that the tests in question regulate the discretion of the physician in determining the viability of the fetus, but they found that the requirement of the tests permissibly furthered the State's interest in protecting potential human life. *Id.* at 519.

In Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), the Supreme Court, in a plurality opinion, rejected the trimester framework, which it did not view to be part of the essential holding of Roe v. Wade. The Court determined that only when state regulation imposes an undue burden on a woman's ability to have an abortion, does the power of the State infringe on the woman's constitutionally protected liberty interest.

Applying the undue burden standard, the Court reversed the position it had taken in several previous cases and upheld provisions of a Pennsylvania statute that required physicians to provide patients with information about the nature of the abortion procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the fetus. The Court also upheld the requirement that the physician or qualified nonphysician inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father and a list of agencies which provide adoption and other services as alternatives to abortion.

POLICIES OF MAJOR MEDICAL SOCIETIES ON LATE-TERM ABORTION

At this time, medical societies have responded in a variety of ways to the recent controversy over late-term abortion and procedures used to perform late-term abortions. In October, 1995, for example, the Board of Trustees of the American Medical Association voted to remain neutral with regard to the "Partial Birth Abortion Ban Act of 1995." In December, 1996, the AMA House of Delegates adopted Substitute Resolution 208 which, as described earlier, reaffirmed existing AMA policy on abortion, resolved to undertake a study of late-term pregnancy termination techniques and circumstances to ensure that they conform to the standards of good medical practice, and resolved that the AMA would work with

pertinent medical specialty organizations to develop clinical practice guidelines appropriate for late term pregnancy termination.

As of April, 1997, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have not issued formal policies on late-term abortion. Both organizations, however, sent representatives to the study group convened by the American Medical Association in April, 1997.

The American College of Obstetricians and Gynecologists was the first medical specialty society to oppose the "Partial Birth Abortion Act of 1995" and to develop formal policy on intact dilatation and extraction. In November, 1995, ACOG released a statement in which it expressed its disappointment that the Congress "has attempted to regulate medical decision-making today by passing a bill on so-called "partial-birth" abortion."⁵³ The statement noted that "the College finds it very disturbing that any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community—demonstrating why Congressional opinion should never be substituted for professional medical judgment."⁵³

In January, 1997, ACOG released a Statement of Policy on Intact Dilatation and Extraction. According to the College, intact dilatation and extraction (intact D&X) contains four elements: "Deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus."¹⁹ The policy notes that "because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D&X."¹⁹ The policy further states that "abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D&X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based on the patient's individual circumstances. . . . Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D&X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision-making is inappropriate, ill-advised, and dangerous."¹⁹

RECOMMENDATIONS

The Board of Trustees recommends the adoption of the following statements of policy and that the remainder of this report be filed:

1. The American Medical Association reaffirms current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995 (see page 3). In summary:
the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate

- facilities;
 abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;
 support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures;
 neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.
2. The term 'partial birth abortion' is not a medical term. The American Medical Association will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.
 3. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.
 4. The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.
 5. In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.
 6. The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines will address indications and contra-indications for such procedures, identify techniques which conform to standards of good medical practice and, whenever possible, should be evidence-based and patient-focused.

7. **The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.**
8. **The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment and education. Such measures should help women who elect to terminate a pregnancy through induced abortion to receive those services at the earliest possible stage of gestation.**

MEDICAL ETHICS REGARDING ABORTIONMajor Ethics Principles Applied to Abortion in General

There are many methods of ethics reasoning, none of which has produced conclusive arguments on all the issues of abortion. The most common current form of reasoning in medical ethics involves the application of four basic ethics principles, with balancing of conflicting principled positions and of practical considerations according to the specific circumstances. While there are good reasons to use additional methods, for the sake of brevity, this common form of reasoning is used here.

Autonomy: There are four main arguments that apply the principle of autonomy. The first supports abortion as a matter of the woman's choice. The second supports abortion in defined circumstances. The third is applicable in different ways depending on the circumstance. The fourth opposes abortion.

The first argument has features in common with an ownership argument, and states that as long as the fetus is in the woman's body and is unwanted, the woman has the right to end the fetus' life, the fetus being afforded significantly weaker rights than the woman. This will be referred to as the 'autonomy/ownership' argument.

The argument by Judith Jarvis Thomson asserts that a fetus' claim to continued existence while dependent on the pregnant woman's body depends on that woman's welcome. The argument states that a woman who does not consent to pregnancy is not obligated to lend her body to support the fetus. This argument applies even if the fetus is attributed full standing as a person. It does not apply after viability since delivery can remove the fetus from being dependent.

The third argument attributes some measure of person status to the fetus and asserts that the fetus' rights challenge the woman's after acquisition of sufficient developmental status. Positions vary on when that status is achieved, and on whether there is a single threshold or a continuum of developing status and rights. This will be referred to as the 'conditional fetal rights' argument.

The last argument in this list attributes full person status to the conceptus and all subsequent stages, and debars abortion except for threat to the life of the woman. This will be referred to as the 'full fetal rights' argument.

Nonmaleficence: Nonmaleficence argues for non-destructive procedures for the fetus. It also would debar sacrificing the life of the woman for the fetus, and would seek to minimize damage to the woman of either a physical or an emotional nature. While arguments can be slanted to emphasize one form of harm over another, the principle of nonmaleficence is not determinative by itself of a general position on abortion.

Beneficence: Beneficence for one individual is also limited by the needs of beneficence to others. Beneficence to the fetus would preempt all abortion. Beneficence to the woman would permit abortion in circumstance when childbearing would be detrimental to the woman.

Justice: Justice is about balancing the deserts of different individuals. Fairness for women to compete in society can be used as an argument in favor of abortion. On the other hand, if the fetus is ascribed full

rights, then justice could debar abortion except perhaps in circumstances which threaten the life of the woman.

The autonomy arguments are the most pertinent and will be used in preference to the other principles' arguments in the remainder of this appendix.

Relevant Features of the Fetus

Three considerations guide the way in which these autonomy arguments do or do not apply: attribution of personhood to the fetus and if so at what stage; viability of the fetus outside the woman's body; and position of the fetus inside or outside the woman's body.

Attribution of personhood has differed among traditions and among individuals. Possible time points for such attribution have included: conception; some level of neurological development; viability; birth; and (among cultures that tolerate infanticide) weaning. All positions have received some endorsement and some condemnation from different traditions, different moral theorists, and different individuals.

Viability is a moving target as medical advances continue, and is also situation-dependent, being quite different in a rural area of a developing country versus the immediate proximity of an advanced neonatal intensive care unit. In general it is best to estimate viability for the situation in which the woman or potential infant exist and must remain during the potential critical care period.

The position of the fetus with respect to the mother's body matters for two reasons. First, the autonomy arguments rest on bodily rights and once the fetus is outside the woman's body, the woman's rights change to those of a parent which are less encompassing. Second, the fetus's status changes to that of an infant when outside the woman's body.

When the fetus is part way in and part way out of the woman's body, the ethics arguments converge and balance becomes particularly difficult. In such cases, other factors become more important or important in different ways. For instance, the reason preventing full delivery, becomes important (e.g., abortion and delivery of a dead fetus is desired, versus a mechanical impossibility of vaginal delivery any other way, versus maternal future fertility factors, versus immediate threat to the woman's health). In addition, the question of fetal viability might become especially weighty. For instance, an 8-week intact abortion may not acquire the status of infant even if transiently alive, but a 25-week fetus probably would.

Relevant Features of Gestational Age: Third Trimester and Late Second-trimester

The balance of autonomy claims shift as the late second and third trimester are reached. The woman's claims to be free of unwanted interference or presence in her body are increasingly controverted by the growing tendency to attribute personhood to the fetus and the growing likelihood of fetal viability outside the woman. The autonomy/ownership argument is still applicable, but weaker as the remaining time until normal delivery declines; the argument by Thomson does not apply if there is fetal viability; the conditional fetal rights argument applies increasingly against abortion; and the full fetal rights argument applies as always.

The balance is more toward, or less opposed to, abortion when the fetus is so deformed that personhood is less attributable and viability is absent. In intermediate cases when the fetus is deformed but viable, or

viability is in question, a gray zone exists. In such cases, precise interpretations of what constitutes personhood and viability become weighty.

When fetal abnormalities are such that exit through the birth canal is mechanically impossible, and if abortion has been justified, a second question arises, namely: is there an ethical preference between types of abortion procedure. For instance, might one of the following have more justifiability than the other: delivery by cesarean section with expected fetal demise; hysterotomy; D&X with in utero destruction; or D&X with destruction when partly outside of the woman's body. This question requires a revisitation of the above mentioned relevant factors: attributed personhood; fetal viability; the relevance or not of the fetus' bodily boundaries; and fetal suffering if there is reason to believe it is sensate. In such cases, well defined meanings for personhood and viability are necessary, and as much knowledge as possible about sensation is desirable.

It is worth noting that D&X procedures are not generally applicable in early second and first trimesters. The AMA is not currently revisiting its position on abortion at these stages of gestation.

Relevant Features of Procedures Used to Induce Abortion

One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body. A second relevant feature is whether the procedure occurs electively, with intent to abort, or during spontaneous labor with severe medical complications. In the latter case it may be closer to an emergency delivery and still-birth and should be distinguished from an intended abortion. Nonetheless, the technical steps of the procedures may have similarity. Since the ethical features differ, but the technical steps may be similar any position on the matter should take both circumstances and procedure into account.

Third, D&E and D&X abortions share the feature of going beyond the bodily boundaries of the fetus for the purpose of its destruction. This feature is not significant to the autonomy/ownership argument, or to the conditional fetal rights argument if the fetus is not attributed personhood or viability. It is relevant to Thomson's argument since her argument justifies fetal removal and does not speak to fetal destruction, and the applicability of the argument, especially after viability, would therefore be in question. If the fetus is attributed personhood and is viable this feature would emphasize the applicability of the conditional fetal rights, now arguing against abortion. The full fetal rights argument would find the feature relevant and reason against abortion.

Fourth, suffering of the fetus may be relevant, but does not lead to conclusively different positions about types of procedure under any of the four arguments. Close-to-full-gestation normal fetuses presumably have similar sensation to a newborn infant, but there are no good data to guide estimates of suffering as a result of one course of action over another, either for close-to-full-gestation or any other fetal stage. Once sensate, autonomy indicates a fetal interest in comfort. Some procedures include a lethal procedure prior to the destructive process, which some accounts suggest would reduce fetal suffering. Under the autonomy/ownership argument fetal suffering is arguably irrelevant, but compassion might indicate minimization of suffering. Under Thomson's argument, the same reasoning applies. Under the conditional fetal rights argument, the sensate fetus' suffering is relevant, and how well prior ending of the fetus' life to avoid suffering is justified varies. For instance, it may be easier to justify the act if there is no fetal viability outside the uterus and harder to justify it if there is viability. Under the full fetal rights argument, fetal suffering is relevant, but opposition to suffering may be trumped by the interest in life if survival entails suffering.

Ethical Implications of Various Policy Positions

The ethics of policy positions are distinct from the ethics of particular acts. For instance, it is possible that acts are not ethically defensible, but their debarment is even less defensible; the correct policy in such cases permit wrong acts as a matter of choosing the lesser wrong. Conversely, it is possible that acts are ethically defensible in themselves, but the consequences of policy permitting them would be indefensible; the correct policy in such cases debar defensible acts as a matter of choosing the lesser wrong. So, although the above reasoning may lead a person to a reasoned position regarding particular instance of abortion, it would not lead by simple extrapolation to an obvious policy position. The ethics of medical policy positions is also distinct from legal policy positions.

The question for the medical profession of whether or not to endorse these abortion procedures is three fold: 1) Are the procedures necessary parts of the medical sphere for some well defined circumstances? 2) If so, are the procedures also optional procedures in a wider range of circumstances? If so, their use should be a matter for decision-making between the woman and the physician, based on personal morals and medical judgment. 3) Are the procedures medically unnecessary and therefore open for legislation?

Corresponding to these three question there are three general options.

Option 1: Restriction of the procedure: This option could involve a range of types of restriction, some stringent, some less so. The restriction of the procedures to emergency circumstances would permit only the version of the reduction procedure that may not even be classifiable as an elective abortion. Elective D&E and D&X would not be allowed. Restriction of the procedures to circumstances involving a morbidly abnormal fetus would permit both D&E and elective D&X but would still prevent destructive procedures for a viable fetus.

Option 2: Keep decisions exclusively in the medical realm. This option would allow the woman, in consultation with her physician, to determine the propriety of using the procedure. It would leave informed consent as the ethical safeguard to misuse of the procedure. Although some have noted the difficulty of this standard for such extenuating and complex circumstances and have recommended additional safeguards such as involvement of an ethics committee, others object that such procedures would be either intrusive or evidence of an *a priori* position.

Option 3: Abandonment of the procedures. It could be possible to abandon elective D&X without preventing women from having a termination by another procedure. The ethical distinction between the procedures, as noted above, is that with D&X the fetus is partly emerged from the birth canal prior to the destructive procedure. However, logical distinction in the policy arena may be difficult due to the similarities between elective D&X and D&E, and the similarities between D&X for intended abortion and D&X for emergency circumstances that started with intent to deliver a baby but was precluded by major medical complications.

Some physicians believe that all situations permit a cesarean section or hysterotomy as a reasonable alternative, and note that there are risks to the woman for both D&E and D&X. If this is accepted from a medical point of view, abandonment of both these two categories of abortion is possible. This position would result in the live birth of many of the malformed or disabled but viable infants that could have been aborted under Option 2, and morbidly abnormal fetuses would die as a result of their condition rather than from abortion. Such a policy would have to address whether or not early induced delivery to reduce viability would be permissible.

Although these types of arguments, types of circumstances and types of policy option may help clarify

discussion, they do not lead to one clearly preferred ethical position. All these options could receive coherent ethical justification if the relevant principles are invoked. All these options could be logically compatible with existing AMA policy on other abortion procedures and circumstances. All options are, from the viewpoint of ethics reasoning, compatible with the Roe v. Wade Supreme Court decision, under which third term abortion for a normal pregnancy can be banned by state action. All positions leave open the question of state versus federal legislative action.

REFERENCES

1. Mohr JC. *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*. New York, NY: Oxford University Press; 1978.
2. Sarvis B, Rodman H. *The Abortion Controversy. 2nd ed.* New York, NY: Columbia University Press; 1974.
3. Doe v. Bolton. 410 U.S. 179, 193 (1973).
4. Roe v. Wade. 410 U.S. 113, 160 (1973).
5. *Id.* at 164-65.
6. *Id.*
7. Planned Parenthood of Central Missouri v. Danforth. 428 U.S. 52, 64 (1976).
8. *Id.*
9. Webster v. Reproductive Health Services. 492 U.S. 490, 515 (1989).
10. Planned Parenthood of Southeastern Pennsylvania v. Casey. (505 U.S. 833, 835-36 (1992).
11. "Partial Birth Abortion Act of 1995," HR1833, U.S. Congress.
12. "Partial Birth Abortion Act of 1995," HR1833, U.S. Congress, p. 1
13. *Hearings on HR 1833 Before the Subcommittee on the Constitution of the House Judiciary Committee*, 104th Cong, 1st Sess. (1995) (testimony of Brenda Shafer, RN).
14. Haskell M. Second-trimester D&X, 20 Weeks and Beyond; D&E for Late Second-trimester Abortion. Presented at National Abortion Federation on Second-trimester Abortion. Abortion, Fall Risk Management Seminar; September 13-14, 1992; Dallas TX.
15. Letter dated February 24, 1997 from Pamela Smith, MD, President of the American Association of Pro Life Obstetricians and Gynecologists. The letter was addressed to Frederic D. Frigoletto, Jr, MD, President of the American College of Obstetricians and Gynecologists.
16. Romer N, Smith P, Cook C, DeCook JL. "Partial-birth abortion is bad medicine." *The Wall Street Journal*. September 19, 1996, p. A1
17. Letter dated January 29, 1997, from Physicians' Ad Hoc Coalition for Truth. The letter was addressed to Frederic D. Frigoletto, Jr, MD, President of the American College of Obstetricians and Gynecologists.

18. *Hearings on HR 1833 Before the Subcommittee on the Constitution of the House Judiciary Committee*, 104th Cong, 1st Sess. (1995) (testimony of Helen Alvarez, Director of Planning and Information, National Conference of Catholic Bishops).
19. American College of Obstetricians and Gynecologists. *Statement on Intact Dilatation and Extraction*. January, 1997.
20. The Society of Physicians for Reproductive Choice and Health. *PRCH Policy Statement on the Dilatation and Extraction Procedure*. January, 1997.
21. Allan Rosenfield, MD, Dean of Columbia School of Public Health. Letter to the *Washington Post* on Late-Term Abortion, September 25, 1996.
22. National Abortion and Reproductive Rights Action League.
23. Katherine Q. Seelye, "House, by broad margin, backs ban on a type of late abortion." *New York Times*, March 21, 1997. A1, A14.
24. Centers for Disease Control. *Abortion Surveillance, 1981*. Atlanta, Ga: Centers for Disease Control; 1985.
25. Koonin LM, Smith JC, Ramick M, Green CA. *Abortion Surveillance---United States, 1992*. *MMWR*. 1996;45SS-3:1-36.
26. Atrash HK, Lawson HW, Smith JC. Legal abortion in the US: trends and mortality. *Contemp OB/GYN*. 1990;35:58-69.
27. The Alan Guttmacher Institute. *Issues in brief: The limitations of US statistics on abortion*. New York, NY: The Alan Guttmacher Institute. 1997. (NOTE: The Centers for Disease Control and Prevention plans to publish abortion surveillance data from 1993 and 1994 by June, 1997. The updated information will be included in the report when it becomes available.)
28. Torres A, Forrest JD. Why do women have abortions?" *Fam Plann Persp*. 1988;20:169-176.
29. Santee B, Henshaw SK. The abortion debate: Measuring gestational age. *Fam Plann Persp*. 1992;24:172-173.
30. Policar MJ, Pollack AE (eds.) *Clinical Training Curriculum in Abortion Practice*. Washington, DC: National Abortion Federation; 1995.
31. Slupik RI, ed. *American Medical Association Complete Guide to Women's Health*. New York, NY: Random House; 1996.
32. Grimes D. Management of abortion. In: Rock JA, Thompson JD, eds. *Te Linde's Operative Gynecology*. 8th ed. Philadelphia, Pa: Lippincott-Raven. 1997; chap 23.
33. Shulman LP, Grimes DA, Stubblefield PG. Abortion. *ACOG Update*. 1997;22;7:1-9.
34. Koonin LM, Smith JC Ramick M. *Abortion Surveillance---United States, 1991*. *MMWR*.

1995;44SS-2:23-53.

35. Centers for Disease Control. *Abortion Surveillance, 1978*. Atlanta, Ga: Centers for Disease Control. 1980.
36. Cates W Jr, Schulz KF, Grimes DA. et al. Dilatation and evacuation procedures and second-trimester abortions: the role of physician skill and hospital setting. *JAMA*. 1982;248:559-563.
37. Sabbagha R. Ultrasonic evaluation. In: Berger GS, Brenner WE, Deith LG, eds. *Second-Trimester Abortion*. Boston, Ma: John Wright/PSG. 1981:57-67.
38. Cates W Jr, Grimes DA. Deaths from second-trimester abortion by dilatation and evacuation: Causes, prevention, facilities. *Obstet Gynecol*. 58;1981:401-408.
39. Grimes DA, Schulz KF. Morbidity and mortality from second-trimester abortions. *J Reprod Med*. 1985;30:505-514.
40. Shulman LP, Ling FW, Meyers CM, Shanklin DR, Simpson JL, Elias S. Dilatation and evacuation for second-trimester genetic pregnancy termination. *Obstet Gynecol*. 1990;75:1037-1040.
41. Grimes DA. Second-trimester abortions in the United States. *Fam Plann Persp*. 1984;16:260-266.
42. Atrash HK, Peterson B, Cates W Jr, Grimes DA. The risk of death from combined abortion-sterilization procedures: Can hysterotomy or hysterectomy be justified? *Am J Obstet Gynecol*. 1982;142:269.
43. The Alan Guttmacher Institute. *Facts in brief: induced abortion*. New York, NY: The Alan Guttmacher Institute. 1996.
44. Lawson HW, Frye A, Atrash HK et al. Abortion mortality, United States, 1972 through 1987. *Am J Obstet Gynecol*. 1994;171:1365.
45. Binkin N. Trends in induced legal abortion morbidity and mortality. *Clin Obstet Gynecol*. 1986;13:83-93.
46. Cates W Jr, Grimes DA. Morbidity and mortality of abortion in the United States. In: Hodgson JE, ed. *Abortion and Sterilization: Medical and Social Aspects*. New York, NY: Academic Press, Inc; 1981:155-180.
47. Tietze C, Henshaw SK. *Induced Abortion: A World View, 1986*. New York, NY: The Alan Guttmacher Institute; 1986.
48. Council on Scientific Affairs, American Medical Association. Induced termination of pregnancy before and after Roe v Wade: Trends in the mortality and morbidity of women. *JAMA*. 1992;268:3231-3239.
49. Henshaw SK. Induced abortion: A world view, 1990. *Fam Plann Persp*. 1990;22:76-89.
50. Kaltreider NB, Goldsmith S, Margolis AJ. The impact of midtrimester abortion techniques on

patients and staff. *Am J Obstet Gynecol.* 1979;135:235-238.

51. Crist T, Williams P, Lee SH, Hulka JF. Midtrimester pregnancy termination: A study of the cost effectiveness of dilatation and evacuation in a free standing facility. *North Caroline Med J.* 1983;44:549-551.

52. Rhoads GG, Jackson LG, Schlesselman SE, et al. The safety and efficacy of chorionic villus sampling for early prenatal diagnosis of cytogenetic abnormalities. *N Engl J Med.* 1989;320:609-616.

53. American College of Obstetricians and Gynecologists. Statement on HR1833, the "Partial-Birth Abortion Ban Act of 1995." November 1, 1995.

APPENDIX A

UNITED STATES SUPREME COURT DECISIONS REGARDING ABORTION

The following is an analysis of Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705 (1973), and other Supreme Court decisions concerning abortions.

Roe v. Wade

A pregnant single woman (Roe) brought a class action suit challenging the constitutionality of a Texas criminal abortion law, which proscribed procuring or attempting an abortion except on medical advice for the purpose of saving the mother's life. A licensed physician (Hallford), who had two state abortion prosecutions pending against him, was permitted to intervene in the suit. A childless married couple (the Does) separately brought an action, basing alleged injury on the future possibilities of contraceptive failure, pregnancy, unpreparedness for parenthood and impairment of the wife's health.

A three-judge District Court consolidated the actions, and held that Roe and Hallford, and members of their classes, had standing to sue. The court ruled that declaratory (i.e., specific ruling by the court), though not injunctive (i.e., prohibitions on future conduct), relief was warranted, and declared the abortion statute void as vague and overly broad in infringing the plaintiff's Ninth and Fourteenth Amendment rights. The court ruled the Does' complaint not justiciable. Appellants (Roe and Hallford) appealed to the U.S. Supreme Court on the injunctive rulings, and appellee (Wade, District Attorney of Dallas County) cross-appealed from the District Court's grant of declaratory relief to Roe and Hallford.

The U.S. Supreme Court held that state criminal abortion laws that except from criminality only a life-saving procedure on the mother's behalf without regard to the stage of her pregnancy and other interests involved, violate the Due Process Clause of the Fourteenth Amendment, which protects the right to privacy, including a woman's qualified right to terminate her pregnancy, from infringement by state action. Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705 (1973). In reaching its decision, the Court concluded that the word "person" as used in the Fourteenth Amendment does not include the unborn.

The Court declined to "resolve the difficult question of when life begins." *Id.* at 159. However, the Court established guidelines for state regulation of abortion based on gestational stage and viability that determine the level of regulations that states can impose: 1) for the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician, 2) for the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health, and 3) for the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. The Court also held that the State may define the term "physician" to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

In reaching its holding, the Court reasoned that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman and in protecting the potentiality of human life. These two interests are separate and distinct, with each growing in substantiality as the woman approaches full term and, at a point during pregnancy, each becomes a "compelling" interest that may warrant increasing levels of regulation.

The Court asserted that with respect to the state's interest in the health of the mother, the compelling point, in light of medical knowledge at the time, is at approximately the end of the first trimester. The Court reached this conclusion because of the medical fact that until the end of the first trimester, the mortality rate from abortion may be less than the mortality rate from normal childbirth. From this, the Court held that from and after the end of the first trimester, a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. The Court cited examples of permissible state regulation including requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the abortion is to be performed (i.e., whether it must be a hospital or may be a clinic or some other place of less-than-hospital like status); as to the licensing of the facility and the like. *Id.* at 163.

Prior to this compelling point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

With respect to the State's interest in potential life, the Court found that the compelling point is at viability, because the fetus then presumably has the capability of meaningful life outside the mother's womb. The Court held that if the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother. The Court did not define when viability occurs. In dicta, the Court stated: "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Id.* at 160.

Doe v. Bolton

The case of Doe v. Bolton, 410 U.S. 179, 93 S. Ct. 739 (1973), was decided with Roe v. Wade. The case involved a Georgia law which proscribed an abortion except as performed by a duly licensed Georgia physician when necessary in his best clinical judgment because continued pregnancy would endanger a pregnant woman's life or injure her health; the fetus would likely be born with a serious defect; or the pregnancy resulted from rape. The law also imposed certain requirements including that the woman be a resident of Georgia, and posed three procedural conditions: 1) that the abortion be performed in a hospital accredited by the JCAH; 2) that the procedure be approved by the hospital staff abortion committee; and 3) that the performing physician's judgment be confirmed by independent examinations of the patient by two other licensed physicians.

The District Court gave declaratory, but not injunctive, relief, invalidating as an infringement of privacy and personal liberty the limitation to the three situations and certain other provisions, but holding that the State's interest in health protection and the existence of a potential of independent human existence justified regulation of the manner of performance as well as the quality of the final decision to abort.

The appellant (Doe) appealed to the U.S. Supreme Court, which invalidated the provisions of the Georgia law that required that: a) any abortion be performed in a hospital; b) a woman secure the approval of three physicians and a hospital committee before obtaining an abortion; and c) a woman seeking to obtain an abortion be a resident of the state.

The Court also found that the requirement that a physician's decision to perform an abortion must rest upon his or her best clinical judgment of its necessity was not unconstitutionally vague. The Court

reasoned that whether “an abortion is necessary” is a professional judgment that the Georgia physician will be called upon to make routinely. *Id.*, at 192. The Court went on to state: “that the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage of, the pregnant woman.” *Id.*, at 192.

Planned Parenthood of Central Missouri v. Danforth

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 96 S. Ct. 2831 (1976), involved two Missouri-licensed physicians, one of whom performed abortions at hospitals and the other of whom supervised abortions at Planned Parenthood. These physicians had brought suit for injunctive and declaratory relief challenging the constitutionality of a Missouri abortion statute. Specifically, the provisions of the statute that they challenged were: 1) a provision defining viability as “that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems;” 2) a provision requiring that before submitting to an abortion during the first 12 weeks of pregnancy a woman must consent in writing to the procedure and certify that her consent is informed and freely given and is not the result of coercion; 3) a provision requiring, for the same period, the written consent of the spouse of a woman seeking an abortion unless a licensed physician certifies that the abortion is necessary to preserve the mother’s life; 4) a provision requiring, for the same period, and with the same proviso, the written consent of a parent or person in loco parentis to the abortion of an unmarried woman under age 18; 5) a provision requiring the physician to exercise professional care to preserve the fetus’ life and health, failing which he is deemed guilty of manslaughter and is liable in an action for damages; 6) a provision declaring an infant who survives an attempted abortion not performed to save the mother’s life or health an abandoned ward of the State, and depriving the mother and a consenting father of parental rights; 7) a provision prohibiting after the first 12 weeks of pregnancy the abortion procedure of saline amniocentesis as “deleterious to maternal health;” and 8) provisions prescribing reporting and recordkeeping requirements for health facilities and physicians performing abortions.

The District Court upheld the above provisions, with the exception of the professional-skill requirement, which was held to be unconstitutionally overbroad because it failed to exclude the pregnancy stage prior to viability.

The U.S. Supreme Court held that the definition of viability did not conflict with the definition in Roe v. Wade. The Court found that the provision maintained the flexibility of the term “viability” recognized in Roe. The Court reasoned that it was not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The Court stated that: “The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.” *Id.*, at 64.

Also of interest is the Court’s ruling regarding the provision in the Missouri statute prohibiting the use of saline amniocentesis after the first 12 weeks of pregnancy. The statute imposed the prohibition on the ground that the technique was deleterious to maternal health. The Court held that the outright legislative proscription of saline failed as a reasonable regulation for the protection of maternal health. The Court stated that the provision was an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks; thus, the provision could not

withstand constitutional challenge.

In reaching this holding, the Court was persuaded by the following factors: 1) the prevalence of the use of saline amniocentesis as an accepted medical procedure (employed in a substantial majority of all post-first-trimester abortions), 2) the severe limitations on the availability of the prostaglandin technique suggested as an alternative to saline amniocentesis by appellees, and 3) the fact that alternative methods of hysterotomy and hysterectomy are significantly more dangerous for the woman than the saline technique, yet were not proscribed by the statute.

With respect to the other provisions challenged by appellants, the Court found that the consent provision was not unconstitutional, the spousal consent provision was unconstitutional, the blanket parental consent provision was unconstitutional, the reporting and recordkeeping requirements were constitutional if administered in a way that was not unduly burdensome, and the requirement that a physician preserve the fetus' life and health was impermissible.

Webster v. Reproductive Health Services

State-employed health professionals and private nonprofit corporations providing abortion services brought suit for declaratory and injunctive relief challenging the constitutionality of a Missouri statute regulating the performance of abortions. Among other things, the statute: 1) set forth findings in its preamble that the life of each human being begins at conception and that unborn children have protectable interests in life, health, and well-being and required that all state laws be interpreted to provide unborn children with the same rights enjoyed by other persons, subject to the Federal Constitution and the Supreme Court's precedents; 2) specified that a physician, prior to performing an abortion on any woman whom he or she had reason to believe was 20 or more weeks pregnant, must ascertain whether the fetus is "viable" by performing such medical examinations and tests as are necessary to make a finding of the fetus' gestational age, weight, and lung maturity; 3) prohibited the use of public employees and facilities to perform or assist abortions not necessary to save the mother's life; and 4) made it unlawful to use public funds, employees or facilities for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life.

The District Court struck down each of the above provisions, among others, and enjoined their enforcement. The Court of Appeals affirmed, ruling that the provisions violated Roe v. Wade. In Webster v. Reproductive Health Services, 492 U.S. 490, 109 S. Ct. 3040 (1989), the Supreme Court did not determine the constitutionality of the Act's preamble, but reasoned that the preamble did not by its terms regulate abortion or any other aspect of appellees' medical practice. Rather, the Court asserted that the preamble could be read to express a value judgment favoring childbirth over abortion.

The Supreme Court upheld the Missouri Act's restrictions on the use of public employees and facilities for the performance or assistance of abortions not necessary to save the life of the mother. The Court's view was that Missouri's refusal to allow public employees to perform abortions in public hospitals left a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all. The challenged provision only restricted a woman's ability to obtain an abortion to the extent that she chose to use a physician affiliated with a public hospital.

On the issue of the use of public funds, employees or facilities for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life, appellees contended that they were not adversely affected under the state's interpretation of the provision. The Court concluded that

there was no longer a case or controversy on the issue.

On the viability-testing provision, the Court construed the provisions as not requiring a physician to perform tests irrelevant to the expressed statutory purpose of determining viability. The Court reasoned that to interpret the provision to require a physician to perform those tests needed to make the three specified findings in all circumstances (i.e., gestational age, weight and lung maturity), including when the physician's reasonable professional judgment indicates that the tests would be irrelevant to determining viability or even dangerous to the mother and the fetus, would make that portion of the provision conflict with the other requirement that a physician apply his reasonable professional skill and judgment.

The Court asserted that the viability-testing provision was concerned with promoting the state's interest in potential human life, rather than in maternal health, and created what is essentially a presumption of viability at 20 weeks which the physician must rebut with tests indicating the fetus is not viable prior to performing an abortion.

Although the Court acknowledged that the tests called for in the Missouri statute increase the expense of abortion, and regulate the discretion of the physician in determining the viability of the fetus, the Court was satisfied that the requirement of these tests permissibly furthered the State's interest in protecting potential human life. The Court held the provision to be constitutional.

Of particular note, the Court stated in dicta that the Roe trimester framework falls into the category of prior constructions of the Constitution that have proved unsound in principle and unworkable in practice. The Court declared that: "[t]he key elements of the Roe framework--trimesters and viability--are not found in the text of the Constitution or in any place else one would expect to find a constitutional principle." *Id.* at 518. Significantly, the Court questioned why the State's interest in protecting potential human life should come into existence only at the point of viability.

The appellants and the United States as *amicus curiae* urged the Court to overrule its decision in *Roe v. Wade*; however, the Court determined that the facts of *Webster* differed from those at issue in *Roe* and thus the case afforded the Court no occasion to revisit the holding in *Roe*. The Court did state that to the extent indicated in the opinion, the Court would modify and narrow *Roe* and succeeding cases.

Planned Parenthood of Southeastern Pennsylvania v. Casey

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S. Ct. 2791 (1992), Justices O'Connor, Kennedy and Souter delivered the opinion of the Court, with Justices Stevens, Blackmun, Rehnquist and Scalia concurring in parts and dissenting in parts. At issue in the case were five provisions of the Pennsylvania Abortion Control Act of 1992 which required that a woman seeking an abortion give her informed consent prior to the procedure and specified that she be provided with certain information 24 hours before the abortion is performed. The law also mandated the informed consent of one parent for a minor to obtain an abortion (with a judicial bypass provision) and required that a married woman, with certain exceptions, sign a statement indicating that she had notified her husband. Under the law, certain reporting requirements were also imposed on facilities providing abortion services.

The District Court issued a permanent injunction against enforcement of the regulations which they found to be unconstitutional. The Court of Appeals for the Third Circuit affirmed in part and reversed in part,

upholding all the regulations except the spousal notification provision.

The Supreme Court reaffirmed the “central holding” of Roe v. Wade. The Court defined that central holding to be: 1) a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State, 2) a confirmation of the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman’s life or health, and 3) the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. Id. at 846.

Of particular note, the Court rejected the trimester framework, which it did not view to be part of the essential holding of Roe. The Court reasoned that the trimester framework suffers from certain basic flaws: “in its formulation it misconceives the nature of the pregnant woman’s interest; and in practice it undervalues the State’s interest in potential life, as recognized in Roe.” Id. at 873. The Court determined that only when state regulation imposes an “undue burden” on a woman’s ability to have an abortion, does the power of the State infringe on the woman’s constitutionally protected liberty interest.

In discussing the “undue burden” standard, the Court concluded that a finding of an undue burden signifies a conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.

The Court stated that as with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.

With respect to the specific provisions of the Pennsylvania statute, the Court upheld the informed consent requirement which mandated that at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the unborn child. The statute also required that the physician or a qualified nonphysician inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.

In upholding the informed consent requirement, the Court overruled the Akron I and Thornburgh cases to the extent that they found a constitutional violation when the government required the giving of “truthful, nonmisleading information” about the nature of the procedure, the attendant health risks and those of childbirth and the probable gestational age of the fetus. The Court also declared that the conclusion in Akron I that a 24-hour waiting period did not further the State’s legitimate interest that the woman’s decision be informed was wrong. Although the Court acknowledged that the 24-hour waiting period might increase the cost and risk delay of abortions, the Court did not find that the waiting period constituted an undue burden.

The Court found that the spousal notification requirement did place an undue burden, and, therefore, held it to be invalid. The Court upheld the parental consent provision, noting that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure. The Court also upheld the recordkeeping and reporting requirements of the Pennsylvania statute, except for the provision requiring a married woman to report her reason for failure to provide notice to her spouse.

Chief Justice Rehnquist, Justice Scalia, Justice White and Justice Thomas, concluded that the Court was mistaken in Roe when it classified a woman's decision to terminate her pregnancy as a "fundamental right" that could be abridged only in a manner which withstood strict scrutiny. These Justices concluded that a woman's decision to abort her unborn child is not a constitutionally protected "liberty" because: 1) the Constitution says nothing about it and 2) the long-standing traditions of American society have permitted it to be legally prohibited. Under the rational basis test, these four Justices stated that the Pennsylvania statute should be upheld in its entirety.

Justice Blackmun concluded that application of the strict scrutiny standard of review required by the Court's previous abortion decisions required the invalidation of all the challenged provisions of the Pennsylvania statute.

Justice Stevens, concurring in part and dissenting in part, agreed with the Court's reaffirmation of Roe v. Wade, but disagreed with its rejection of the trimester framework. He did not view it as a contradiction to recognize that the State may have a legitimate interest in potential human life and to conclude that that interest does not justify the regulation of abortion before viability. Instead, he asserted that it was appropriate to consider the nature of the interests at stake in order to determine when, if ever, the State's interest outweighs the pregnant woman's interest in personal liberty.

AMA/ACOG JOINT STATEMENT ON HR1122

As partners in many valuable and effective efforts to improve women's health care, both AMA and ACOG are concerned about the negative impact caused by different positions reached by our organizations on restricting a procedure called intact D & X. Although much of the attention has been on the areas where the organizations disagree, we believe the areas of agreement are significant.

Both organizations oppose aborting the healthy viable fetus of a healthy woman.

Both organizations support Report 26, entitled "Late-Term Pregnancy Termination Techniques" pending before Reference Committee B at this House of Delegates meeting. We urge its adoption, without substantial amendment.

Both organizations believe that reducing unintended pregnancy should be a national goal and that our organizations should work in concert with other elements of society to address this national tragedy.

Although our organizations take different positions on the legislation, with the AMA supporting the amended legislation and ACOG opposing it, we agree that each organization believed and believes the position it took furthers the best interests of patients.

AMA and ACOG agree that clarity in definition is critical to any legislation prescribing the conduct of physicians, particularly when the penalties are criminal. However, as to whether the pending legislation meets this goal the organizations disagree. ACOG acknowledges AMA engaged in negotiations with the Senate designed to improve the bill and endorsed the bill only after amendments were accepted that AMA believes make clear that the bill restricts only intact D & X and could not be construed as restricting other obstetric or abortion procedures. Further ACOG believes that AMA improved the bill by making clear that physicians who, at the outset, are intending to deliver an infant, but who ends up performing the procedure, are not covered by the legislation. ACOG remains concerned that the legislation is still vague, may be interpreted to limit other abortion techniques, or that doctors will fear using abortion techniques other than intact D & X because of the threat of prosecution.

If the application of the statute in any way expands beyond what AMA believes is the intent, AMA, together with ACOG, will vigorously oppose such applications and will fully support any physician who is prosecuted in an application beyond this intent.

AMA and ACOG agree where state legislation is pending, at the minimum, the AMA amendments should be adopted. Other amendments to further improve the legislation should be evaluated.

AMA was instrumental in including a provision for review by state medical boards. ACOG believes that this provision should be stronger.

ACOG and AMA disagree about the intact D & X procedure ethically being different from other abortion procedures. ACOG and AMA disagree about comparison of intact D & X to other procedures that have been regulated, such as female genital mutilation. ACOG believes that intact D & X may be a medically appropriate procedure in certain circumstances and its 1997 policy statement indicates this.

In conclusion, AMA & ACOG agree on important aspects of this issue. We provide this summary of agreements and disagreements to assure that interested parties get a fair understanding of the exact nature of our disagreements. AMA and ACOG have agreed to work together to advance these and other matters in the best interests of our patients.

PHACT**Physicians'
Ad Hoc
Coalition for
Truth**

1150 South Washington Street
Suite 230
Alexandria, VA 22314
(703) 583-5004

Communications Counsel:
Gene Tarte, Michelle Powers

FOUNDING MEMBERS

Hon. Tom A. Coburn, M.D.
Family Practitioner,
Obstetrician
Member, U.S. House of
Representatives (OK-2)

Nancy Romer, M.D.
Fellow, American College
of Obstetricians &
Gynecologists (FACOG)
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of
Ob/Gyn, Miami Valley
Hospital, OH

Pamela Smith, M.D.
Director of Medical
Education
Dept. of Obstetrics &
Gynecology
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

James Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Butterworth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College
of Obstetricians &
Gynecologists (FACOG)

William Stalter, M.D.
Clinical Associate
Professor, Obstetrics &
Gynecology, Wright State
University, OH

Bernard Nathanson, M.D.
Visiting Scholar
Center for Clinical &
Research Ethics, Vanderbilt
University

GENERAL MEMBERS
(updated 9/17)

Bob Christmas, M.D.
FACOG
Marietta, GA

Eugene Rudd, M.D.
FACOG
Bristol, TN

Kathy Santi, M.D.
Port Orange, FL

James Long, M.D.
FACOG
West Point, GA

Edward Hannigan, M.D.
Director, Dept. of Obstetrics
and Gynecology, University
of TX Medical Branch at
Galveston

Denis Cavanagh, M.D.
Professor, Obstetrics and
Gynecology, University of
FL at Tampa

James R. Freeman, M.D.
FACOG
Lawrenceville, GA

Russell B. Dieterich, M.D.
FACOG
Clinical Instructor,
Washington University
School of Medicine
St. Louis, MO

Donovan Hanson, M.D.
FACOG
Clinical Professor,
University of Washington,
Seattle

David W. Adcock, II, M.D.
Ob/Gyn
Moultrie, GA

Camilla Hersh, M.D.
Ob/Gyn
Vienna, VA

Hoyt C. Dees, M.D.
Ob/Gyn
Atlanta, GA

Robert B. Alase, Jr., M.D.
Ob/Gyn
Atlanta, GA

Donna Harrison, M.D.
FACOG
Berrien, MI

Brayden Richmond, M.D.
JFACOG
Helen Keller Hospital
Tusculumbia, GA

Elizabeth Street, M.D.
FACOG
Marietta, GA

Lewis J. Marold, M.D.
Chairman, Dept. of
Obstetrics and Gynecology,
St. Clare's Hospital
Schenectady, NY

Linda M. Gourash, M.D.
Developmental Pediatrician
Pittsburgh, PA

Seok Mie Choi, M.D.
Ob/Gyn
Mishawaka, IN

Lawrence Burdge, M.D.
FACOG
Perry, GA

Jean Stapleton, M.D.
Anesthesiologist
Wellesley, MA

Thomas J. Giblin, M.D.
Ob/Gyn
Wellesley, MA

William F. Coliton, M.D.
FACOG
Clinical Professor,
Obstetrics and Gynecology,
The George Washington
University Medical Center,
Washington, D.C.

Leslie Hansen, M.D.
Ob/Gyn
Charlotte, NC

Thomas J. Kennedy, M.D.,
A.P.M.C.
OB/GYN
Metairie, LA

Brad Fields, M.D.
FACOG
Jonesboro, AR

Frank Giglio, M.D., P.A.
FACOG
Clinical Assistant Professor
Dept. of OB/GYN, Texas
University Medical Branch
Beaumont, TX

Hugh Gavin Grimes, M.D.
Assistant Clinical Professor
Dept. OB/GYN,
Northwestern University
Chicago, IL

James G. Linn, M.D.
Chairman, Dept. OB/GYN,
St. Mary's Hospital,
Assistant Clinical Professor
OB/GYN, Medical College
of Wisconsin, Milwaukee

- James R. Dillon, M.D.
FACOG
Former Director of
Obstetrics at St. Francis
Hospital, Evanston, IL
Former clinical instructor of
OB/GYN at Loyola
University, Stritch School
of Medicine, Chicago, IL
- Jerome L. Sinsky, M.D.
FACOG
Escondido, CA
- Jerry A. Wittingen, M.D.
Clinical Associate Professor
of OB/GYN, Michigan state
College of Human Medicine
Grand Rapids, MI
- Julie A. Mickelson, M.D.
OB/GYN
Milwaukee, WI
- Kamal M. Behnam, M.D.
FACOG
Clinical Professor, Dept.
OB/GYN, W.Va University
School of Medicine,
Martinsburg, W.VA
- Mark G. Lewis, D.O.
OB/GYN
Obstetrics Coordinator
Family Practice Residency
St. Joseph's Medical Center
South Bend, IN
- Matthew J. Bulfin, M.D.
OB/GYN
Fort Lauderdale, FL
- Michael Soderling, M.D.
FACOG
West Bend, WI
- Ted E. Fogwell, M.D., P.A.
OB/GYN
Dallas, TX
- Thaddeus A. Figlock, M.D.,
P.C.
OB/GYN
Taunton, MA
- Thomas Theodorides,
M.D.
OB/GYN
Elkhart, IN
- J. Michael Fite, M.D.
FACOG
Fort Worth, TX
- Adam B. Binkley, M.D.
OB/GYN
Clinical Instructor, Dept of
OB/GYN at Michigan State
University College of
Medicine
Grand Rapids, MI
- Lawrence Dunagan, M.D.
Pediatrician
Pittsburgh, PA
- Herb Atkinson, M.D.
OB/GYN
Bridgman, MI
- Bennie P. Nobles, M.D.
OB/GYN
Metairie, LA
- Leonard E. Marona, M.D.
FACOG
East Syracuse, NY
- Frank Zarika, M.D.
OB/GYN
San Jose, CA
- John J. Choby, M.D.
OB/GYN
North Wales, PA
- Mark T. Karnes, D. O.
FACOG; OB/GYN Surgery
Muskegon, MI
- Harvey T. Huddleston,
M.D.
Associate Professor of
Clinical Obstetrics and
Gynecology,
Head of Section,
Urogynecology/Pelvic
Reconstructive Surgery,
LSU School of Medicine
- David V. Foley, M.D.
Clinical Professor of
OB/GYN, Medical College
of Wisconsin
- William R. Dorsey, D.O.
FACOG
Chairman Section
OB/GYN,
Grandview/Southview
Hospital, OH
Canterville, OH
- Matthew J. Batulich, M.D.
FACOG
Carson City, NE
- Karin E. Shinn, D.O.
Assistant Attending, Coney
Island Hospital; Clinical
Instructor, St. Georges
Medical School, Grenada,
West Indies; Adjunct
Clinical Instructor, New
York College of
Osteopathic Medicine, Old
Westbury, NY
- Brendan Mitchell, M.D.
OB/GYN
Shawnee Mission, KS
- Peter B. Greenapan, D.O.
FACOG; Assistant Clinical
Professor, Dept of
OB/GYN, Truman Medical
Center, University of
Missouri, Kansas City
School of Medicine; Asst.
Professor, University of
Health Science, College of
Osteopathic Medicine
Lee's Summit, MO
- Anne B. Ward, M.D.
OB/GYN
Chicago, IL
- John M. Dodge, M.D.
FABOG, FACOG
Texarcana, TX
- Karen Rainer, M.D.
OB/GYN; Assistant
Director, Perinatology,
Bayfront Medical Center,
St. Petersburg, FL
- Matthew Anderson, M.D.
OB/GYN
Burlington, IA
- Gordon Blake Clark, M.D.
FACOG
Lexington, MO
- Rajendra M. Ratnesar,
M.D.
FACOG
Clinical Asst. Instructor,
Stanford University
Castro, CA
- Joe A. Cloud, M.D.
FACOG
Russellville, AR
- Michael R. Watkins, M.D.
FACOG; Clinical Asst.
Professor of OB/GYN,
Medical University of S.C.,
Spartanburg, SC
- Albert M. Bringardner,
M.D., FACOG
Sr. Vice President, Medical
Affairs, Lake Hospital
System, OH
- Karl H. Johansson, M.D.
OB/GYN
Oroville, CA
- Christopher Roberts, M.D.
OB/GYN
Joplin, MO
- Howard Roberts, M.D.
OB/GYN
Joplin, MO
- Robert Wealdreyer, M.D.
FACOG
- L. Carl Jurgens, M.D.
DABOG
Holland, MI
- Calvin J. Siegers, M.D.
FACOG
- Kirk Tyler, M.D.
FACOG
- James Girard, M.D.
OB/GYN

- Barbara Puzycski, M.D.
OB-GYN
- David J. Young, M.D.
Internal Medicine
Holland, MI
- Theresa Shedenhelm, M.D.
Family Physician
Muskegon, MI
- J.M. Lackey M.D. P.A.
FACOG
Pocatello, ID
- Jeffrey Keenan, M.D.
FACOG
Director, Division of
Reproductive
Endocrinology & Infertility,
Department of Obstetrics &
Gynecology, University of
Tennessee Medical Center;
Associate Professor, Dept.
OB/GYN, University of
Tennessee Medical Center
Knoxville, TN
- John James DeMarco, M.D.
OB/GYN
Erie, PA
- Robert LaCava
FACOG
Bennetsville, SC
- Ronald G. Ryan, M.D.
Cardiologist
Muskegon, MI
- Michael Draper, M.D.
OB/GYN; Instructor
Bowman Gray School of
Medicine
Salt Lake City, UT
- J.M. Arrunategui, M.D.
F.C.
OB/GYN
Clinical Assistant Professor,
Elizabeth General Medical,
St. Elizabeth Hospital
Elizabeth, NJ
- Jerry Zabielski, M.D.
OB/GYN
Scottsdale, AZ
- William L.T. Fong, M.D.
FACOG
- Harley A. Grim, M.D.
OB/GYN
Cincinnati, OH
- Grace Valente, M.D.
OB/GYN
Macon, GA
- Robert Swan, M.D.
OB/GYN, Female Cancer,
GYN Oncologist, Dir
GYN/ONC St. Johns Mercy
Med. Center, St. Lewis
University
Grover, MO
- Robert Flambeck M.D.
FACOG; Chairman of
OB/GYN Department at
Bryan Memorial Hospital
Lincoln, NE
- John Murphy, M.D.
OB/GYN
Associate Professor,
University of IL School of
Medicine
- James O'Connor, M.D.
FACOG
Gloucester, VA
- Vincent J. McPeak, M.D.
OB/GYN
- William J. Polzin, M.D.
OB/GYN Maternal-Fetal
Medicine
Cincinnati, OH
- Dorothy Roels M.D.
Corpus Christi, TX
- Gustav K. Barkett, D.O.
FACOG
Muskegon, MI
- Dominick A. Caselnova,
M.D.
FACOG
Dade City, FL
- G. Russell Edwards, M.D.
P.A. JFACOG
Katy, TX
- Lawrence J. Smith, M.D.
OB/GYN
Goshen, IN
- James R. Van Curen, M.D.
OB/GYN
Goshen, IN
- Kenneth D. Petersen, M.D.
OB/GYN
Goshen, IN
- Fred A. Simon, M.D.
OB/GYN
Goshen, IN
- Steven A. Roth, M.D.
FACOG
Inverness, FL
- David Meyer, M.D. P.C.
OB/GYN
Holland, MI
- Ralph P. Miesch, M.D.
Ph.D.
Associate Professor Dept. of
Pharmacology, Physiology,
& Biotechnology, Brown
University School of
Medicine, Providence
E. Providence, RI
- Richard Switzer, M.D.
Internalist & Pediatrician
Grandville, MI
- John Heffron
Clinical Professor of
OB/GYN Creighton
University, Omaha
Omaha, NE
- Angelica M. Zaid, M.D.
OB/GYN
Encinitas, CA
- Robert F. Scanlon, Jr.,
M.D.
Huntington, NY
- Walter B. Hull, M.D.
OB/GYN
Assistant Professor, Ohio
State University, Columbus
Dublin, OH
- Alan Murnane, M.D.
FACOG
Associate Chairman, Dept.
of OB/GYN, St. Vincent
Medical Center, Toledo
Volunteer Clinical
Associate Professor
Dept. OB/GYN Medical
College of Ohio, Toledo
- Frank C. Morrone, M.D.
OB/GYN
Dallas, TX
- Anthony J. Linn, M.D.
Milwaukee, WI
- David A. Rueff, M.D.
FACOG
Clinical Instructor,
University of TN Hospital
Knoxville, TN
- Steven A. Foley, M.D.
FACOG
Indianapolis, IN
- Thomas A. Noone, M.D.
FACOG
Haddonfield, NJ
- Douglas John Doty, M.D.
Anesthesiology
Holland, MI
- James F. Hartman, MD
OB/GYN
Denver, CO
- Fernand H. Prussing, M.D.
FACOG
Assistant Clinical Professor
of OB/GYN, UCLA
Downey, CA
- J. Shan Young, M.D.
OB/GYN
Chief of Staff of Obstetrics
at Jacksonville Hospital
Jacksonville, AL

- I.W. Bryant, M.D.
OB/GYN
Springfield, OH
- Michael W. Sullivan, M.D.
OB/GYN
Eau Claire, WI
- J. Frederick Walk, M.D.
OB/GYN
Winchester, VA
- Steve Calvin, M.D.
FACOG
Maternal-Fetal Medicine
Specialist, High-Risk
Obstetrics, University MN
Minneapolis, MN
- Joseph Harmon, M.D.
OB/GYN
South Bend, IN
- Laura Langley, M.D. P.A.
OB/GYN
Orange, TX
- E. Peter Anzaldo, M.D.
OB/GYN; Assoc. Clinical
Professor, Dept. of
OB/GYN, University of
California at Irvine
Irvine, CA
- Loren Warner, M.D.
FACOG
Blusston, IN
- Rafael E. Vicens, M.D.
FACOG
Humacao, PR
- Robert Lowden, M.D.
Arlington, WA
- Joseph Kevehel, D.O.
FACOG; Professor of
OB/GYN Chairman of
Dept. of OB/GYN
Oklahoma State University
College of Osteopathic
Medicine, Tulsa
Tulsa, OK
- Gary L. Forcier, M.D.
FACOG
Elk Grove Village, IL
- James Hanser, M.D.
OB/GYN
Fairfield, CA
- James Presley, M.D.
OB/GYN
Vero Beach, FL
- Edward J. Mila Prats, M.D.
P.A.
OB/GYN
Port St. Lucie, FL
- John Sand, M.D.
OB/GYN
Ellensburg, WA
- Kathi A. Aultman, M.D.
F.A. FACOG
Department Chairman,
OB/GYN at Orang Park
Medical Center
Orange Park, FL
- Frank D. Setzler, Jr., D.O.
FACOG
Palestine, TX
- Richard R. Temple, M.D.
FACOG
Rhinebeck, NY
- Windsor A Holt, M.D.
OB/GYN
Raleigh, NC
- Lance Radbill, D.O.
FACOG
Birmingham, AL
- Daniel Voss, M.D.
Obstetrics
Georgetown, TX
- Robert E. Hedican, M.D.
FACOG
Clinical Faculty, Black
Hawk Area Family Practice
Program, Waterloo, IA
- Harry C. Beaver, M.D.
FACOG; Clinical Professor
OB/GYN, George
Washington University
School of Medicine and
Health Sciences
Annandale, VA
- William L. Toffler, M.D.
Family Practice Associate
Professor of Family
Medicine, Director of
Education, Dept. of Family
Medicine Oregon Health
Sciences University,
Portland
- John D. Holmes, M.D. P.C.
OB/GYN
Mesa, AZ
- Thomas Ritter, M.D.
FACOG
St. Joseph, MI
- Timothy Dindoffler, M.D.
FACOG
West Bloomfield, MI
- James L. Gildner, M.D.
FACOG
President Elect, Medical
Staff, Memorial Medical
center; Medical Director,
Women and Infants
Services, Springfield Dept.
of Public Health; Clinical
Assoc., Dept of OB/GYN,
Department of Family
Practice, Springfield Illinois
University School of
Medicine
Springfield, IL
- Gerald Corcoran, M.D.
Family Physician; Assistant
Professor of Family and
Community Medicine,
UMASS Medical School
Needham, MA
- Robert C. Laliberte, M.D.
FACOG
Past Chairman, Dept. of
OB/GYN, Phoenix Indian
Medical Center
Phoenix, AZ
- Tom Whalen, M.D.
OB/GYN
St. Louis, MO
- Kurt R. Finberg, M.D.
OB/GYN
Bakersfield, CA
- Dirk T. Carlson, M.D.
FACOG
Boise, ID
- James Statt, M.D.
OB/GYN; Associate fellow
of the American College of
OB/GYN
Phoenix, AZ
- James J. Delaney, M.D.
OB/GYN; Associate Clinical
Professor of OB/GYN at the
University of Colorado
Health Science Center
Highlands Ranch, CO
- J. Michael Davidson, M.D.
FACOG
Florence, SC
- J. Kenneth Davis, M.D.
OB/GYN
Associate Clinical Professor
at the Northeast Ohio
Universities College of
Medicine
Akron, OH
- Richard Robie, M.D.
OB/GYN
Wiloughby, OH
- Albert M. Bringardner,
M.D.
FACOG
Senior VP Medical Affairs,
Lake Hospital System
Painesville, OH
- William M. Petty, M.D.
OB/GYN
Gynecologic Oncology
Portland, OR
- Michele P. Johnson, M.D.
OB/GYN
Abilene, TX
- Nathan Hoeltdtke, M.D.
OB/GYN
Tocoma, WA

- Byron C. Calhoun, M.D.
FACOG
Associate Professor of
Clinical OB/GYN,
Uniformed Services,
University of Health
Sciences, F. Edward Hebert
School of Medicine,
Bethesda, MD
- Steve Adam, M.D.
FACOG
Florence, SC
- Paul S. Kruger, M.D.
OB/GYN
Watertown, NY
- Bane Travis, M.D.
OB/GYN
- Eugene J. Sweeney, M.D.
MPH
FACOG
Rye Beach, NH
- Jerry S. Putman, M.D.
OB/GYN
Tyler, TX
- Albert E. Rathe, Jr., M.D.,
P.A.
OB/GYN
New Braunfels, TX
- Fred A. Williams, M.D.
FACOG
Pairs, TX
- Simon Solano, M.D.
OB/GYN
Springfield, VT
- Donna L. Schmitz, M.D.
Pediatrics
Milwaukee, WI
- Stephen T. Torday, M.D.
OB/GYN
Fountain Valley, CA
- Clifford Sherwood, M.D.
FACOG
Colorado Springs, CO
- John J. Cheby, M.D.
Clinical Care Associate
Doylestown Woman's
Health Center, University of
Pennsylvania Health System
Doylestown, PA
- Marica Bohn Rbell, M.D.
OB/GYN
Beckley, WV
- Marshall W. White, Jr.
M.D.
OB/GYN
Hamilton, MT
- Edward M. Sullivan, M.D.
OB/GYN
Clinical Professor of
OB/GYN, Thomas
Jefferson University
Medical School
Media, PA
- Marshall D. Matthews,
M.D. FACOG
Moses Lake, WA
- Julio Guerra, M.D.
OB/GYN
Paris, TN
- Harvey T. Huddleston,
M.D.
OB/GYN; Associate
Professor of Clinical
OB/GYN Louisiana State
Univ. School of Medicine,
Department of OB/GYN
Director, Division of
Benign Gynecology
Head of Section,
Urogynecology/Pelvic
Reconstructive Surgery,
L.S.U. School of Medicine,
Dept. OB/GYN L.S.U.
Medical Center-Sherveport
Shreveport, LA
- Thomas B. Leberz, M.D.
OB/GYN; Professor
Emeritus, Dept. OB/GYN,
UCLA School of Medicine
Los Angeles, CA
- Joseph W. Cleary, M.D.
Bismarck, ND
- Donald T. Green, M.D.
FACOG
Montgomery, AL
- Edward C. Ryan, M.D.,
S.C.
FACOG
Orland Park, IL
- Don Gambrell, Jr., M.D.
FACOG
Clinical Professor of
Endocrinology and
OB/GYN, Dept. of
Physiology and
Endocrinology Medical
College of Georgia,
Augusta, GA
- James Gumber, D.O.
FACOG
Lancaster, OH
- Laurence Burns, D.O.
OB/GYN
Grand Rapids, MI
- Miles J. Murphy, M.D.
OB/GYN
Grand Rapids, MI
- John G. Hartmann, M.D.
OB/GYN
Grand Rapids, MI
- Stephen A. Hickner, M.D.
OB/GYN
Grand Rapids, MI
- Timothy F. Murphy, M.D.
OB/GYN
Grand Rapids, MI
- Scott Farhart, M.D.
FACOG
PA
- David T. McKnight, M.D.
OB/GYN
Murfreesboro, TN
- Paul E. Jarrett, Jr., M.D.
OB/GYN
Indianapolis, IN
- Thomas C. Christiansen,
M.D.
OB/GYN
Joliet, IL
- Paul A. Capelli, M.D.
FACOG
Kenosha, WI
- J. Peter Forney, III, M.D.,
P.A.
OB/GYN
New Braunfels, TX
- Hans E. Geisler, M.D.
FACOG
Gyn Oncology & Gyn
Surgery
Clinical Staff, Dept.
OB/GYN, Indiana
University Medical Center
Indianapolis, IN
- Margaret C. Nordell, M.D.
- Robert M. St. John, M.D.
FACOG
Butte, MT
- Pete Verrill, M.D.
FACOG
President Elect, Medical
Staff, Winter Haven
Hospital
Winter Haven, FL
- Joseph Pastorek, M.D.
Louisiana State Univ.
Dept. OB/GYN &
Infectious Disease Section
Medical Center
New Orleans, LA
- Robert B. Albee Jr. M.D.
FACOG
Dunwoody, GA
- Jerry M. Obrisch, M.D.
OB/GYN
Bismarck, ND
- Stephen R. Belton, M.D.
OB/GYN
San Jose, CA

- Gary L. Forcier, M.D.
FACOG
Clinical Instructor, Rush
Medical College, Chicago
Elk Grove Village, IL
- Myles Datto, M.D.
FACOG
Woodcliff Lake, NJ
- Sid Crosby, M.D.
AAFP
Jacksonville, AL
- Carol Miller, M.D.
FACOG
Endicott, NY
- Thomas W. Spanks, M.D.
FACOG
Baton Rouge, LA
- William Treat, M.D.
FACOG
San Diego, CA
- Noel T. Carlson, DO
Anesthesiologist
Holland, MI
- Lenita C. Massey, M.D.
OB/GYN
Richardson, TX
- Joseph A. Zavaletta, M.D.
OB/GYN
Brownsville, TX
- Margaret Gary, M.D.
FACOG
Norfolk, VA
- Barbara Falamo, M.D.
FACOG
Export, PA
- Thomas Falamo, M.D.
Pathologist
Export, PA
- Robert Kenneth Clark,
M.D. FACOG
Chairman, Dept. of
OB/GYN, Southwest
Medical Center, Oklahoma
City, OK
- Marvin Eastlund, M.D.
FACOG
Fort Wayne, IN
- William D. Lawrence, M.D.
FACOG
Phoenix, AZ
- Gregory Polito, M.D.
Urologist
Whittier, CA
- Neil Jovenat, M.D.
OB/GYN
Yorba Linda, CA
- Christina Cirucci, M.D.
OB/GYN
Richmond, VA
- Gary W. Smith, M.D.
OB/GYN
Hagerstown, MD
- Don Russell, M.D.
Pediatric Immunology
Asheville, NC
- Tim Durkee, M.D.
OB/GYN
Elk Grove, IL
- Edward C. Hall, M.D.
OB/GYN
Volunteer Assistant Clinical
Professor, Dept. of
OB/GYN, University of
Cincinnati College of
Medicine
Edgewood, KY
- Richard D. Hockett, M.D.
FACOG
Clinical Assistant Professor,
Dept of OB/GYN,
University of South Dakota
Mitchelle, SD
- James Matheson, D.O.
FACOG
Vermillion, OH
- Joseph P. Narins, M.D.
FACOG
Greensboro, NC
- Beverly A. McMillan, M.D.
FACOG
Jackson, MS
- Mary Lee Lobach, M.D.
OB/GYN
Clinical Assistant Professor,
Dept of Family Medicine,
Duke University Medical
Center, Durham, NC
- David Lobach, M.D., PhD
Durham, NC
- Lloyd Burns, M.D.
FACOG
Greensboro, GA
- John P. Curtin, M.D.
OB/GYN
Jackson, TN
- Joel R. DeKoning, M.D.
OB/GYN
Wausau, WI
- Jeffrey J. Barrows, D.O.
FACOG
Belle Fontaine, OH
- J. Douglas Morrison, M.D.
FACOG
Tempe, AZ
- Ralph Wiegman, M.D.
FACOG
Grand Prairie, TX
- Richard Goddard, M.D.
FACOG
Travis AFB, CA
- Andrew Steele, M.D.
JFACOG
Travis AFB, CA
- D. Scott Wiersma, M.D.
JFACOG
Travis AFB, CA
- George Vick, M.D.
OB/GYN
Knoxville, TN
- Leo J. Holmsten, M.D.
FACOG
Senior Attending OB/GYN
Genesee Hospital,
Rochester, NY
- Joe McIlhenny, Jr., M.D.
FACOG
Austin, TX
- Raymond Jennett, M.D.
OB/GYN
Director Emeritus, Division
of Reproductive Medicine,
St. Joseph's Hospital and
Medical Center,
Phoenix, AZ
- Larry G. Johnson, M.D.
OB/GYN
Loveland, OH
- Donovan D. Hanson, M.D.
P.S.
OB/GYN
Clinical Assistant Professor
University of Washington;
Medical director, Pregnanc
Help Medical Center,
Seattle
- Michael Goodin, M.D.
Pediatrician
Long Beach, CA
- Marie T. Sohner, M.D.
FACOG
Tomball, TX
- Michael A. Rodriguez,
M.D.P.A.
OB/GYN
Tomball, TX
- Arie Fischbach, M.D.
OB/GYN
Menot, ND
- Otto A. Carabbe, Jr., M.D.
OB/GYN
Staten Island, NY
- John Gerlach, M.D.
Milwaukee, WI

- Thomas Murphy Goodwin, M.D.
OB/GYN
Associate Professor of OB/GYN, Division of Maternal & Fetal Medicine, University of Southern California;
Director of Maternal & Fetal Medicine, Good Samaritan Hospital, CA
Menrovia, CA
- Kyle A. Rasikas, M.D.
Assistant Clinical Professor, Dept. of Internal Medicine, Michigan State University; Co-Director, Michigan Medical Specialists, Lipid Disorder Center
Grand Rapids, MI
- Gerard M. DiLeo, M.D.
FACOG
Chief of Staff, Cloumbia Lakeview Regional Medical Center, Mandeville, LA
- Thomas L. Gray, M.D.
FACOG
Memphis, TN
- Raymond J. Jaglowski, M.D.
Byron Center, MI
- Roy Stringfellow, M.D.
FACOG
Colorado Springs, CO
- Edward Lundblad
FACOG
Colorado Springs, CO
- Michael Duell
OB/GYN
Colorado Springs, CO
- Mark Lindstrom, D.O.
Family Practitioner
Milwaukee, WI
- James C. Glenn, M.D.
OB/GYN
Amarillo, TX
- K. Michael Kearns, M.D.
Gynecologic Oncology
Hartford, CT
- Frank Wilson, M.D. [LMOI]
OB/GYN
Natick, MA
- W.A. Krotoski, M.D., Ph.D., MPH
Medical Director, USPHS (Ret)
Baton Rouge, LA
- Richard M. Thorne, M.D., P.C.
OB/GYN
Salem, OR
- Richard G. Moutvic, M.D.
OB/GYN
Clinical Professor, Loyola University School of Medicine
Chicago Heights, IL
- Anthony Culotta, DDS
Washington, DC
- Margaret Culotta Norton, DDS
Washington, DC
- Mark G. Campbell, M.D., MHA
Grand Rapids, MI
- Karyn Grinnon Herndon, M.D.
OB/GYN
Director, Medical Education, Dept. of OB/GYN, Evanston Hospital; Instructor, Northwestern Medical School
Evanston, IL
- James W. Stough, M.D.
Gynecologist
Winfield, IL
- Carl Christman, M.D.
OB/GYN
Assistant Professor, University of Kansas School of Medicine, Wichita, KS
- James M. Burkhead III, M.D.
OB/GYN
Houston, TX
- Harold Chotiner, M.D.
FACOG
Reno, NV
- Dr. James P. Hartley, M.D.
OB/GYN
Bethesda, MD
- William J. Hogan, M.D.
OB/GYN
Rockville, MD
- Patrick Marmion, M.D.
OB/GYN
Fellow, American College of Preventive Medicine; Director, OH/KY/IN Perinatal Program
Cincinnati, OH
- Steve Nickisch, M.D.
JFACOG
Clinical Faculty, University of North Carolina
Asheville, NC
- David Kawasaki, M.D.
OB/GYN
Mission Viejo, CA
- Laurie Scott, M.D.
FACOG
Assistant Professor, Dept. of OB/GYN, Southwestern Medical Center, Dallas
Boca Raton, FL
- Lawrence C. Cairns, M.D.
FACOG
Stevensville, MI
- Mark Harrison, M.D.
FACOG
Fairfax Station, VA
- J. Michael Rollins, M.D.
FACOG
Clinical Assistant Professor, Dept. of OB/GYN, West Virginia University
Morgantown, WV
- Ronald P. Blake, M.D.
Family Practice
Stevensville, MI
- Marc G. Meininger, M.D.
OB/GYN
Sunnyside, WA
- Jonathan P. Daniels, M.D.
OG/GYN
Yankton, SD
- Mark Neerhof, D.O.
OB/GYN
Assistant Professor, OB/GYN, Northwestern University, Chicago;
Member, American College of Osteopathic OB/GYN; Society of Perinatal Obstetricians
Deerfield, IL
- Charles Hanes, M.D.
FACOG
Mobile, AL
- Douglas D. Boyette, M.D.
FACOG
Rocky Mount, NC
- James Napier, M.D.
Assistant Clinical Professor, Neurology, Case Western Reserve
Cleveland, OH
- Philip Hulsman, M.D.
FACOG
Louisville, KY
- Mary L. Davenport, M.D.
FACOG
Oakland, CA
- Albertine E. Omani, M.D.
OB/GYN
Oakland, CA
- Stephen M. Crane, M.D.
Family Practice
Oakland, CA
- Richard R. Romanowski, M.D.
OB/GYN
Williamsville, NY

Michael T. Valley, M.D.
OB/GYN
Assistant Professor of
OB/GYN
Jacksonville, FL

Bradley G. Beck, M.D.,
M.S.
Fellow, American College
of Preventative Medicine
Clinical Associate
Professor, University of
Texas Medical Branch;
Clinical Associate
Professor, Wright State
University

Don L. Marketto, Jr., M.D.
FACOG, FACS
Las Cruces, NM

John F. McLeay, M.D.
FACS
Clinical Professor of
Surgery, Creighton
University
Omaha, NE

James V. Ortman, M.D.
Assistant Professor of
Clinical Medicine,
Creighton University
Omaha, NE

Delwyn J. Nagengast, M.D.
Associate, Family Practice,
University of Nebraska
Medical Center
Omaha, NE

Michael Sullivan, III, M.D.
Omaha, NE

Herbert Reese, M.D.
FACS
Omaha, NE

John H. Chain, M.D.
NE

Dennis Weisenberger, M.D.
Omaha, NE

Michael G. Skoch, M.D.
Adjunct Assistant Professor,
Family Medicine, U. of
Nebraska Medical center
Omaha, NE

Peter R. DeMarco, M.D.
Omaha, NE

Thomas W. Hilgers, M.D.
Omaha, NE

J. Thomas Fitch, M.D., P.A.
San Antonio, TX

John G. Saint, M.D.
Springfield, IL

Ann J. Yadnsky, M.D.
OB/GYN
Raleigh, NC

Philip Horner, M.D.
ABFP
Farmington, NH

Timothy F. Murphy, M.D.
FACOG
Assistant Professor
OB/GYN
Michigan State University
College of Human Medicine
Grand Rapids, MI

David Hager, M.D.
FACOG
Professor, University of
Kentucky, Dept of
OB/GYN, College of
Medicine
Lexington, KY

Terrence A. Pfeifer, M.D.
FACOG
Clinical Associate
Professor, OB/GYN
University of Washington
Kirkland, WA



**The American College of Obstetricians and
Gynecologists
On The Subject Of
"Partial-Birth Abortions" Bans**

The American College of Obstetricians and Gynecologists (ACOG), an organization of 44,000 physicians dedicated to women's health care, continues to oppose Federal legislation known as "partial birth abortion" bans.

ACOG has concluded there are circumstances under which this type of procedure would be the most appropriate and safest procedure to save the life or health of a woman. Only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision.

This bill violates a fundamental principle at the very heart of the doctor-patient relationship: that the doctor, in consultation with the patient, based on that patient's individual circumstances, must choose the most appropriate method of care for the patient. This bill removes decision-making about medical appropriateness from the physician and the patient. ACOG's members, whatever their beliefs about abortion, share an interest in opposing laws that interfere with a physician's ability to exercise his or her best medical judgment in providing care for each patient.

ACOG opposes legislation such as HR 4965 as an inappropriate, ill-advised and dangerous intervention into medical decision making. HR 4965 is vague and broad, with the potential to restrict other techniques in obstetrics and gynecology. It fails to use recognized medical terminology and fails to define explicitly the prohibited medical techniques it criminalizes. ACOG notes particularly that imposing criminal penalties for use of a procedure that includes elements of recognized gynecologic and obstetric techniques could outlaw use of those techniques in both abortion and non-abortion circumstances. Some of these techniques can be critical to the lives and health of American women.

ACOG's opposition to this particular legislation must be viewed in the larger context of its overall position on abortion and family planning. ACOG advocates the need to reduce the number of abortions in the United States. As recently as the 2000 reaffirmed Policy Statement on Abortion, ACOG said:

"The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system. [...] The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies."

ACOG believes preventing unwanted and unintended pregnancies – not legislative intervention into private, protected medical decisions – is the best means for reaching a shared national goal of reducing abortion.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96920 WASHINGTON DC 20090-6920
Phone: 202/638-5577
Internet: <http://www.acog.org>



ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

continued . . .

STATEMENT ON INTACT DILATATION AND EXTRACTION (continued)
Page Two

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board
January 12, 1997

ACOG NEWS RELEASE

For Release February 13, 2002

Statement on So-Called "Partial Birth Abortion" Laws By The American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) continues to oppose state or federal legislation known as so-called "partial birth abortion" bans. "Partial birth abortion" is a non-medical term apparently referring to a particular abortion procedure known as intact dilatation and extraction (intact D&X, or D&X), a rare variant of a more common midterm abortion procedure known as dilatation and evacuation (D&E).

In June 2000, the US Supreme Court struck down a Nebraska "partial birth abortion" law in the case of *Stenberg v. Carhart*, ruling that the law violated the US Constitution by (1) failing to provide any exception "for the preservation of the health of the mother," and (2) being so broadly written that it could prohibit other types of abortion procedures such as D&E, thereby "unduly burdening a women's ability to choose abortion itself."

As stated in a 1997 Statement of Policy issued by ACOG's Executive Board, and in ACOG's *amicus curiae* brief filed in the *Stenberg* case, ACOG continues to find it disturbing that legislators would take any action that would supersede the medical judgment of a trained physician, in consultation with a patient, as to what is the safest and most appropriate medical procedure for that particular patient.

ACOG's 1997 Statement of Policy affirmed that position and explained why ACOG believes such legislation to be "inappropriate, ill advised, and dangerous." The policy statement noted that although a select panel convened by ACOG could identify no circumstances under which intact D&X would be the *only* option to protect the life or health of a woman, intact D&X "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

The Statement of Policy further reads that such legislation has the potential to outlaw other abortion techniques that are critical to the lives and health of American women. This was the second basis upon which the Supreme Court struck down the Nebraska law in the *Stenberg* case. Such "partial birth" laws are invariably overly broad or imprecisely drawn, frequently using terms -- such as "partial birth abortion" -- that are not recognized by the very constituency (physicians) whose conduct the law would criminalize. They purport to address a single procedure, yet describe elements of other procedures used in obstetrics and gynecology. Thus, even when legislators add an exception to a so-called "partial birth abortion" ban that includes protecting a woman's health, the ban may fail to have the necessary specificity to avoid encroaching on other safe and constitutionally protected medical procedures. For this reason, the ban would fail the two-part test outlined by the Supreme Court in the *Stenberg* decision.

The misinformation currently circulating in political discussions of abortion procedures only reinforces ACOG's position: in the individual circumstances of each particular medical case, the patient and physician -- not legislators -- are the appropriate parties to determine the best method of treatment.

###

The American College of Obstetricians and Gynecologists (ACOG) is the national medical organization representing nearly 40,000 physicians who provide health care for women.



February 6, 1997

Dennis Cavanagh, MD
University of South Florida
Dept. of Ob/Gyn
Harbourside Medical Tower
4 Columbia Drive
Tampa, FL 33606

Stephen H. Cruikshank, MD
Wright State University
School of Medicine
One Wyoming Street
Dayton, OH 45409

Joseph DeCook, MD
2238 Tony Drive
Fennville, MI 49408

Hans E. Geisler, MD
Gyn Oncology and Gyn Surgery
Clinical Staff, Dept. of Ob/Gyn
Indiana University Medical Center
8424 Naab Road, Ste. 2-M
Indianapolis, IN 46260

Pamela Smith, MD
Director of Medical Education
Dept. of Ob/Gyn, Mt. Sinai
Medical Center
1950 South Avers Avenue
Chicago, IL 60623

Curtis Cook, MD
Maternal-Fetal Medicine
Michigan State College
of Human Medicine
3830 Iris Drive
Grandville, MI 49418

Don Gambrell, Jr., MD
Clinical Prof. of Endocrinology
and Ob/Gyn
Medical College of Georgia,
Augusta
903 - 15th Street
Augusta, GA 30901

Nancy Komer, MD
Wright State University
Chairman, Dept. of Ob/Gyn
Miami Valley Hospital, OH
208 Old Church Road Ct.
Dayton, OH 45429

William Stalter, MD
Clinical Assoc. Prof., Ob/Gyn.
Wright State University
30 East Apple Street
Suite 5252
Dayton, OH 45409

Dear Fellows:

Thank you for writing to me regarding ACOG's Inset D & X statement. I appreciate hearing the views of our fellows. Differences with regard to the substance of what ACOG states in any document can occur. I regret that you have differences with our statement, but it remains ACOG's statement.

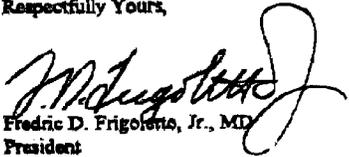
I am concerned about your allegations about being excluded from the ACOG process. You specifically cite the lack of consultation in the development of this statement. I am unclear as to whether you are asserting this as individual members of the College or on behalf of PHACT, so I will respond to each. With regard to PHACT as an organization, I am personally unaware of any attempt by PHACT prior to this letter to communicate with the College on the issue of Intact D and X. If I am in error and there have been other communications, I would appreciate receiving copies of such communications. However, I do have some awareness of your organization through information provided by Congressional sources.

The views of individual fellows are critical to me and to ACOG. I welcome you to write or call at any time to share your views. On the other hand, in developing policy ACOG relies upon selected groups -- committees, task forces, etc. -- to provide both medical and policy expertise. Ultimately, the Board adopts policy. The Board is composed of the elected representatives of the College; these members act on Fellows' behalf.

In the case of the "Intact D & X" statement, the Board, at my request, formally agreed at one of its meetings that I could appoint a task force to look into this issue. Since that time, I made it a specific point to inform attendees at ACOG District meetings and other College forums at which I spoke of the work of the task force. Members of the public did in fact contact ACOG about the task force during this period. Upon completion of the task force's work, the Board reviewed its recommended statement and amended and approved it at its January 1997 meeting. The statement was unanimously approved.

As stated previously, I believe the process for the development of this statement was a sound one and I, and the ACOG Board, stand firmly behind ACOG's policy. Clearly, our organizations do not agree on the content of the statement. I hope that we can respect these differences.

Respectfully Yours,



Fredric D. Frigoletto, Jr., MD
President

American College of Obstetricians and Gynecologists

PHACT

Physicians' Ad Hoc Coalition for Truth

January 29, 1997

Fredric D. Frigoletto, Jr. M.D.
President of the Executive Board
American College of Obstetricians and Gynecologists

Dear Dr. Frigoletto:

We write to you on behalf of the hundreds of doctors nationwide who are members of the Physicians' Ad hoc Coalition for Truth (PHACT). PHACT was formed to address expertly one issue: partial-birth abortion. While the coalition includes physicians from all medical specialties, the vast majority of its members are obstetricians and gynecologists. Of these, a sizeable number are also Fellows of the American College of Obstetricians and Gynecologists (ACOG).

With this in mind, we are writing to express our surprise and concern over a recent statement issued by ACOG, dated January 12, 1997, on the subject of partial-birth abortion. Surprise, because those of us who are fellows were never informed that ACOG was even investigating this subject, with the goal of issuing a public statement, presumably on behalf of us and the others within ACOG's membership. And concern, because the statement that was issued, by endorsing a practice for which no recognized research data exist, would seem to be violating ACOG's own standards.

Let us address the latter concern -- content -- first.

The statement correctly notes at the outset that the procedure in question is not recognized in the medical literature. The same, it should be noted, can be said of the name you have chosen to call it -- "Intact Dilatation and Extraction," or "Intact D&X" -- and all the other names proponents of this procedure have concocted for it. We have closely followed the issue of partial-birth abortion -- again, it is the *only* issue PHACT addresses -- and the term Intact Dilatation and Extraction is new to us and would appear to be unique to you. The late Dr. James McMahon, until his death a leading provider of partial-birth abortions, called them "Intact Dilatation and Evacuation (Intact D&E)" while another provider, Dr. Martin Haskell of Ohio, calls them "Dilatation and Extraction (D&X)." Planned Parenthood, for example, calls them D&X abortions, while the National Abortion Federation prefers Intact D&E, so there is no agreement, even among proponents of this procedure, as to what to call it. Indeed, in its January, 1996 newsletter, ACOG then referred to it as "Intact dialation (sic) and evacuation." Your new coinage would seem to be a combination of these various "names" floating about, but to what end is not clear. What is clear is that none of these terms, including your own "Intact D&X" can be found in any of the standard medical textbooks or databases.

FOUNDING MEMBERS

Howe Tom A. Coburn, M.D.
Family Practitioner, Obstetrician
Member, U.S. House of
Representatives (R-O)

Nancy Rorer, M.D.
Fellow, American College of
Obstetricians & Gynecologists
Clinical Professor, Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn,
Miami Valley Hospital, OH

Patricia Rubin, M.D.
Director of Medical Education
Dept. of Ob/Gyn
Mt. Sinai Medical Center,
Chicago, IL
Member, Association of
Professors of Ob/Gyn

James Jones, M.D.
Professor/Chair, Ob/Gyn
New York Medical College
Chair, Ob/Gyn
St. Vincent's Hospital &
Medical Center, NYC

Curtis R. Cook, M.D.
Maternal Fetal Medicine
Baylor-Worth Hospital
Michigan State College of
Human Medicine

Joseph L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Stalter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

David Cavanaugh, M.D.
Professor, Ob/Gyn
University of South Florida
College of Medicine, Tampa
FACOG

1150 South Washington Street
Suite 230
Alexandria, VA 22314
(703) 683-5004

Communications Counsel:
Cecilia Turner, Michelle Powers

It is wrong to say, as your statement does, that descriptions, at least the description in last year's Partial-Birth Abortion Ban Act, are "vague" and "could be interpreted to include elements of many recognized" medical techniques. The description in the federal legislation is very precise as to what is being proscribed and is based on Dr. Haskell's own descriptions. Moreover, the legislation is so worded as to clearly distinguish the procedure being banned from recognized obstetric techniques, and recognized abortion techniques, such as D&E, which would be unaffected by the proposed ban.

By far, however, the most disturbing part of ACOG's statement is the assertion that "An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the mother."

On what possible basis does ACOG make this rather astounding assertion?

Many of our members hold teaching positions or head departments of obstetrics and gynecology or perinatology at universities and medical centers. To our knowledge there are no published peer-reviewed safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure. We can think of no data that could possibly support such an assertion. If ACOG or its "select panel" has such data, we would, as teachers and practicing ob/gyns, certainly like to review it.

The best that your statement does to back this claim is the very vague assertion that "other data show that second trimester transvaginal instrumental abortion is a safe procedure." While this may be true, it is, as surely you must be aware, totally beside the point. Such data may exist regarding, e.g., second trimester D&E abortion, but this is irrelevant to the fact that no similar data, at least to our knowledge, exists with respect to partial-birth abortion (or, as you prefer, "intact D&X" or whatever other medical-sounding coinage supporters of this procedure may use). To include such an assertion that can only refer to second trimester abortion procedures *other* than partial-birth is deceptive and misleading at best.

ACOG clearly recognizes that in no circumstances is partial-birth abortion the only option for women. In other words, ACOG agrees that there are other, *medically recognized*, and standard procedures available to women other than partial-birth abortion. Given ACOG's acceptance of this medical fact, your claim that a totally unrecognized, non-standard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations, simply defies understanding.

If ACOG is truly committed to standing by this claim, then it would appear to be violating its own standards by recommending the use of a procedure for which no peer-reviewed studies or safety data exist.

In contrast, our research of the subject leads us to conclude that there are no obstetrical situations that would necessitate or even favor the medically unrecognized partial-birth abortion procedure as the safest or most appropriate option. Indeed, we have concerns that this procedure may itself pose serious health risks for women.

Ordinarily, we would agree that the intervention of legislative bodies into medical decision making is usually inappropriate. However, when the medical decision making *itself* is inappropriate, and may be putting women at risk by subjecting them to medically unrecognized procedures, then the intervention of a legislative body, such as the U.S. Congress, may be the only way to protect mothers and infants threatened by the partial-birth abortion procedure.

In addition to these concerns over the content of the statement, we are also concerned as to the procedure by which it came to be issued.

As mentioned, the vast majority of PHACT members are specialists and sub-specialists (i.e. perinatologists) in obstetrics and gynecology, and many of these are also fellows of ACOG. After them, our membership consists largely of family practitioners and pediatricians. Former Surgeon General C. Everett Koop, perhaps the nation's leading pediatric surgeon, has been associated with PHACT and his public statements on partial-birth abortion are in agreement with PHACT. Our membership is open to any doctor, regardless of his or her political views on the larger question of abortion rights, precisely because our focus is strictly on the medical realities that relate to this procedure. (In fact, doctors who are pro-choice have publicly stated their opposition, on medical grounds, to the use of this abortion method).

We cannot recall receiving any notification whatsoever that the American College of Obstetricians and Gynecologists was even reviewing the issue of partial-birth abortion toward the end of issuing a statement of policy. We cannot recall ever being informed that ACOG was going to convene a "select panel" to accomplish this. We find it unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations. Those of us who are fellows of ACOG were kept completely in the dark as to what ACOG's leadership was doing in regard to this issue.

In truth, this statement is the product of a panel -- whose membership ACOG has not made public -- that was working behind closed doors and with no real participation from ACOG's membership itself. In crafting this statement, ACOG simply ignored its own members. There is the danger that in issuing this statement, ACOG is giving the larger public the impression that the statement somehow represents the thinking of its members on this subject. It does not. ACOG members had no knowledge of this statement until it was issued as a *fait accompli*.

In conclusion, this statement clearly does *not* represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of the partial-birth abortion method. We ask you to provide the medical data, research and all other relevant materials which could possibly have led to such an assertion. We ask that you also make available the names of those on the select panel who arrived at such a conclusion. We would also ask that the leadership of ACOG officially withdraw this statement until the matter at issue -- partial-birth abortion -- has been subject to a thorough and open discussion among the members of ACOG and those doctors in related specialties who have significant knowledge regarding this issue. We look forward to your response.

Sincerely:

Denis Cavanaugh
Denis Cavanaugh, M.D.
Professor of Ob/Gyn
Director, Division of Ob/Gyn
University of South Florida
College of Medicine
FACOG

Curtis R. Cook MD
Curtis Cook, M.D.
Maternal-Fetal Medicine
Michigan State College
of Human Medicine
FACOG

Joseph L. DeCook MD
Joseph DeCook, M.D.
Ob/Gyn
FACOG

Don Gambrell, Jr. MD
Don Gambrell Jr., M.D.
Clinical Prof. of Endocrinology
and Ob/Gyn
Medical College of Georgia,
Augusta
V. President, South Atlantic Assoc.
of Ob/Gyns
FACOG

Hans E. Geisler
Hans E. Geisler, M.D.
Gyn Oncology and Gyn Surgery
Clinical Staff, Dept. of Ob/Gyn
Indiana University Medical Center
FACOG

Nancy Romer MD
Nancy Romer, M.D.
Clinical Prof., Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn
Miami Valley Hospital, OH
FACOG

Pamela Smith MD
Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn, Mt. Sinai
Medical Center, Chicago
Member, Assoc. of Professors of
Ob/Gyn
FACOG

William Statter MD
William Statter, M.D.
Clinical Assoc. Prof., Ob/Gyn
Wright State University
FACOG

Stephen H. Cruikshank
Stephen H. Cruikshank, M.D.
Nicholas J. Thompson Professor and Chairman
Department of Obstetrics and Gynecology
Wright State University, OH

**FACT SHEET ON ACOG POLICY STATEMENT
REGARDING INTACT DILATATION AND EXTRACTION**

(On January 12, 1997, the Executive Board of The American College of Obstetricians and Gynecologists (ACOG) issued a policy statement on so-called "partial birth abortion" legislation then pending in Congress. Since then, some 30 states have passed similar bills, but the courts have declared many of these laws unconstitutional. The US Supreme Court will review a Nebraska law on this subject in the spring of 2000. To answer many of the frequently asked questions about abortion techniques at issue in such laws, ACOG has updated the following 1997 fact sheet.)

Question: Why did The American College of Obstetricians and Gynecologists issue a statement on the subject of Intact Dilatation and Extraction?

Answer: As the leading medical organization in women's health care, ACOG has a responsibility to respond to proposed legislation concerning women's reproductive health. Other reasons why ACOG commented on legislative proposals such as the 1997 so-called "Partial Birth Abortion Ban Act" included:

- the constituency affected by proposals to criminalize certain medical actions included obstetrician-gynecologists and their patients;
- the proposed ban on a particular surgical procedure used terminology not recognized in the medical literature, and alluded to a surgical technique known to some physicians and not to others;
- the language as written could be easily interpreted to include most abortions; and
- there was much unclear or inaccurate information generated in public debate on the subject.

Q. What is the essence of ACOG's response in this statement?

A. The 1997 ACOG Policy Statement, still in effect, has three components.

First, ACOG clarifies the surgical procedure alluded to in proposed "partial birth abortion" legislation. Federal and state legislative proposals have not defined the procedure precisely. However, based on federal and state legislative testimony, ACOG believes the intent of such bans is to criminalize an abortion technique that is a variation of mid-trimester transvaginal instrumental abortion techniques (sometimes referred to as Dilatation and Evacuation or D&E techniques) which some practitioners have termed

"Intact Dilatation and Extraction" (Intact D&X). This particular variation under legislative discussion is composed of four elements: dilatation of the cervix; conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and decompression of the head of a living fetus to effect vaginal delivery of a dead but intact fetus.

Second, ACOG evaluates the possible uses of the procedure. Although ACOG could identify no circumstances under which this procedure would be the *only* option to save the life or health of a woman, it concluded that this may be the most appropriate and safest procedure in certain circumstances to save the life or health of a specific patient, "and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

Finally, ACOG opposes such legislation as "inappropriate, ill-advised and dangerous intervention into medical decision making." ACOG notes particularly that imposing criminal penalties for use of a procedure that includes elements of recognized gynecologic and obstetric techniques could outlaw use of those techniques in both abortion and non-abortion circumstances. Some of these techniques can be critical to the lives and health of American women.

Q. But if ACOG concedes this procedure is not the only method of protecting the life or health of a woman, why would it oppose a ban on this procedure?

A. ACOG's objection is two-fold. First, there may be circumstances where the physician and patient would reach the conclusion that this procedure is most appropriate. Second, and equally important, the proposed legislation could be interpreted to include and thus outlaw -- or, as a practical matter, be enforced so as to inhibit -- many other widely-used, accepted and safe abortion and operative obstetric techniques.

Q. What are the circumstances in which a doctor and patient would find this procedure appropriate?

A. In abortion procedures occurring after the first trimester, a doctor and patient could have reasons to choose a transvaginal instrumental abortion as opposed to an abortion method of labor induction, which may involve a longer period of time or more discomfort to the woman.

For example, ACOG considers such legislation ill advised and dangerous because it could prevent the evacuation of a severely infected pregnancy with maternal sepsis where

hysterotomy (incision of the uterus) could lead to peritonitis, shock and even death. Some

Page 3

bill as drafted could prevent the completion of a spontaneous abortion of a living 16-week fetus with known hydrocephalus, presenting with the body delivered and the head entrapped by the woman's cervix. A physician may believe that the best management is by decompression of the fetal head, to obviate the risk of extensive cervical laceration or a ruptured uterus in the woman. ACOG believes this management decision is for the physician to make, in accordance with his or her own knowledge and skills and a risk-benefit analysis for the patient. However, some bans, because they would prohibit such a management decision except to save the woman's life and "*only if no other medical procedure would suffice for that same purpose*" (emphasis added), would apparently require the physician to force the patient through prolonged labor or a hysterotomy instead. Either of these alternatives could involve more significant risks to the patient in certain medical circumstances. Yet failure to use such procedures under certain legislative proposals would subject the physician to imprisonment and to other penalties such as civil action by the father of the fetus.

Q. But aren't there some doctors who perform late-term abortions who disagree about the use of this procedure?

A. Yes, as with many other surgical techniques in obstetrics and gynecology or other areas of medicine, there are strongly held opinions about the advantages or use of one technique over another. It is precisely because there is no basis for legislating one specific technique for mid-trimester abortion, and because there is a need for flexibility in handling unexpected situations, that ACOG opposes an absolute ban on a technique that in the judgment of a physician and patient may be most appropriate.

Q. What justifies ACOG's fear that this legislation could intrude into other areas of obstetrics and gynecology?

A. Legislation by nature is often broadly or imprecisely drawn, and that is particularly the case with so-called "partial birth abortion" bans. For example, these bans use terms not recognized by the very constituency (physicians) whose conduct the law would criminalize. The bans may fail to distinguish between natural and induced pregnancy termination. They may purport to address a single procedure, some elements of which are used in other areas of ob-gyn, but do not carefully define that procedure. Finally, since bans such as the Nebraska law at issue before the Supreme Court do not define the gestational age at which the legislation would apply, the laws could prohibit techniques performed before fetal viability -- thus potentially affecting procedures at all stages of pregnancy.

For example, such bills might be interpreted or enforced to include the results of a procedure needed to drain excess fluid in the brain of a live hydrocephalic fetus during the course of a delivery that results in death. Zealous enforcement could arguably extend to cases of incomplete spontaneous abortion where the removal of the fetus is accomplished by the same techniques as an induced abortion; or to many other gynecologic or obstetric procedures where the fetus shows signs of life when the procedure begins.

The concern that criminal statutes would be interpreted or enforced beyond a specific technique of induced abortion is not unfounded. In legislation where political discussion has reflected much confusion about medical terminology and technique, the likelihood for misinterpretation is high. Such laws would have a chilling effect on the practice of medicine, leading doctors with an understandable fear of prosecution to avoid medical procedures or surgical techniques that could in any way fall within the scope of such legislation.

Q. Hasn't there been inaccurate information about the number of these procedures performed each year?

A. There are no data from the Centers for Disease Control and Prevention (CDC) on the exact number of these procedures. The CDC tracks total numbers of abortion, but it does not distinguish between different types of abortion procedures except in very broad categories, and thus does not specifically count D&X procedures apart from other mid-trimester abortion procedures.

An abortion provider survey by the Alan Guttmacher Institute (AGI), published in 1998, estimated that the D&X procedure is rarely used, accounting for about 0.03%-0.03% of all abortions in 1996.

The CDC does record abortion data by stage of pregnancy -- and these data indicate that abortions in the later stages of pregnancy are infrequent. CDC figures for 1995 show that only 4% of abortions were performed at 16-20 weeks of gestation and only 1.4% were performed after 20 weeks. Less than one-tenth of one percent of abortions are performed after 24 weeks, according to 1995 figures from AGI. In its 1996 provider survey, AGI estimated that the large majority of D&X procedures were provided at 20-24 weeks.

Q. What about allegations that such legislation is justified because this procedure may be less safe than others?

A. ACOG is unaware of any comparative maternal morbidity studies specifically evaluating Intact D&X procedures with other methods of abortion. However, since 1972,
Page 5

the CDC has collected data on maternal mortality and morbidity in abortion generally, which show that the overall mortality/morbidity rates with abortion, including after the first trimester, are low. In addition, there have been peer-reviewed studies from CDC data looking at maternal mortality rates for both labor induction and D&E procedures (which would encompass D&X procedures), finding them roughly comparable.

Some proponents of this legislation have argued that in the absence of peer-reviewed, outcome-based studies specifically comparing the D&X procedure with other mid-trimester abortion procedures used at the same gestational age, legislation is justified that would criminalize this particular technique. However, this argument imposes a more exacting standard of research for these abortion techniques than for many other surgical procedures in medicine, where often there is still a lack of peer-reviewed, outcome-based comparative studies. In the meantime, as noted above, other data have shown that second trimester instrumental abortion is safe.

It's unclear why some proponents would justify legislating a particular procedure out of existence on safety grounds, in the absence of data suggesting a public health or safety problem. Questions of the relative safety of particular surgical procedures are properly investigated in the medical arena.

Q. Doesn't this statement by ACOG appear to condone induced abortion of a viable fetus?

A. In over 30 years of filing court *amicus* briefs on abortion, ACOG has never supported post-viability abortions except for the constitutionally protected exception of saving the life or health of a woman. A 1997 reaffirmation of ACOG's 1993 Policy Statement on Abortion noted, "ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman."

ACOG's opposition to this particular type of legislation must be viewed in the larger context of its overall position on abortion and family planning. ACOG has consistently supported a woman's right to make health care decisions, including pregnancy termination, in consultation with her physician. However, ACOG also has a long history of recognizing the diversity of opinion on abortion. The organization supports a woman's decision not to have an abortion as well as a physician's right not to perform abortions. ACOG advocates the need to reduce the number of abortions in the United States. As recently as its 1997 reaffirmed Policy Statement on Abortion, ACOG said:

“The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system. [...] The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies.”

ACOG continues to believe that this policy -- not legislative intervention into private, protected medical decisions -- is the best means for reaching a shared national goal of reducing abortion. It is for this reason, and in this long tradition, that the ACOG Executive Board unanimously adopted the policy statement of January 12, 1997.

###

April 1997 Fact Sheet
Revised April 2000

The American College of Obstetricians and Gynecologists (ACOG) is the national medical organization representing over 40,000 physicians who provide health care for women. About 95 percent of all ob-gyns in the US are affiliated with ACOG. ACOG policy is established by the Executive Board of the College under a defined process.



The New England Journal of Medicine

Established in 1812 as The NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

Abstracts in the
advertising
sections

VOLUME 317

NOVEMBER 19, 1987

NUMBER 21

Original Articles

- Survival with the Acquired Immunodeficiency Syndrome: Experience with 5833 Cases in New York City** 1297
 RICHARD ROTHENBERG, MARY WOELFEL,
 RAND STONEBURNER, JOHN MÜLBERG,
 ROBERT PARKER, AND BENEDICT TRUMAN

- Relative and Absolute Excess Risks of Coronary Heart Disease among Women Who Smoke Cigarettes** 1303
 WALTER C. WILLETT, ADELE GREEN,
 MEIR J. STAMPPER, FRANK E. SPEIZER,
 GRAHAM A. COLDITZ, BERNARD ROSNER,
 RICHARD R. MONSON, WILLIAM STASON,
 AND CHARLES H. HENNEKENS

- The Course and Prognosis of Different Forms of Chronic Airways Obstruction in a Sample from the General Population** 1309
 BENJAMIN BURROWS, JOHN W. BLOOM,
 GAYLE A. TRAVER,
 AND MARTHA G. CLINE

- Effects of Treatment on Fertility in Long-Term Survivors of Childhood or Adolescent Cancer** 1315
 JULIANNE BYRNE AND OTHERS

Special Article

- Pain and Its Effects in the Human Neonate and Fetus** 1321
 K.J.S. ANAND AND P.R. HICKEY

Medical Intelligence

- Plasma R Binder Deficiency and Neurologic Disease** 1330
 SAMUEL HAROLD SIGAL, CHARLES A. HALL,
 AND JACK P. ANTEL

Case Records of the

Massachusetts General Hospital

- A 79-Year-Old Cuban Native with Asthma, Weight Loss, Vomiting, Eosinophilia, and Past Meningitis** 1332
 ROGER J. MAY AND CAROLYN C. COMPTON

Editorials

- Smoking and Women: Tragedy of the Majority** 1343
 JONATHAN E. FIELDING
- Atopy and Airways Responsiveness in Chronic Obstructive Pulmonary Disease** 1345
 SCOTT T. WEISS
- Pain in the Neonate** 1347
 ANNE B. FLETCHER
- Massachusetts Medical Society** 1348

Correspondence

- Enalapril for Congestive Heart Failure** 1349
- HIV Testing of Surrogate Mothers** 1351
- Ten-Year Longitudinal Study of Children at High Risk of Insulin-Dependent Diabetes Mellitus** 1352
- Ethical Dilemmas in the Early Detection of Malignancy by NMR Spectroscopy of Plasma** ... 1353
- Malpractice and the Quality of Care** 1353
- Doctors and the Dispensing of Drugs** 1354

- Book Reviews** 1355

- Notices** 1358

- Correction**
Bone Marrow Transplantation for Thalassemia .. 1360

CRS C

Published, and ©Copyrighted, 1987, by the Massachusetts Medical Society

(ISSN 0028-4793) is published weekly from editorial offices at 10 Shattuck Street, Boston, MA 02115-6094. \$66.00 per year. Second-class postage paid at Boston and at additional mailing offices.

POSTMASTER: Send address changes to P.O. Box 803, Waltham, MA 02254-0903.

9. Fairley KF, Barrie JU, Johnson W. Sterility and testicular atrophy related to cyclophosphamide therapy. *Lancet* 1972; 1:568-9.
10. Rowley MJ, Leach DR, Warner GA, Heller CG. Effect of graded doses of ionizing radiation on the human testis. *Radiat Res* 1974; 59:665-78.
11. King DJ, Ratcliffe MA, Dawson AA, Bennett B, Macgregor JE, Klopper AI. Fertility in young men and women after treatment for lymphoma: a study of a population. *J Clin Pathol* 1985; 38:1247-51.
12. Chapman RM, Sutcliffe SB, Malpas JS. Cytotoxic-induced ovarian failure in women with Hodgkin's disease. *JAMA* 1979; 242:1877-81.
13. Mandelstam MT, Li FP. Survival of children with cancer. *JAMA* 1986; 255:1572.
14. Goorin AM, Abelson HT, Fici E III. Osteosarcoma: fifteen years later. *N Engl J Med* 1985; 313:1637-43.
15. Glick JH, Office of Medical Applications of Research. Adjuvant chemotherapy for breast cancer. *JAMA* 1985; 254:3461-3.
16. Byrne J, Mulvihill JJ, Myers MH, et al. Marriage, fertility and premature menopause in survivors of childhood and adolescent cancer. *Proc ASCO* 1987; 6:228.
17. Mantel N, Haenszel W. Statistical aspects of the analysis of data from retrospective studies of disease. *JNCI* 1959; 22:719-48.
18. Cox DR. Regression models and life-tables (with discussion). *J R Stat Soc* 1972; B34:187-220.
19. Kaplan EL, Meier P. Nonparametric estimation from incomplete observations. *J Am Stat Assoc* 1958; 53:457-81.
20. Mosher WD, Pratt WF. Fecundity and infertility in the United States, 1965-82. In: *Advance data from vital and health statistics*, no. 104. Hyattsville, Md.: Public Health Service, Feb. 11, 1985. (DHHS publication no. (PHS) 85-1250.)
21. Watson AR, Taylor J, Rance CP, Bain J. Gonadal function in women treated with cyclophosphamide for childhood nephrotic syndrome: a long-term follow-up study. *Fertil Steril* 1986; 46:331-3.
22. Schilsky RL, Sherins RJ, Hubbard SM, Wesley MN, Young RC, DeVita VT. Long-term follow up of ovarian function in women treated with MOPP chemotherapy for Hodgkin's disease. *Am J Med* 1981; 71:552-6.
23. Herzig SJ, Hoppe RT, Kaplan HS, Rosenberg SA. Female reproductive potential after treatment for Hodgkin's disease. *N Engl J Med* 1981; 304:1377-82.
24. Ash P. The influence of radiation on fertility in man. *Br J Radiol* 1980; 53:271-8.
25. Schilsky RL, Sherins RJ. Gonadal dysfunction. In: DeVita VT, Hellman S, Rosenberg SA, eds. *Cancer: principles & practice of oncology*, 2nd ed. Vol. 2. Philadelphia: J.B. Lippincott, 1985:2032-9.
26. Siris ES, Leventhal BG, Vaitukaitis JL. Effects of childhood leukemia and chemotherapy on puberty and reproductive function in girls. *N Engl J Med* 1976; 294:1143-6.
27. Byrne JM, Mulvihill JJ, Myers MH, et al. Marriage and fertility rates decreased in survivors of childhood and adolescent cancer. *Pediatr Res* 1986; 20:226A, abstract.
28. Teta MJ, Del Po MC, Kasl SV, Meigs JW, Myers MH, Mulvihill JJ. Psychosocial consequences of childhood and adolescent cancer survival. *J Chronic Dis* 1986; 39:751-9.
29. Holmes GE, Baker A, Iltisstein RS, et al. The availability of insurance to long-time survivors of childhood cancer. *Cancer* 1986; 57:190-3.
30. Kelaghan J, Myers MH, Mulvihill JJ, et al. Educational achievement in longtime survivors of childhood and adolescent cancers. *Med Pediatr Oncol* (in press).

SPECIAL ARTICLE

PAIN AND ITS EFFECTS IN THE HUMAN NEONATE AND FETUS

K.J.S. ANAND, M.B.B.S., D.PHIL., AND P.R. HICKEY, M.D.

THE evaluation of pain in the human fetus and neonate is difficult because pain is generally defined as a subjective phenomenon.¹ Early studies of neurologic development concluded that neonatal responses to painful stimuli were decorticate in nature and that perception or localization of pain was not present.² Furthermore, because neonates may not have memories of painful experiences, they were not thought capable of interpreting pain in a manner similar to that of adults.³⁻⁵ On a theoretical basis, it was also argued that a high threshold of painful stimuli may be adaptive in protecting infants from pain during birth.⁶ These traditional views have led to a widespread belief in the medical community that the human neonate or fetus may not be capable of perceiving pain.^{7,8}

Strictly speaking, nociceptive activity, rather than pain, should be discussed with regard to the neonate, because pain is a sensation with strong emotional associations. The focus on pain perception in neonates and confusion over its differentiation from nociceptive activity and the accompanying physiologic responses

have obscured the mounting evidence that nociception is important in the biology of the neonate. This is true regardless of any philosophical view on consciousness and "pain perception" in newborns. In the literature, terms relating to pain and nociception are used interchangeably; in this review, no further distinction between the two will generally be made.

One result of the pervasive view of neonatal pain is that newborns are frequently not given analgesic or anesthetic agents during invasive procedures, including surgery.⁹⁻¹⁹ Despite recommendations to the contrary in textbooks on pediatric anesthesiology, the clinical practice of inducing minimal or no anesthesia in newborns, particularly if they are premature, is widespread.⁹⁻¹⁹ Unfortunately, recommendations on neonatal anesthesia are made without reference to recent data about the development of perceptual mechanisms of pain and the physiologic responses to nociceptive activity in preterm and full-term neonates. Even Robinson and Gregory's landmark paper demonstrating the safety of narcotic anesthesia in preterm neonates cites "philosophic objections" rather than any physiologic rationale as a basis for using this technique.²⁰ Although methodologic and other issues related to the study of pain in neonates have been discussed,²¹⁻²³ the body of scientific evidence regarding the mechanisms and effects of nociceptive

From the Department of Anaesthesia, Harvard Medical School, and Children's Hospital, Boston. Address reprint requests to Dr. Anand at the Department of Anesthesia, Children's Hospital, 300 Longwood Ave., Boston, MA 02115.

activity in newborn infants has not been addressed directly.

ANATOMICAL AND FUNCTIONAL REQUIREMENTS FOR PAIN PERCEPTION

The neural pathways for pain may be traced from sensory receptors in the skin to sensory areas in the cerebral cortex of newborn infants. The density of nociceptive nerve endings in the skin of newborns is similar to or greater than that in adult skin.²⁴ Cutaneous sensory receptors appear in the perioral area of the human fetus in the 7th week of gestation; they spread to the rest of the face, the palms of the hands, and the soles of the feet by the 11th week, to the trunk and proximal parts of arms and legs by the 15th week, and to all cutaneous and mucous surfaces by the 20th week.^{25,26} The spread of cutaneous receptors is preceded by the development of synapses between sensory fibers and interneurons in the dorsal horn of the spinal cord, which first appear during the sixth week of gestation.^{27,28} Recent studies using electron microscopy and immunocytochemical methods show that the development of various types of cells in the dorsal horn (along with their laminar arrangement, synaptic interconnections, and specific neurotransmitter vesicles) begins before 13 to 14 weeks of gestation and is completed by 30 weeks.²⁹

Lack of myelination has been proposed as an index of the lack of maturity in the neonatal nervous system³⁰ and is used frequently to support the argument that premature or full-term neonates are not capable of pain perception.^{9,19} However, even in the peripheral nerves of adults, nociceptive impulses are carried through unmyelinated (C-poly-modal) and thinly myelinated (A-delta) fibers.³¹ Incomplete myelination merely implies a slower conduction velocity in the nerves or central nerve tracts of neonates, which is offset completely by the shorter interneuron and neuromuscular distances traveled by the impulse.³² Moreover, quantitative neuroanatomical data have shown that nociceptive nerve tracts in the spinal cord and central nervous system undergo complete myelination during the second and third trimesters of gestation. Pain pathways to the brain stem and thalamus are completely myelinated by 30 weeks; whereas the thalamocortical pain fibers in the posterior limb of the internal capsule and corona radiata are myelinated by 37 weeks.³³

Development of the fetal neocortex begins at 8 weeks of gestation, and by 20 weeks each cortex has a full complement of 10⁹ neu-

rons.³⁴ The dendritic processes of cortical neurons undergo profuse arborization and develop synaptic targets for the incoming thalamocortical fibers and intracortical connections.^{35,36} The timing of the thalamocortical connection is of crucial importance for cortical perception, since most sensory pathways to the neocortex have synapses in the thalamus. Studies of primate and human fetuses have shown that afferent neurons in the thalamus produce axons that arrive in the cerebrum before mid-gestation. These fibers then "wait" just below the neocortex until migration and dendritic arborization of cortical neurons are complete and finally establish synaptic connections between 20 and 24 weeks of gestation (Fig. 1).³⁶⁻³⁸

Functional maturity of the cerebral cortex is suggested by fetal and neonatal electroencephalographic patterns, studies of cerebral metabolism, and the behavioral development of neonates. First, intermittent electroencephalographic bursts in both cerebral hemispheres are first seen at 20 weeks' gestation; they become sustained at 22 weeks and bilaterally synchronous at 26 to 27 weeks.³⁹ By 30 weeks, the distinction between wakefulness and sleep can be made on the basis of electroencephalographic patterns.^{39,40} Cortical components of visual and auditory evoked potentials have been recorded in pre-term babies (born earlier than 30 weeks of gestation),^{40,41} whereas olfactory and tactile stimuli may also cause detectable changes in electroencephalograms of neonates.^{40,42} Second, in vivo measurements of cerebral glucose utilization have shown that maximal metabolic activity is located in sensory

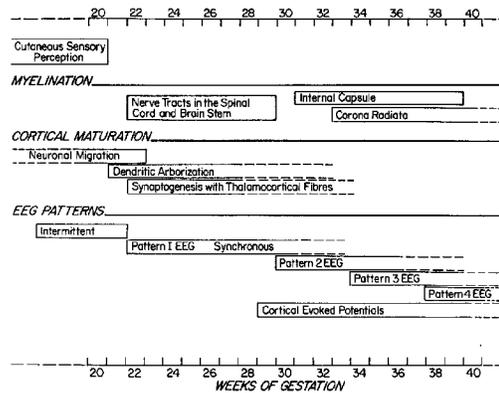


Figure 1. Schematic Diagram of the Development of Cutaneous Sensory Perception,²⁵ Myelination of the Pain Pathways,³² Maturation of the Fetal Neocortex,³⁵⁻³⁷ and Electroencephalographic Patterns³⁹⁻⁴² in the Human Fetus and Neonate.

areas of the brain in neonates (the sensorimotor cortex, thalamus, and midbrain–brain-stem regions), further suggesting the functional maturity of these regions.⁴³ Third, several forms of behavior imply cortical function during fetal life. Well-defined periods of quiet sleep, active sleep, and wakefulness occur in utero beginning at 28 weeks of gestation.⁴⁴ In addition to the specific behavioral responses to pain described below, preterm and full-term babies have various cognitive, coordinative, and associative capabilities in response to visual and auditory stimuli, leaving no doubt about the presence of cortical function.⁴⁵

Several lines of evidence suggest that the complete nervous system is active during prenatal development and that detrimental or developmental changes in any part would affect the entire system.^{25,26,42,46} In studies in animals, Ralston found that somatosensory neurons of the neocortex respond to peripheral noxious stimuli and proposed that “it does not appear necessary to postulate a subcortical mechanism for appreciation of pain [in the fetus or neonate].”⁴⁷ Thus, human newborns do have the anatomical and functional components required for the perception of painful stimuli. Since these stimuli may undergo selective transmission, inhibition, or modulation by various neurotransmitters, the neurochemical mechanisms associated with pain pathways in the fetus and newborn are considered below.

NEUROCHEMICAL SYSTEMS ASSOCIATED WITH PAIN PERCEPTION

The Tachykinin System

Various putative neurotransmitters called the tachykinins (substance P, neurokinin A, neuromedin K, and so forth) have been identified in the central nervous system, but only substance P has been investigated thoroughly and shown to have a role in the transmission and control of pain impulses.⁴⁸⁻⁵⁶ Neural elements containing substance P and its receptors appear in the dorsal-root ganglia and dorsal horns of the spinal cord at 12 to 16 weeks of gestation.⁵⁷ A high density of substance P fibers and cells has been observed in multiple areas of the fetal brain stem associated with the pathways for pain perception and control and the visceral reactions to pain.⁵⁸⁻⁶³ Substance P fibers and cells have also been found in the hypothalamus, mamillary bodies, thalamus, and cerebral cortex of human fetuses early in their development.⁵⁸ Many studies have found higher densities of substance P and its receptors in neonates than in adults of the same species, although the importance of this finding is unclear.^{61,64-68}

The Endogenous Opioid System

With the demonstration of the existence of stereospecific opiate receptors^{69,70} and their endogenous ligands,⁷¹ the control of pain was suggested as a primary

role for the endogenous opioid system.⁷² Both the enkephalinergetic and the endorphinergetic systems may modulate pain transmission at spinal and supraspinal levels.^{56,73} In the human fetus, however, there are no data on the ontogeny and distribution of specific cells, fibers, and receptors (μ -, δ -, and κ -opiate receptors) that are thought to mediate the antinociceptive effects of exogenous and endogenous opioids.⁷⁴ However, functionally mature endorphinergetic cells in fetal pituitary glands have been observed at 15 weeks of gestation and possibly earlier.^{75,76} Beta-endorphin and beta-lipotropin were found to be secreted from fetal pituitary cells at 20 weeks in response to *in vitro* stimulation by corticotropin-releasing factor.⁷⁷ In addition, more production of beta-endorphin may occur in fetal and neonatal pituitary glands than in adult glands.^{78,79}

Endogenous opioids are released in the human fetus at birth and in response to fetal and neonatal distress.⁸⁰ Umbilical-cord plasma levels of beta-endorphin and beta-lipotropin from healthy full-term neonates delivered vaginally or by cesarean section have been shown to be three to five times higher than plasma levels in resting adults.^{78,81} Neonates delivered vaginally by breech presentation or vacuum extraction had further increases in beta-endorphin levels, indicating beta-endorphin secretion in response to stress at birth.⁸² Plasma beta-endorphin concentrations correlated negatively with umbilical-artery pH and partial pressure of oxygen and positively with base deficit and partial pressure of carbon dioxide, suggesting that birth asphyxia may be a potent stimulus to the release of endogenous opioids.^{81,83-87} Cerebrospinal fluid levels of beta-endorphin were also increased markedly in newborns with apnea of prematurity,⁸⁸⁻⁹⁰ infections, or hypoxemia.^{88,91,92} These elevated values may have been caused by the “stress” of illness,⁹³ the pain associated with these clinical conditions, or the invasive procedures required for their treatment. However, these high levels of beta-endorphin are unlikely to decrease anesthetic or analgesic requirements,⁹⁴ because the cerebrospinal fluid levels of beta-endorphin required to produce analgesia in human adults have been found to be 10,000 times higher than the highest recorded levels in neonates.⁹⁵

The high levels of beta-endorphin and beta-lipotropin in cord plasma decreased substantially by 24 hours after birth^{87,96} and reached adult levels by five days, whereas the levels in the cerebrospinal fluid fell to adult values in 24 hours.^{87,97,98} In newborn infants of women addicted to narcotics, massive increases in plasma concentrations of beta-endorphin, beta-lipotropin, and met-enkephalin occurred within 24 hours, with some values reaching 1000 times those in resting adults. Markedly increased levels persisted for up to 40 days after birth.⁸⁷ However, these neonates were considered to be clinically normal, and no behavioral effects were observed (probably because of the development of prenatal opiate tolerance).

PHYSIOLOGIC CHANGES ASSOCIATED WITH PAIN

Cardiorespiratory Changes

Changes in cardiovascular variables, transcutaneous partial pressure of oxygen, and palmar sweating have been observed in neonates undergoing painful clinical procedures. In preterm and full-term neonates undergoing circumcision^{99,100} or heel lancing,¹⁰¹⁻¹⁰³ marked increases in the heart rate and blood pressure occurred during and after the procedure. The magnitude of changes in the heart rate was related to the intensity and duration of the stimulus¹⁰⁴ and to the individual temperaments of the babies.¹⁰⁵ The administration of local anesthesia to full-term neonates undergoing circumcision prevented the changes in heart rate and blood pressure,^{99,100,106} whereas giving a "pacifier" to preterm neonates during heel-stick procedures did not alter their cardiovascular or respiratory responses to pain.¹⁰¹ Further studies in newborn and older infants showed that noxious stimuli were associated with an increase in heart rate, whereas non-noxious stimuli (which elicited the attention or orientation of infants) caused a decrease in heart rate.^{22,107,108}

Large fluctuations in transcutaneous partial pressure of oxygen above and below an arbitrary "safe" range of 50 to 100 mm Hg have been observed during various surgical procedures in neonates.¹⁰⁹⁻¹¹¹ Marked decreases in transcutaneous partial pressure of oxygen also occurred during circumcision,^{106,112} but such changes were prevented in neonates given local analgesic agents.^{100,106,112} Tracheal intubation in awake preterm and full-term neonates caused a significant decrease in transcutaneous partial pressure of oxygen, together with increases in arterial blood pressure¹¹³⁻¹¹⁵ and intracranial pressure.¹¹⁶ The increases in intracranial pressure with intubation were abolished in preterm neonates who were anesthetized.¹¹⁷ In addition, infants' cardiovascular responses to tracheal suctioning were abolished by opiate-induced analgesia.¹¹⁸

Palmar sweating has also been validated as a physiologic measure of the emotional state in full-term babies and has been closely related to their state of arousal and crying activity.¹¹⁹ Substantial changes in palmar sweating were observed in neonates undergoing heel-sticks for blood sampling, and subsequently, a mechanical method of heel lancing proved to be less painful than manual methods, on the basis of the amount of palmar sweating.¹²⁰

Hormonal and Metabolic Changes

Hormonal and metabolic changes have been measured primarily in neonates undergoing surgery, although there are limited data on the neonatal responses to venipuncture and other minor procedures. Plasma renin activity increased significantly 5 minutes after venipuncture in full-term neonates and returned to basal levels 60 minutes thereafter; no changes occurred in the plasma levels of cortisol, epinephrine,

or norepinephrine after venipuncture.¹²¹ In preterm neonates receiving ventilation therapy, chest physiotherapy and endotracheal suctioning produced significant increases in plasma epinephrine and norepinephrine; this response was decreased in sedated infants.¹²² In neonates undergoing circumcision without anesthesia, plasma cortisol levels increased markedly during and after the procedure.^{123,124} Similar changes in cortisol levels were not inhibited in a small number of neonates given a local anesthetic,¹²⁵ but the efficacy of the nerve block was questionable in these cases.

Further detailed hormonal studies¹²⁶ in preterm and full-term neonates who underwent surgery under minimal anesthesia documented a marked release of catecholamines,¹²⁷ growth hormone,¹²⁸ glucagon,¹²⁷ cortisol, aldosterone, and other corticosteroids,^{129,130} as well as suppression of insulin secretion.¹³¹ These responses resulted in the breakdown of carbohydrate and fat stores,^{127,132,133} leading to severe and prolonged hyperglycemia and marked increases in blood lactate, pyruvate, total ketone bodies, and nonesterified fatty acids. Increased protein breakdown was documented during and after surgery by changes in plasma amino acids, elevated nitrogen excretion, and increased 3-methylhistidine:creatinine ratios in the urine (Anand KJS, Aynsley-Green A: unpublished data). Marked differences also occurred between the stress responses of premature and full-term neonates (Anand KJS, Aynsley-Green A: unpublished data) and between the responses of neonates undergoing different degrees of surgical stress.¹³⁴

Possibly because of the lack of deep anesthesia, neonatal stress responses were found to be three to five times greater than those in adults, although the duration was shorter.¹²⁶ These stress responses could be inhibited by potent anesthetics, as demonstrated by randomized, controlled trials of halothane and fentanyl. These trials showed that endocrine and metabolic stress responses were decreased by halothane anesthesia in full-term neonates¹³⁵ and abolished by low-dose fentanyl anesthesia in preterm neonates.¹³⁶ The stress responses of neonates undergoing cardiac surgery were also decreased in randomized trials of high-dose fentanyl and sufentanil anesthesia.^{126,137,138} These results indicated that the nociceptive stimuli during surgery performed with minimal anesthesia were responsible for the massive stress responses of neonates. Neonates who were given potent anesthetics in these randomized trials were more clinically stable during surgery and had fewer postoperative complications as compared with neonates under minimal anesthesia.^{126,129} There is preliminary evidence that the pathologic stress responses of neonates under light anesthesia during major cardiac surgery may be associated with an increased postoperative morbidity and mortality (Anand KJS, Hickey PR: unpublished data). Changes in plasma stress hormones (e.g., cortisol) can also be correlated with the behavioral states of newborn infants,^{124,139,140} which are im-

portant in the postulation of overt subjective distress in neonates responding to pain.

BEHAVIORAL CHANGES ASSOCIATED WITH PAIN

Simple Motor Responses

Early studies of the motor responses of newborn infants to pinpricks reported that the babies responded with a "diffuse body movement" rather than a purposeful withdrawal of the limb,² whereas other studies found reflex withdrawal to be the most common response.¹⁴¹⁻¹⁴³ More recently, the motor responses of 124 healthy full-term neonates to a pinprick in the leg were reported to be flexion and adduction of the upper and lower limbs associated with grimacing, crying, or both, and these responses were subsequently quantified.^{144,145} Similar responses have also been documented in very premature neonates, and in a recent study, Fitzgerald et al. found that premature neonates (<30 weeks) not only had lower thresholds for a flexor response but also had increased sensitization after repeated stimulation.¹⁴⁶

Facial Expressions

Distinct facial expressions are associated with pleasure, pain, sadness, and surprise in infants.¹⁴⁷ These expressions, especially those associated with pain, have been objectively classified and validated in a study of infants being immunized.^{102,148} With use of another method of objectively classifying facial expressions of neonates, different responses were observed with different techniques of heel lancing and with different behavioral states¹⁴⁹ (and Grunau RVE, Craig KD: unpublished data). These findings suggest that the neonatal response to pain is complex and may be altered by the behavioral state and other factors at the time of the stimulus.¹⁵⁰

Crying

Crying is the primary method of communication in newborn infants and is also elicited by stimuli other than pain.¹⁵¹ Several studies have classified infant crying according to the type of distress indicated and its spectrographic properties.¹⁵²⁻¹⁵⁴ These studies have shown that cries due to pain, hunger, or fear can be distinguished reliably by the subjective evaluation of trained observers and by spectrographic analysis.¹⁵⁵⁻¹⁶⁰ This has allowed the cry response to be used as a measure of pain in numerous recent studies.^{22,99,100,102,106,152}

The pain cry has specific behavioral characteristics and spectrographic properties in healthy full-term neonates.¹⁶¹⁻¹⁶⁴ Pain cries of preterm neonates and neonates with neurologic impairment, hyperbilirubinemia, or meningitis are considerably different, thereby indicating altered cortical function in these babies.¹⁶⁵⁻¹⁶⁸ Changes in the patterns of neonatal cries have been correlated with the intensity of pain experienced during circumcision and were accurately differentiated by adult listeners.¹⁶⁹ In other studies of the cry response to painful procedures, neonates were

found to be more sensitive to pain than older infants (those 3 to 12 months old) but had similar latency periods between exposure to a painful stimulus and crying or another motor response.^{99-101,103,152,170} This supports the contention that slower conduction speed in the nerves of neonates is offset by the smaller inter-neuron distances traveled by the impulse.

Complex Behavioral Responses

Alterations in complex behavior and sleep-wake cycles have been studied mainly in newborn infants undergoing circumcision without anesthesia. Emde and coworkers observed that painful procedures were followed by prolonged periods of non-rapid-eye-movement sleep in newborns and confirmed these observations in a controlled study of neonates undergoing circumcision without anesthesia.¹⁷¹ Similar observations have been made in adults with prolonged stress. Other subsequent studies have found increased wakefulness and irritability for an hour after circumcision, an altered arousal level in circumcised male infants as compared with female and uncircumcised male infants, and an altered sleep-wake state in neonates undergoing heel-stick procedures.^{103,172,173} In a double-blind, randomized controlled study using the Brazelton Neonatal Behavioral Assessment Scale, 90 percent of neonates had changed behavioral states for more than 22 hours after circumcision, whereas only 16 percent of the uncircumcised infants did.¹⁷⁴ It was therefore proposed that such painful procedures may have prolonged effects on the neurologic and psychosocial development of neonates.¹⁷⁵ A similar randomized study showed the absence of these behavioral changes in neonates given local anesthetics for circumcision.¹⁷⁶ For two days after circumcision, neonates who had received anesthetics were more attentive to various stimuli and had greater orientation, better motor responses, decreased irritability, and a greater ability to quiet themselves when disturbed. A recent controlled study showed that intervention designed to decrease the amount of sensory input and the intensity of stressful stimuli during intensive care of preterm neonates was associated with improved clinical and developmental outcomes.¹⁷⁷ Because of their social validity and communicational specificity, the behavioral responses observed suggest that the neonatal response to pain is not just a reflex response.¹⁷⁸⁻¹⁸⁰

MEMORY OF PAIN IN NEONATES

The persistence of specific behavioral changes after circumcision in neonates implies the presence of memory. In the short term, these behavioral changes may disrupt the adaptation of newborn infants to their postnatal environment,¹⁷⁴⁻¹⁷⁶ the development of parent-infant bonding, and feeding schedules.^{181,182} In the long term, painful experiences in neonates could possibly lead to psychological sequelae,²² since several workers have shown that newborns may have a much greater capacity for memory than was previously thought.¹⁸³⁻¹⁸⁶

Pain itself cannot be remembered, even by adults¹⁸⁷; only the experiences associated with pain can be recalled. However, the question of memory is important, since it has been argued that memory traces are necessary for the "maturation" of pain perception,³ and a painful experience may not be deemed important if it is not remembered. Long-term memory requires the functional integrity of the limbic system and diencephalon (specifically, the hippocampus, amygdala, anterior and mediodorsal thalamic nuclei, and mamillary nuclei)¹⁸⁸; these structures are well developed and functioning during the newborn period.⁴² Furthermore, the cellular, synaptic, and molecular changes required for memory and learning depend on brain plasticity, which is known to be highest during the late prenatal and neonatal periods.^{189,190} Apart from excellent studies in animals demonstrating the long-term effects of sensory experiences in the neonatal period,¹⁹¹ evidence for memories of pain in human infants must, by necessity, be anecdotal.^{178,192,193} Early painful experiences may be stored in the phylogenetically old "procedural memory," which is not accessible to conscious recall.^{182,183,194} Although Janov¹⁹⁵ and Holden¹⁹⁶ have collected clinical data that they claim indicate that adult neuroses or psychosomatic illnesses may have their origins in painful memories acquired during infancy or even neonatal life, their findings have not been substantiated or widely accepted by other workers.

CONCLUSIONS

Numerous lines of evidence suggest that even in the human fetus, pain pathways as well as cortical and subcortical centers necessary for pain perception are well developed late in gestation, and the neurochemical systems now known to be associated with pain transmission and modulation are intact and functional. Physiologic responses to painful stimuli have been well documented in neonates of various gestational ages and are reflected in hormonal, metabolic, and cardiorespiratory changes similar to but greater than those observed in adult subjects. Other responses in newborn infants are suggestive of integrated emotional and behavioral responses to pain and are retained in memory long enough to modify subsequent behavior patterns.

None of the data cited herein tell us whether neonatal nociceptive activity and associated responses are experienced subjectively by the neonate as pain similar to that experienced by older children and adults. However, the evidence does show that marked nociceptive activity clearly constitutes a physiologic and perhaps even a psychological form of stress in premature or full-term neonates. Attenuation of the deleterious effects of pathologic neonatal stress responses by the use of various anesthetic techniques has now been demonstrated. Recent editorials addressing these issues have promulgated a wide range of opinions, without reviewing all the available evidence.¹⁹⁷⁻²⁰¹ The evidence summarized in this paper provides a physio-

logic rationale for evaluating the risks of sedation, analgesia, local anesthesia, or general anesthesia during invasive procedures in neonates and young infants. Like persons caring for patients of other ages, those caring for neonates must evaluate the risks and benefits of using analgesic and anesthetic techniques in individual patients. However, in decisions about the use of these techniques, current knowledge suggests that humane considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations.

REFERENCES

- Merskey H, Albe-Fessard DG, Bonica JJ, et al. Pain terms: a list with definitions and notes on usage; recommended by the IASP Subcommittee on Taxonomy. *Pain* 1979; 6:249-52.
- McGraw MD. The neuromuscular maturation of the human infant. New York: Columbia University Press, 1943.
- Merskey H. On the development of pain. *Headache* 1970; 10:116-23.
- Levy DM. The infant's earliest memory of inoculation: a contribution to public health procedures. *J Gen Psychol* 1960; 96:3-46.
- Harris FC, Lahey BB. A method for combining occurrence and nonoccurrence interobserver agreement scores. *J Appl Behav Anal* 1978; 11: 523-7.
- Bondy AS. Infancy. In: Gabel S, Erickson MT, eds. Child development and developmental disabilities. Boston: Little, Brown, 1980:3-19.
- Eland JM, Anderson JE. The experience of pain in children. In: Jacox AK, ed. Pain: a source book for nurses and other health professionals. Boston: Little, Brown, 1977:453-73.
- Wallerstein E. Circumcision: the uniquely American medical enigma. *Urol Clin N Am* 1985; 12:123-32.
- Annand KJS, Aynsley-Green A. Metabolic and endocrine effects of surgical ligation of patent ductus arteriosus in the human preterm neonate: Are there implications for further improvement of postoperative outcome? *Mod Probl Paediatr* 1985; 23:143-57.
- Lippmann N, Nelson RJ, Emmanouilides GC, Diskin J, Thibeault DW. Ligation of patent ductus arteriosus in premature infants. *Br J Anaesth* 1976; 48:965-9.
- Shaw EA. Neonatal anaesthesia. *Hosp Update* 1982; 8:423-34.
- Katz J. The question of circumcision. *Int Surg* 1977; 62:490-2.
- Swafford LI, Allan D. Pain relief in the pediatric patient. *Med Clin North Am* 1968; 52:131-6.
- Rees GJ. Anesthesia in the newborn. *Br Med J* 1950; 2:1419-22.
- Betts EK, Downes JJ. Anesthetic considerations in newborn surgery. *Semin Anesth* 1984; 3:59-74.
- Inkster JS. Paediatric anaesthesia and intensive care. *Int Anesthesiol Clin* 1978; 16:58-91.
- Norman EA. Pulse oximetry during repair of congenital diaphragmatic hernia. *Br J Anaesth* 1986; 58:534-5.
- Hatch DJ. Analgesia in the neonate. *Br Med J* 1987; 294:920.
- Shearer MH. Surgery on the paralysed, unanesthetized newborn. *Birth* 1986; 13:79.
- Robinson S, Gregory GA. Fentanyl-air-oxygen anesthesia for ligation of patent ductus arteriosus in preterm infants. *Anesth Analg* 1981; 60:331-4.
- Weiss C. Does circumcision of the newborn require an anesthetic? *Clin Pediatr (Phila)* 1968; 7:128-9.
- Owens ME. Pain in infancy: conceptual and methodological issues. *Pain* 1984; 20:213-30.
- Richards T. Can a fetus feel pain? *Br Med J* 1985; 291:1220-1.
- Gleiss J, Stuttgart G. Morphologic and functional development of the skin. In: Stave U, ed. Physiology of the perinatal period. Vol. 2. New York: Appleton-Century-Crofts, 1970:889-906.
- Humphrey T. Some correlations between the appearance of human fetal reflexes and the development of the nervous system. *Prog Brain Res* 1964; 4:93-135.
- Valman HB, Pearson JF. What the fetus feels. *Br Med J* 1980; 280:233-4.
- Okado N. Onset of synapse formation in the human spinal cord. *J Comp Neurol* 1981; 201:211-9.
- Woźniak W, O'Rahilly R, Olczewska B. The fine structure of the spinal cord in human embryos and early fetuses. *J Hirnforsch* 1980; 21:101-24.
- Rizvi T, Wadhwa S, Bijlani V. Development of spinal substrate for nociception. *Pain [Suppl]* 1987; 4:195.
- Tilney F, Rosett J. The value of brain lipids as an index of brain development. *Bull Neurol Inst NY* 1931; 1:28-71.
- Schulte FJ. Neurophysiological aspects of brain development. *Mead Johnson Symp Perinat Dev Med* 1975; 6:38-47.

32. *Idem*. Gestation, wachstum und hirnentwicklung. In: Linneweh F, ed. *Fortschritte der Paedologie*. Vol. 2. Berlin: Springer-Verlag, 1968:46-64.
33. Gilles FJ, Shankle W, Dooling EC. Myelinated tracts: growth patterns. In: Gilles FH, Leviton A, Dooling EC, eds. *The developing human brain: growth and epidemiologic neuropathology*. Boston: John Wright, 1983: 117-83.
34. Marin-Padilla M. Structural organization of the human cerebral cortex prior to the appearance of the cortical plate. *Anat Embryol (Berl)* 1983; 168:21-40.
35. Moliver ME, Kostović I, Van der Loos H. The development of synapses in cerebral cortex of the human fetus. *Brain Res* 1973; 50:403-7.
36. Rakic P, Goldman-Rakic PS. Development and modifiability of the cerebral cortex: early developmental effects: cell lineages, acquisition of neuronal positions, and areal and laminar development. *Neurosci Res Prog Bull* 1982; 20:433-51.
37. Kostović I, Rakic P. Development of prestriate visual projections in the monkey and human fetal cerebrum revealed by transient cholinesterase staining. *J Neurosci* 1984; 4:25-42.
38. Kostović I, Goldman-Rakic PS. Transient cholinesterase staining in the mediolateral nucleus of the thalamus and its connections in the developing human and monkey brain. *J Comp Neurol* 1983; 219:431-47.
39. Spielmann R. In: *EEG primer*. New York: Elsevier/North-Holland, 1981:159-65.
40. Torres F, Anderson C. The normal EEG of the human newborn. *J Clin Neurophysiol* 1983; 2:89-103.
41. Henderson-Smart DJ, Pettigrew AG, Campbell DJ. Clinical apnea and brain-stem neural function in preterm infants. *N Engl J Med* 1983; 308:353-7.
42. Prechtl HFR, ed. *Continuity of neural functions from prenatal to postnatal life*. Oxford: Blackwell, 1984.
43. Chugani HT, Phelps ME. Maturational changes in cerebral function in infants determined by ¹⁸F-DG positron emission tomography. *Science* 1986; 231:840-3.
44. Arduini D, Rizzo G, Giorlandino C, Valensise H, Dell'acqua S, Romanici C. The development of fetal behavioural states: A longitudinal study. *Prenat Diagn* 1986; 6:117-24.
45. Sammons WAH. Premature behavior and the neonatal intensive care unit environment. In: Clukey JP, Stark AR, eds. *Manual of neonatal care*. Boston: Little, Brown, 1980:359-63.
46. Flower MJ. Neuroimmaturity of the human fetus. *J Med Philos* 1985; 10:237-51.
47. Ralston HJ. Synaptic organization of spinothalamic projections to the thalamus, with special reference to pain. *Adv Pain Res Ther* 1984; 6:183-95.
48. Nawa H, Hirose T, Takashima H, Inayama S, Nakanishi S. Nucleotide sequences of cloned cDNAs for two types of bovine brain substance P precursor. *Nature* 1983; 306:32-6.
49. Watson SP, Sandberg BEB, Hanley MR, Iversen LL. Tissue selectivity of substance P alkyl esters: suggesting multiple receptors. *Eur J Pharmacol* 1983; 87:77-84.
50. Manysh PW, Maggio JE, Hunt SP. The autoradiographic distribution of kasin and substance K binding sites is different from the distribution of substance P binding sites in rat brain. *Eur J Pharmacol* 1984; 102:361-4.
51. Valentino KL, Tatemoto K, Hunter J, Barchas JD. Distribution of neuropeptide K-immunoreactivity in the rat central nervous system. *Peptides* 1986; 7:1043-59.
52. Pernow B. Substance P. *Pharmacol Rev* 1983; 35:85-141.
53. Otsuka M, Kōishi S. Substance P — the first peptide neurotransmitter? *Trends Neurosci* 1983; 6:317-20.
54. Henry JL. Relation of substance P to pain transmission: neurophysiological evidence. In: Porter R, O'Connor M, eds. *Substance P in the nervous system*. Ciba Foundation Symposium 91. London: Pitman, 1982:206-24.
55. Pearson J, Brandeis L, Cuello AC. Depletion of substance P-containing axons in substantia gelatinosa of patients with diminished pain sensitivity. *Nature* 1982; 295:61-3.
56. Jessel T, Iversen LL. Opiate analgesics inhibit substance P release from rat trigeminal nucleus. *Nature* 1977; 268:549-51.
57. Charney Y, Paulin C, Chayvialle J-A, Dubois PM. Distribution of substance P-like immunoreactivity in the spinal cord and dorsal root ganglia of the human foetus and infant. *Neuroscience* 1983; 10:41-55.
58. Paulin C, Charney Y, Dubois PM, Chayvialle J-A. Localisation de substance P dans le système nerveux du fœtus humain: résultats préliminaires. *C R Acad Sci Paris [Series D]* 1980; 291:257-60.
59. Pickel VM, Sumal KK, Reis DJ, Miller RJ, Hervonen A. Immunocytochemical localization of enkephalin and substance P in the dorsal tegmental nuclei in the human fetal brain. *J Comp Neurol* 1980; 193:805-14.
60. Roizen MF, Newfield P, Eger EI II, Hosobuchi Y, Adams JE, Lamis S. Reduced anesthetic requirement after electrical stimulation of periaqueductal gray matter. *Anesthesiology* 1985; 62:120-3.
61. Dei Fiacco M, Dessì ML, Leranti MC. Topographical localization of substance P in the human post-mortem brainstem: an immunohistochemical study in the newborn and adult tissue. *Neuroscience* 1984; 12:591-611.
62. Nomura H, Shiosaka S, Inagaki S, et al. Distribution of substance P-like immunoreactivity in the lower brainstem of the human fetus: an immunohistochemical study. *Brain Res* 1982; 252:315-25.
63. Helke CA, Charlton CG, Keeler JR. Bulbosplinal substance P and sympathetic regulation of the cardiovascular system: a review. *Peptides* 1985; 6:Suppl 2:69-74.
64. Inagaki S, Sakanaka M, Shiosaka S, et al. Ontogeny of substance P-containing neuron system of the rat: immunohistochemical analysis. *Neuroscience* 1982; 7:251-77, 1097-126.
65. Quirion R, Dam T-V. Ontogeny of substance P receptor binding sites in rat brain. *J Neurosci* 1986; 6:2187-99.
66. Jonsson G, Hallman H. Substance P counteracts neurotoxin damage on norepinephrine neurons in rat brain during ontogeny. *Science* 1982; 215:75-7.
67. *Idem*. Effect of substance P on neonatally axotomized noradrenergic neurons in rat brain. *Med Biol* 1983; 61:179-85.
68. Narami S, Fujita T. Stimulatory effects of substance P and nerve growth factor (NGF) on neurite outgrowth in embryonic chick dorsal root ganglia. *Neuropharmacology* 1978; 17:73-6.
69. Pert CB, Snyder SH. Opiate receptor: demonstration in nervous tissue. *Science* 1973; 179:1011-4.
70. Terenius L. Stereospecific interaction between narcotic analgesics and a synaptic plasma membrane fraction of rat cerebral cortex. *Acta Pharmacol Toxicol (Copenh)* 1973; 32:317-20.
71. Hughes J. Isolation of an endogenous compound from the brain with pharmacological properties similar to morphine. *Brain Res* 1975; 88:295-308.
72. Jacob JIC, Ramabhadran K. Role of opiate receptors and endogenous ligands in nociception. In: Williams NE, Wilson H, eds. *Pain and its management*. Oxford: Pergamon Press, 1983:13-32.
73. Hosobuchi Y, Li CH. The analgesic activity of human beta-endorphin in man. *Commun Psychopharmacol* 1978; 2:33-7.
74. Paterson DJ, Robson LE, Kosterlitz HW. Classification of opioid receptors. *Br Med Bull* 1983; 39:31-6.
75. Bégeot M, Dubois MP, Dubois PM. Immunologic localization of α - and β -endorphins and β -lipotropin in corticotrophic cells of the normal and anencephalic fetal pituitaries. *Cell Tissue Res* 1978; 193:413-22.
76. Li JY, Dubois MP, Dubois PM. Ultrastructural localization of immunoreactive corticotropin, β -lipotropin, α - and β -endorphin in cells of the human fetal anterior pituitary. *Cell Tissue Res* 1979; 204:37-51.
77. Gibbs DM, Stewart RD, Liu JH, Vale W, Rivier J, Yen SSC. Effects of synthetic corticotropin-releasing factor and dopamine on the release of immunoreactive β -endorphin/ β -lipotropin and α -melanocyte-stimulating hormone from human fetal pituitaries in vitro. *J Clin Endocrinol Metab* 1982; 55:1449-52.
78. Csontos K, Rüst M, Höök V, Mahr W, Kromer W, Teschemacher HJ. Elevated plasma β -endorphin levels in pregnant women and their neonates. *Life Sci* 1979; 25:835-44.
79. Vuolteenaho O, Leppäljuoto J, Höyhty M, Hirvonen J. β -endorphin-like peptides in autopsy pituitaries from adults, neonates and foetuses. *Acta Endocrinol (Copenh)* 1983; 102:27-34.
80. Gaudray JP, Jollivet A, Vireh JP, Guillemin R. Presence of immunosayable β -endorphin in human amniotic fluid: elevation in cases of fetal distress. *Am J Obstet Gynecol* 1977; 129:211-2.
81. Wardlaw SL, Stark RI, Baxi L, Frantz AG. Plasma β -endorphin and β -lipotropin in the human fetus at delivery: correlation with arterial pH and pO₂. *J Clin Endocrinol Metab* 1979; 49:888-91.
82. Puolukka J, Kauppila A, Leppäljuoto J, Vuolteenaho O. Elevated beta-endorphin immunoreactivity in umbilical cord blood after complicated delivery. *Acta Obstet Gynecol Scand* 1982; 61:513-4.
83. Shaaban MM, Hung TT, Hoffman DI, Lobo RA, Goebelsmann U. β -endorphin and β -lipotropin concentrations in umbilical cord blood. *Am J Obstet Gynecol* 1982; 144:560-9.
84. Browning AJF, Butt WR, Lynch SS, Shakespear RA, Crawford JS. Maternal and cord plasma concentrations of β -lipotropin, β -endorphin and γ -lipotropin at delivery: effect of analgesia. *Br J Obstet Gynaecol* 1983; 90:1152-6.
85. Pohjavuori M, Rovamo L, Laatikainen T. Plasma immunoreactive β -endorphin and cortisol in the newborn infant after elective caesarean section and after spontaneous labour. *Eur J Obstet Gynecol Reprod Biol* 1985; 19:67-74.
86. Pohjavuori M, Rovamo L, Laatikainen T, Kariniemi V, Pettersson J. Stress of delivery and plasma endorphins and catecholamines in the newborn infant. *Biol Res Pregnancy Perinatol* 1986; 7:1-5.
87. Panerai AE, Martini A, Di Giulio AM, et al. Plasma β -endorphin, β -lipotropin, and met-enkephalin concentrations during pregnancy in normal and drug-addicted women and their newborn. *J Clin Endocrinol Metab* 1983; 57:537-43.
88. MacDonald MG, Moss JR, Kefale GG, Ginzburg HM, Fink RJ, Chin L. Effect of naltrexone on apnea of prematurity and on plasma beta-endorphin-like immunoreactivity. *Dev Pharmacol Ther* 1986; 9:301-9.

89. Orlowski JP. Cerebrospinal fluid endorphins and the infant apnea syndrome. *Pediatrics* 1986; 78:233-7.
90. Sankaran K, Hindmarsh KW, Watson VG. Plasma beta-endorphin concentration in infants with apneic spells. *Am J Perinatol* 1984; 1:331-4.
91. Hindmarsh KW, Sankaran K, Watson VG. Plasma beta-endorphin concentrations in neonates associated with acute stress. *Dev Pharmacol Ther* 1984; 7:198-204.
92. Sankaran K, Hindmarsh KW, Watson VG. Hypoxic-ischemic encephalopathy and plasma β -endorphin. *Dev Pharmacol Ther* 1984; 7:377-83.
93. Hindmarsh KW, Sankaran K. Endorphins and the neonate. *Can Med Assoc J* 1985; 132:331-4.
94. Lerman J, Robinson S, Willis MM, Gregory GA. Anesthetic requirements for halothane in young children: 0-1 month and 1-6 months of age. *Anesthesiology* 1983; 59:421-4.
95. Foley KM, Kourides IA, Inturrisi CE, et al. β -endorphin: analgesic and hormonal effects in humans. *Proc Natl Acad Sci USA* 1979; 76:5377-81.
96. Facchini F, Bugnoli F, Brocci R, Genazzani AR. Plasma opioids in the first hours of life. *Pediatr Res* 1982; 16:95-8.
97. Moss IR, Conner H, Yee WFH, Iorio P, Scarpelli EM. Human β -endorphin-like immunoreactivity in the perinatal/neonatal period. *J Pediatr* 1982; 101:443-6.
98. Burnard ED, Todd DA, John E, Hindmarsh KW. Beta-endorphin levels in newborn cerebrospinal fluid. *Aust Paediatr J* 1982; 18:258-63.
99. Williamson PS, Williamson ML. Physiologic stress reduction by a local anesthetic during newborn circumcision. *Pediatrics* 1983; 71:36-40.
100. Holve RL, Bromberger BJ, Groverman HD, Klauber MR, Dixon SD, Snyder JM. Regional anesthesia during newborn circumcision: effect on infant pain response. *Clin Pediatr (Phila)* 1983; 22:813-8.
101. Owens ME, Todd EH. Pain in infancy: neonatal reaction to a heel lance. *Pain* 1984; 20:77-86.
102. Johnson CC, Strada ME. Acute pain response in infants: a multidimensional description. *Pain* 1986; 24:373-82.
103. Field T, Goldson E. Pacifying effects of nonnutritive sucking on term and preterm neonates during heelstick procedures. *Pediatrics* 1984; 74:1012-5.
104. Clifton RK, Graham FK, Hutton HM. Newborn heart-rate response and response habituation as a function of stimulus duration. *J Exp Child Psychol* 1968; 6:265-78.
105. Kagan J. Heart rate and heart rate variability as signs of a temperamental dimension in infants. In: Izard CE, ed. *Measuring emotions in infants and children*. Cambridge: Cambridge University Press, 1982:36-66.
106. Maxwell LG, Yasser M, Wetzel RC. Penile nerve block reduces the physiologic stress of newborn circumcision. *Anesthesiology* 1986; 65:A432, abstract.
107. Berg KM, Berg WK, Graham FK. Infant heart rate response as a function of stimulus and state. *Psychophysiology* 1971; 8:30-44.
108. Campos JJ. Heart rate: a sensitive tool for the study of emotional development in the infant. In: Lipsitt LD, ed. *Developmental psychobiology*. Hillsdale, N.J.: Lawrence Erlbaum Associates, 1976:1-31.
109. Weile P, Hayden W, Miller T. Continuous measurement of transcutaneous oxygen tension of neonates under general anesthesia. *J Pediatr Surg* 1980; 15:257-60.
110. Venus B, Patel KC, Pratap KS, Konchigeri H, Vidyasagar D. Transcutaneous PO_2 monitoring during pediatric surgery. *Crit Care Med* 1981; 9: 714-6.
111. Messner JT, Loux PC, Grossman LB. Intraoperative transcutaneous pO_2 monitoring in infants. *Anesthesiology* 1979; 51:S319, abstract.
112. Rawlings DJ, Miller PA, Engel RR. The effect of circumcision on transcutaneous pO_2 in term infants. *Am J Dis Child* 1980; 134:676-8.
113. Kelly MA, Finer NN. Nasotracheal intubation in the neonate: physiologic responses and effects of atropine and pancuronium. *J Pediatr* 1984; 105:303-9.
114. Marshall TA, Deoder R, Pai S, Berkowitz GP, Austin TL. Physiologic changes associated with endotracheal intubation in preterm infants. *Crit Care Med* 1984; 12:501-3.
115. Gibbons PA, Swedlow DB. Changes in oxygen saturation during elective tracheal intubation in infants. *Anesth Analg* 1986; 65:558, abstract.
116. Raju TNK, Vidyasagar D, Torres C, Grundy D, Bennett EJ. Intracranial pressure during intubation and anesthesia in infants. *J Pediatr* 1980; 96:860-2.
117. Frisken RH, Honda AT, Thieme RE. Changes in anterior fontanel pressure in preterm neonates during tracheal intubation. *Anesth Analg* 1987; 66:874-8.
118. Hickey PR, Hansen DD, Wessel DL, Lang P, Jonas RA, Elixson EM. Blunting of stress responses in the pulmonary circulation of infants by fentanyl. *Anesth Analg* 1985; 64:1137-42.
119. Harpin VA, Rutter N. Development of emotional sweating in the newborn infant. *Arch Dis Child* 1982; 57:691-5.
120. *Idem*. Making heel pricks less painful. *Arch Dis Child* 1983; 58:226-8.
121. Fieselhor T, Monnens L, Moorman E, Van Munster P, Jansen M, Peer P. Influence of the stress of venopuncture on basal levels of plasma renin activity in infants and children. *Int J Pediatr Nephrol* 1983; 4:181-5.
122. Greisen G, Frederiksen PS, Hertel J, Christensen NJ. Catecholamine response to chest physiotherapy and endotracheal suctioning in preterm infants. *Acta Paediatr Scand* 1985; 74:525-9.
123. Talbot LM, Kraybill EN, Potter HD. Adrenal cortical response to circumcision in the neonate. *Obstet Gynecol* 1976; 48:208-10.
124. Gunnar MR, Fisch RO, Korsvik S, Donhove JM. The effects of circumcision on serum cortisol and behavior. *Psychoneuroendocrinology* 1981; 6:269-75.
125. Williamson PS, Evans ND. Neonatal cortisol response to circumcision with anesthesia. *Clin Pediatr (Phila)* 1986; 25:412-5.
126. Anand KJS. Hormonal and metabolic functions of neonates and infants undergoing surgery. *Curr Opin Cardiol* 1986; 1:681-9.
127. Anand KJS, Brown MJ, Bloom SR, Aynsley-Green A. Studies on the hormonal regulation of fuel metabolism in the human newborn infant undergoing anaesthesia and surgery. *Horm Res* 1985; 22:115-28.
128. Mihne EMG, Elhott IM, Pearson DT, Holden MP, Orskov H, Alberti KGMM. The effect on intermediary metabolism of open-heart surgery with deep hypothermia and circulatory arrest: in infants of less than 10 kilograms body weight. *Perfusion* 1986; 1:29-40.
129. Obara H, Sugiyama D, Maekawa N, et al. Plasma cortisol levels in paediatric anaesthesia. *Can Anaesth Soc J* 1984; 31:24-7.
130. Srinivasan G, Jain R, Pithes KS, Kannan CR. Glucose homeostasis during anaesthesia and surgery in infants. *J Pediatr Surg* 1986; 21: 718-21.
131. Anand KJS, Brown MJ, Causon RC, Christofides ND, Bloom SR, Aynsley-Green A. Can the human neonate mount an endocrine and metabolic response to surgery? *J Pediatr Surg* 1985; 20:41-8.
132. Pinter A. The metabolic effects of anaesthesia and surgery in the newborn infant: changes in the blood levels of glucose, plasma free fatty acids, α amino-nitrogen, plasma amino-acid ratio and lactate in the neonate. *Z Kinderchir* 1973; 12:149-62.
133. Elphick MC, Wilkinson AW. The effects of starvation and surgical injury on the plasma levels of glucose, free fatty acids, and neutral lipids in newborn babies suffering from various congenital anomalies. *Pediatr Res* 1981; 15:313-8.
134. Anand KJS, Aynsley-Green A. Measuring the severity of surgical stress in newborn infants. *J Pediatr Surg* (in press).
135. *Idem*. Does the newborn infant require anesthesia during surgery? Answers from a randomised trial of halothane anesthesia. *Pain Res Clin Manage* (in press).
136. Anand KJS, Sippell WG, Aynsley-Green A. Randomised trial of fentanyl anaesthesia in preterm neonates undergoing surgery: effects on the stress response. *Lancet* 1987; 1:243-8.
137. Anand KJS, Carr DB, Hickey PR. Randomized trial of high-dose sufentanil anesthesia in neonates undergoing cardiac surgery: hormonal and hemodynamic stress responses. *Anesthesiology* 1987; 67:A501, abstract.
138. Anand KJS, Hickey PR. Randomized trial of high-dose sufentanil anesthesia in neonates undergoing cardiac surgery: effects on the metabolic stress response. *Anesthesiology* 1987; 67:A502, abstract.
139. Anders TF, Sachar EJ, Kream J, Roffwarg HP, Hellman L. Behavioral state and plasma cortisol response in the human newborn. *Pediatrics* 1970; 46:532-7.
140. Tennes K, Carter D. Plasma cortisol levels and behavioral states in early infancy. *Psychosom Med* 1973; 35:121-8.
141. Lipsitt LP, Levy N. Electroretinal threshold in the neonate. *Child Dev* 1959; 30:547-54.
142. Dockery FC, Rice C. Responses of newborn infants to pain stimulation. *Ohio State Univ Stud Contrib Psychol* 1934; 12:82-93.
143. Sherman M, Sherman IC. Sensori-motor responses in infants. *J Comp Psychol* 1925; 5:53-68.
144. Rich EC, Marshall RE, Volpe JJ. The normal neonatal response to pinprick. *Dev Med Child Neurol* 1974; 16:432-4.
145. Franck LS. A new method to quantitatively describe pain behavior in infants. *Nurs Res* 1986; 35:28-31.
146. Fitzgerald M, Shaw A, MacIntosh N. The postnatal development of the cutaneous flexor reflex: a comparative study in premature infants and newborn rat pups. *Dev Med Child Neurol* (in press).
147. Ekman P, Oster H. Facial expressions of emotion. *Annu Rev Psychol* 1979; 30:527-54.
148. Izard CE, Huebner RR, Risser D, McGinnes GC, Dougherty LM. The young infant's ability to produce discrete emotional expressions. *Dev Psychol* 1980; 16:132-40.
149. Grunau RVE, Craig KD. Pain expression in neonates: facial action and cry. *Pain* 1987; 28:395-410.
150. Melzack R, Wall PD. Pain mechanisms: a new theory. *Science* 1965; 150:971-9.
151. Lester BM. A biosocial model of infant crying. In: Lipsitt L, ed. *Advances in infancy research*. New York: Ablex, 1984:167-212.
152. Levine JD, Gordon NC. Pain in prelingual children and its evaluation by pain-induced vocalisation. *Pain* 1982; 14:85-93.

153. Wasz-Höckert O, Lind J, Vuorenkoski V. The infant cry: a spectrographic and auditory analysis. *Clin Dev Med* 1968; 2:9-42.
154. Michelsson K, Raes J, Thoden C-J, Wasz-Höckert O. Sound spectrographic cry analysis in neonatal diagnostics: an evaluative study. *J Phonetics* 1982; 10:79-88.
155. Zeskind PL, Sale J, Maio ML, Huntington L, Weisman JR. Adult perceptions of pain and hunger cries: a synchrony of arousal. *Child Dev* 1985; 56:549-54.
156. Boukydis CFZ. Perception of infant crying as an interpersonal event. In: Lester BM, Boukydis CFZ, eds. *Infant crying: theoretical and research perspectives*. New York: Plenum Press, 1985:187-215.
157. Murry T, Amundson P, Hollien H. Acoustical characteristics of infant cries: fundamental frequency. *J Child Lang* 1977; 3:321-8.
158. Wasz-Höckert O, Partanen T, Vuorenkoski V, Valanne E, Michelsson K. Effect of training on ability to identify preverbal vocalizations. *Dev Med Child Neurol* 1984; 6:393-6.
159. Gladding ST. Effects of training versus non-training in identification of cry-signals: a longitudinal study. *Percept Mot Skills* 1979; 48:752-4.
160. Johnston CC, O'Shaughnessy D. Acoustical attributes of infant pain cries: discriminating features. *Pain* 1987; Suppl 4:233.
161. Wolff PH. The natural history of crying and other vocalizations in early infancy. In: Foss BM, ed. *Determinants of infant behaviour*. Vol. 4. London: Methuen, 1969:38-295.
162. Wasz-Höckert O, Michelsson K, Lind J. Twenty-five years of Scandinavian cry research. In: Lester BM, Boukydis CFZ, eds. *Infant crying: theoretical and research perspectives*. New York: Plenum Press, 1985: 83-104.
163. Michelsson K, Järvenpää A-L, Rinne A. Sound spectrographic analysis of pain cry in preterm infants. *Early Hum Dev* 1983; 8:141-9.
164. Friedman SL, Zahn-Waxler C, Radke-Yarrow M. Perceptions of cries of full-term and preterm infants. *Infant Behav Dev* 1982; 5:161-73.
165. Michelsson K, Sirviö P, Wasz-Höckert O. Pain cry in full-term asphyxiated newborn infants correlated with late findings. *Acta Paediatr Scand* 1977; 66:611-6.
166. Fisiichelli VR, Coxie M, Rosenfeld L, Haber A, Davis J, Karelitz S. The phonetic content of the cries of normal infants and those with brain damage. *J Psychol* 1966; 64:119-26.
167. Wasz-Höckert O, Koivisto M, Vuorenkoski V, Partanen TJ, Lind J. Spectrographic analysis of pain cry in hyperbilirubinemia. *Biol Neonate* 1971; 17:260-71.
168. Michelsson K, Sirviö P, Wasz-Höckert O. Sound spectrographic cry analyses of infants with bacterial meningitis. *Dev Med Child Neurol* 1977; 19:309-15.
169. Porter FL, Miller RH, Marshall RE. Neonatal pain cries: effect of circumcision on acoustic features and perceived urgency. *Child Dev* 1986; 57:790-802.
170. Fisiichelli VR, Karelitz S, Fisiichelli RM, Cooper J. The course of induced crying activity in the first year of life. *Pediatr Res* 1974; 8:921-8.
171. Ende RN, Harmon RJ, Metcalf D, Koenig KL, Wagonfeld S. Stress and neonatal sleep. *Psychosom Med* 1971; 33:491-7.
172. Anders TF, Chaitman RJ. The effects of circumcision on sleep-wake states in human neonates. *Psychosom Med* 1974; 36:174-9.
173. Brackbill Y. Continuous stimulation and arousal level in infancy: effects of stimulus intensity and stress. *Child Dev* 1975; 46:364-9.
174. Marshall RE, Stratton WC, Moore JA, Boxerman SB. Circumcision. I. Effects upon newborn behaviour. *Infant Behav Dev* 1980; 3:1-14.
175. Richards MPM, Bernal JF, Brackbill Y. Early behavioral differences: gender or circumcision? *Dev Psychobiol* 1976; 9:89-95.
176. Dixon S, Snyder J, Holve R, Bromberger P. Behavioural effects of circumcision with and without anesthesia. *J Dev Behav Pediatr* 1984; 5:246-50.
177. Als H, Lawhon G, Brown E, et al. Individualized behavioral and environmental care for the very low birth weight preterm infant at high risk for bronchopulmonary dysplasia: neonatal intensive care unit and developmental outcome. *Pediatrics* 1986; 78:1123-32.
178. Darwin C. *The expression of the emotions in man and animals*. London: John Murray, 1872:65-7.
179. Kazdin AE. Assessing the clinical or applied importance of behavior change through social validation. *Behav Modif* 1977; 1:427-52.
180. D'Apolito K. The neonate's response to pain. *Am J Matern Child Nurs* 1984; 9:256-8.
181. Marshall RE, Porter FL, Rogers AG, Moore JA, Anderson B, Boxerman SB. Circumcision. II. Effects upon mother-infant interaction. *Early Hum Dev* 1982; 7:367-74.
182. Osofsky JD. Neonatal characteristics and mother-infant interaction in two observational situations. *Child Dev* 1976; 47:1138-47.
183. Lipsitt LP. The study of sensory and learning processes of the newborn. *Clin Perinatol* 1977; 4:163-86.
184. Stone LJ, Smith H, Murphy LB, eds. *The competent infant: research and commentary*. New York: Basic Books, 1973.
185. Moscovitch M. Infant memory: its relation to normal and pathological memory in humans and other animals. New York: Plenum Press, 1984.
186. Kolata G. Early signs of school age IQ. *Science* 1987; 236:774-5.
187. James E. Pain. *Int J Psychoanal* 1957; 38:255.
188. Squire LR. Mechanisms of memory. *Science* 1986; 232:1612-9.
189. Will B, Schmitt P, Dalrymple-Alford J. Brain plasticity, learning and memory: historical background and conceptual perspectives. *Adv Behav Biol* 1985; 28:1-11.
190. Bischof H-J. Influence of developmental factors on imprinting. *Adv Behav Biol* 1985; 28:51-9.
191. Fillion TJ, Blass EM. Infantile experience with suckling odors determines adult sexual behavior in male rats. *Science* 1986; 231:729-31.
192. Wachter-Shikora NL. Pain theories and their relevance to the pediatric population. *Issues Compr Pediatr Nurs* 1981; 5:321-6.
193. Dale JC. A multidimensional study of infants' responses to painful stimuli. *Pediatr Nurs* 1986; 12:27-31.
194. Reynolds OE, Hutchins HC. Reduction of central hyper-irritability following block anesthesia of peripheral nerve. *Am J Physiol* 1948; 152:658-62.
195. Janov A. *The anatomy of mental illness*. New York: Putnam's Sons, 1971.
196. Holden EM. Primal pathophysiology. *J Psychosom Res* 1977; 21:341-50. abstract.
197. Hatch DJ. Analgesia in the neonate. *Br Med J* 1987; 294:920.
198. Berry FA, Gregory GA. Do premature infants require anesthesia for surgery? *Anesthesiology* 1987; 67:291-3.
199. Booker PD. Postoperative analgesia for neonates? *Anaesthesia* 1987; 42:343-4.
200. Pain, anesthesia and babies. *Lancet* 1987; 2:543-5.
201. Yaster M. Analgesia and anesthesia in neonates. *J Pediatr* 1987; 111: 394-6.

Controversies

Rationale for Banning Abortions Late in Pregnancy

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

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

Partial-Birth Abortion (Intact D&X)

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

See also pp 724, 740, and 747.

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

These accounts indicate that the estimates of performing intact D&X have been grossly understated. The absence of accurate data is at least partly due to the erratic nature of the

data collection process. The Centers for Disease Control and Prevention (CDC), Atlanta, Ga, collects annual abortion data, but these data are incomplete for several reasons. First, all states do not provide abortion-related information to the CDC. Second, data gathered vary widely from state to state, with some states lacking information on as many as 40% to 50% of abortions performed within their jurisdictions. Third, the categories CDC uses to report the method of abortion do not differentiate between dilation and evacuation (D&E) and intact D&X.^{6,8}

Conflicting information about intact D&X and its frequency catalyzed prominent medical organizations to evaluate the procedure. In 1996, the American College of Obstetricians and Gynecologists (ACOG) convened a special committee to review it. According to the ACOG panel, intact D&X has been defined to consist of 4 elements⁹: (1) the deliberate dilation of the cervix, usually over a sequence of days; (2) instrumental conversion of the fetus to a footling breech; (3) breech extraction of the body, excepting the head; and (4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

An ACOG policy statement emanating from the review declared that the select panel "could identify no circumstances under which this procedure . . . would be the only option to save the life or preserve the health of the woman" and that "an intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision."⁹ However, no specific examples of circumstances under which intact D&X would be the most appropriate procedure were given.

Maternal Considerations.—There exist no credible studies on intact D&X that evaluate or attest to its safety. The procedure is not recognized in medical textbooks nor is it taught in medical schools or in obstetrics and gynecology residencies. Intact D&X poses serious medical risks to the mother. Patients who undergo an intact D&X are at risk for the potential complications associated with any surgical midtrimester termination, including hemorrhage, infection, and uterine perforation. However, intact D&X places these patients at increased risk of 2 additional complications. First, the risk of uterine rupture may be increased. An integral part of the D&X procedure is an internal podalic version, during which the physician instrumentally reaches into the uterus, grasps the fetus' feet, and pulls the feet down into the cervix, thus converting the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to *Williams Obstetrics*, "there are very few, if any, indications for internal podalic version other than for delivery of a second twin."¹⁰

From Northwestern University Medical School and Evanston Northwestern Healthcare (Dr Sprang) and the Division of Maternal-Fetal Medicine, Evanston Northwestern Healthcare (Dr Neerhof), Evanston, Ill.
Reprints: M. LeRoy Sprang, MD, Evanston Northwestern Healthcare, 1000 Central St, Suite 700, Evanston, Ill. 60201 (e-mail: mneerhof@nwu.edu).

Controversies section editor: Phil B. Fontanarosa, MD, Senior Editor.

The second potential complication of intact D&X is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. These risks have not been adequately quantified.

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

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

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

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

Beyond the argument of potential viability, many prochoice organizations and individuals assert that a woman should maintain control over that which is part of her own body (ie, the autonomy argument). In this context, the physical position of the fetus with respect to the mother's body becomes relevant. However, once the fetus is outside the woman's body, the autonomy argument is invalid. The intact D&X procedure involves literally delivering the fetus so that only the head remains within the cervix. At this juncture, the fetus is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution. What happens when,

States With Bans on Intact Dilation and Extraction*

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

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

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

Professional, Legislative, and Public Concerns.—An extraordinary medical consensus has emerged that intact D&X is neither necessary nor the safest method for late-term abortion. In addition to American Medical Association (AMA) and ACOG policy statements, Warren Hern, MD, author of *Abortion Practice* has questioned the efficacy of intact D&X. "I have very serious reservations about this procedure. . . . You really can't defend it. . . . I would dispute any statement that this is the safest procedure to use." Hern states that turning the fetus to a breech position is "potentially dangerous."¹⁵ In Illinois, a November 1996 survey of all physicians in Sangamon County (the city of Springfield and surrounding area) demonstrated that 91% of more than 180 respondents supported a ban of intact D&X (Perry M. Santos, MD, MS, written communication, November 5, 1996). In April 1997, more than 200 physician delegates who attended the Illinois State Medical Society annual meeting voted to support a ban on intact D&X. The AMA established its own committee to study partial-birth abortion and adopted the recommendations of that committee's report, as well as an official position of support for HR 1122, federal legislation banning partial-birth abortions that the AMA worked to improve and clarify prior to passage.¹⁶

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

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

Termination of Late-term Pregnancies

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

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

Maternal Considerations.—The risk of maternal mortality and morbidity associated with termination of pregnancy increases with advancing gestational age. Induced midtrimester abortion accounts for an estimated 10% to 20% of all abortions, and for two thirds of abortion-related major complications especially maternal mortality.²² Women undergoing legal abortions during the first 8 weeks of gestation have the lowest risk of death (0.4 per 100 000 abortions), whereas procedures performed beyond 20 completed weeks of gestation are associated with the highest risk (10.4 per 100 000 abortions).²³ On average, the mortality from induced abortions increases 30% with each passing week of gestation.²⁴ At 21 weeks or more, the risk of death from abortion is 1 in 6000 and exceeds the risk of maternal death from childbirth, 1 in 13 000.²⁵ The risk of abortion-related maternal morbidity also increases with advancing gestational age. Among the immediate complications of abortions, the incidence of hemorrhage, laceration of the cervix, and uterine perforation is 1.2% at 8 weeks' gestation but increases to 3.6% at 15 weeks and beyond.²⁶ The risk of uterine perforation and resultant visceral injury also increases as gestation advances.²⁷ The risk of complications requiring hospital admission increases from 5.5% for abortions performed before 14 weeks' gestation to 11.2% for abortions performed subsequent to 14 weeks.²⁸

Termination of pregnancy at more advanced gestational ages may predispose to infertility from endometrial scarring or adhesion formation (documented in 1 study in 23.1% of patients with induced midtrimester abortions²⁹) and from pelvic infections, which occur in 2.8% to 25% of patients following midtrimester terminations.^{30,31} Dilation and evacuation procedures commonly used in induced midtrimester abortion may lead to cervical incompetence, which predisposes to an increased risk of subsequent spontaneous abortion, especially in the midtrimester.^{32,33} Cervical incompetence is more prevalent after midtrimester

termination of pregnancy than first trimester termination because the cervix is dilated to a much greater degree.³⁴

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

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

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

A second ethical principle concerns beneficence, ie, one individual's obligation to act for the benefit of another. As the fetus matures, the majority of individuals would extend greater and greater beneficence to the fetus. According to Stubblefield, "Inevitably, there must be a gestational age limit for abortion. I would avoid performing abortions after 22 weeks unless the mother's life were endangered or unless the fetus had major malformations so severe as to preclude prolonged survival. . . . When termination of pregnancy will be undertaken at or after 23 weeks because of serious risk for maternal health, the fetus should be considered as well."³⁵

A third ethical principle concerns justice and denotes balancing the rights of distinct individuals. As the fetus develops, more and more people recognize that there are 2 distinct individuals involved. To take a position that would make the value of the fetus depend solely on private choice and on the individual exercise of power fails to understand the importance of communal safeguards against capricious power over life and death.³⁶

Conclusions

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

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

1997, the ACOG Executive Board supplemented its policy on abortion toward this end, stating, "ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman."³⁸

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

References

- Jouzaits C. Foes line up anew on late abortions. *Chicago Tribune*. February 27, 1997:3.
- Seelye KQ. House, by broad margin, backs ban on late type of abortion. *New York Times*. March 21, 1997:A1, A14.
- Gianelli DM. Abortion rights leader urges end to "half truths." *American Medical News*. March 3, 1997:4, 55, 56.
- Gianelli DM. Bill banning partial-birth abortions goes to Clinton. *American Medical News*. April 15, 1996:9, 10.
- Statement of representative Charles T. Canady (R-Fla). Congressional Record. July 24, 1996.
- Koonin LM, Smith JC, Ramick M, Green CA. Abortion surveillance—United States, 1992. *MMWR Morb Mortal Wkly Rep*. 1996;45(SS-3):1-36.
- Atraash HK, Lawson HW, Smith JC. Legal abortion in the US: trends and mortality. *Contemp Obstet Gynecol*. 1990;35:58-69.
- Issues in Brief: *The Limitations of US Statistics on Abortion*. New York, NY: Alan Guttmacher Institute; 1997.
- ACOG statement of policy. Approved by the executive board January 12, 1997 and distributed to ACOG chairs.
- Cunningham FG, MacDonald PC, Gant NF, et al. *Williams Obstetrics*. 20th ed. Stamford, Conn: Appleton & Lange; 1997:507.
- Giannakouloupinos X, Sepulveda W, Kourris P, et al. Fetal plasma cortisol and D-endorphin response to intrauterine needling. *Lancet*. 1994;344:77-81.
- Teixeria J, Fogliani R, Giannakouloupinos X, et al. Fetal haemodynamic stress response to invasive procedures. *Lancet*. 1996;347:624.
- Report of the American Veterinary Medical Association panel on euthanasia. *J Am Vet Med Assoc*. 1998;202:226-249.
- Allen MC, Donohue PK, Dusman AE. The limit of viability: neonatal outcome of infants born at 22 to 25 weeks' gestation. *N Engl J Med*. 1993;329:1587-1601.
- Gianelli DM. Outlawing abortion method. *American Medical News*. November 20, 1996:3, 70-72.
- Late-Term Pregnancy Termination Techniques. Chicago, Ill: American Medical Association; 1997. Report 26 of the AMA Board of Trustees (A-97).
- Status of Bans on "Partial-Birth Abortion" and Other Abortion Methods. New York, NY: Center for Reproductive Law and Policy; June 29, 1998.
- Governor Asks to Ban Partial-Birth Abortions: Strikes Clause That Would Give Biological Fathers Standing (news release). Springfield, Ill: Office of Gov Jim Edgar; July 17, 1997.
- The lies that zealots tell [editorial]. *Chicago Tribune*. March 3, 1997:14.
- Hentoff N. Close to infanticide. *Washington Post*. August 30, 1996:A31.
- Gianelli DM, Kent C. The view from Mount Koop. *American Medical News*. August 19, 1996:3.
- Topposada M, Imani AAA. Intrauterine administration of drugs for termination of pregnancy in the second trimester. *Baillieres Clin Obstet Gynecol*. 1990;4:347-349.
- Lawson HW, Frye A, Atrash HK, et al. Abortion mortality, United States, 1972 through 1987. *Am J Obstet Gynecol*. 1994;171:1365-1372.
- Tietze C. *Induced Abortion: A World Wide View*. New York, NY: Population Council; 1983:83.
- Facta in Brief: *Induced Abortion*. New York, NY: Alan Guttmacher Institute; 1996.
- Castadot RG. Pregnancy termination: techniques, risks, and complications and their management. *Fertil Steril*. 1986;45:5-17.
- Stubblefield PJ. Pregnancy termination. In: Gabbe SG, Niebyl JR, Simpson JL, eds. *Obstetrics, Normal and Problem Pregnancies*. 3rd ed. New York, NY: Churchill Livingstone; 1996:1243-1278.
- Sykes P. Complications of termination of pregnancy: a retrospective study of admissions to Christchurch Women's Hospital, 1989 and 1990. *N Z Med J*. 1993;106:83-85.
- Lurie S, Appleman Z, Katz Z. Curettage after midtrimester termination of pregnancy: is it necessary? *J Reprod Med*. 1991;35:796-798.
- Lurie S, Katz Z, Insler V. Midtrimester induction of abortion: comparison of extraovular prostaglandin E₂ and intra-anniotic prostaglandin F_{2α}. *Contraception*. 1993;47:476-481.
- Filshie M, Guillebaud J. *Contraception: Science and Practice*. London, England: Butterworths; 1989:250-274.
- Hogue CJR, Cates W Jr, Tietze C. The effects of induced abortion on subsequent reproduction. *Epidemiol Rev*. 1982;4:96-94.
- Laferla JJ, ed. Termination of pregnancy. *Clin Obstet Gynecol*. 1986;13:1-160.
- Hawkins DF. *Elder M. Human Fertility Control, Theory, and Practice*. London, England: Butterworths; 1979:237-260.
- Callahan D. The abortion debate: can this chronic public illness be cured? In: Chervenak FA, McCullough LD, eds. *Clin Obstet Gynecol*. 1992;35:783-791.
- ACOG Statement of Policy. Approved by executive board and published in ACOG newsletter, July 1997.
- Padawer R. "Partial-birth" battle changing public views. *USA Today*. November 17, 1997:17A.
- Gianelli DM. Medicine adds to debate on late-term abortion. *American Medical News*. March 3, 1997:3, 54-56.

AMA PolicyFinder – HOD, A-99

H-5.982 Late-Term Pregnancy Termination Techniques

(1) The term 'partial birth abortion' is not a medical term. The AMA will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in *Roe v. Wade*, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

(5) The AMA urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each

gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

(6) The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment, education, and contraceptive methods. (BOT Rep. 26, A-97)

Material Submitted by Dr. Curtis Cook



**ISSUES IN
LAW & MEDICINE**

***Partial-Birth Abortion:
The Final Frontier of
Abortion Jurisprudence***

*James Bopp, Jr., J.D.
and Curtis R. Cook, M.D.*

VERBATIM

Partial-Birth Abortion Ban Act of 1997

Testimony of Dr. Curtis R. Cook, M.D.

***Effects of Anesthesia During a
Partial-Birth Abortion***

VOL. 14, NO. 1

SUMMER 1998

*A Publication of the National Legal Center for the Medically Dependent & Disabled, Inc.,
the Horatio R. Storer Foundation, Inc., and the American Academy of Medical Ethics, Inc.*

A peer-reviewed publication of the National Legal Center for the Medically Dependent & Disabled, Inc., the Horatio R. Storer Foundation, Inc., and the American Academy of Medical Ethics, Inc.

Editor-in-Chief
James Bopp, Jr., J.D.

Managing Editor
Larry G. Liggett

Associate Editor
Thomas J. Marzen, J.D.

Contributing Editor
Vincent M. Rue, Ph.D.

Contributing Editor
Curtis E. Harris, M.D.

Rates/Correspondence. The annual subscription rate is \$39 for individuals, \$79 for institutions, for four issues. Single issue \$14.75.

Please address all correspondence, including Letters to the Editor, to: *Issues in Law & Medicine*, Office of Publications, 3 South 6th Street, Terre Haute, IN 47807-3510.

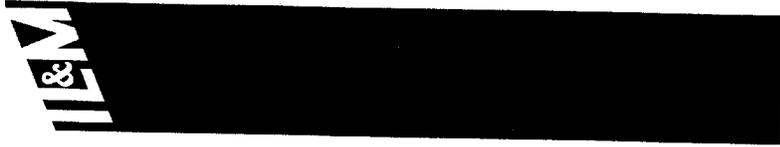
Issues in Law & Medicine (ISSN 8756-8160) is published quarterly, four issues per year, by the National Legal Center for the Medically Dependent & Disabled, Inc., the Horatio R. Storer Foundation, Inc., and the American Academy of Medical Ethics, Inc.

Copyright © 1998 by the National Legal Center for the Medically Dependent & Disabled, Inc.

All rights reserved. No part of this journal may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without written permission from the Publisher.

Issues in Law & Medicine is listed in the following: *Indexes—Index Medicus; Index to Legal Periodicals; Current Contents/Social & Behavioral Sciences; Current Law Index; Ethics Index; Hospital Literature Index; International Nursing Index; and Social Sciences Citation Index; Databases—MEDLARS/MEDLINE; WESTLAW; BIOETHICSLINE; BIOSIS; Child Abuse and Neglect; Legal Resource Index; Legal Trac; PsycALERT; and Research Alert; and Abstracted in—AIDS Literature & News Review; Bioethics Literature Review; BioLaw; Clearinghouse Review; Hastings Center Report; Law, Medicine & Health Care; Psychological Abstracts; and Specialty Law Digest: Health Care Cases.*

Issues in Law & Medicine is printed on acid-free paper.



ISSUES IN LAW & MEDICINE

CONTENTS

Preface	iii
Articles	
Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence <i>James Bopp, Jr., J.D., and Curtis R. Cook, M.D.</i>	3
Verbatim	
Partial-Birth Abortion Ban Act of 1997	61
Testimony of Dr. Curtis R. Cook, M.D.	65
Effects of Anesthesia During a Partial-Birth Abortion	71
Nota Bene	
<i>Evans v. Kelley</i> <i>Barry A. Bostrom, J.D.</i>	103
Abstracts	109
Novi Libri	117

VOL. 14, NO. 1

SUMMER 1998

Dr. Norig Ellison is the president of the American Society of Anesthesiologists. He currently serves as the clinical director of the department of anesthesia at the University of Pennsylvania Hospital and is a professor and vice chair of the department of anesthesia at the University of Pennsylvania School of Medicine.

Following Dr. Ellison, we will hear from Dr. David Birnbach. Dr. Birnbach is the president-elect of the Society of Obstetric Anesthesia and Perinatology. Dr. Birnbach is also director of obstetric anesthesiology at St. Luke's Roosevelt Hospital Center at Columbia University.

Dr. David Chesnut is chairman of the department of anesthesiology at the University of Alabama-Birmingham Hospital. Dr. Chesnut is a professor in both the department of obstetrics and gynecology and the department of anesthesiology at the University of Alabama-Birmingham School of Medicine. He also served as editor of the medical textbook, "Obstetric Anesthesia: Principles and Practice."

The final witness on our second panel today will be Dr. Jean Wright. Dr. Wright is the medical director at Eggleston Children's Hospital at Emory University. She is also an associate professor in the department of pediatrics and anesthesiology at Emory.

Again, thank you for being here. Dr. Ellison.

**Statement of Norig Ellison, M.D., President,
American Society of Anesthesiologists**

Dr. ELLISON. Chairman Canady, members of the subcommittee, my name is Norig Ellison. I am the president of the American Society of Anesthesiologists, a professional society consisting of over 34,000 anesthesiologists and other scientists engaged or particularly interested in the medical practice of anesthesiology. I am also professor and vice chair of the department of anesthesia at the University of Pennsylvania School of Medicine in Philadelphia and a staff anesthesiologist at the hospital of the University of Pennsylvania.

I appear here today for one purpose and one purpose only, to take issue with the testimony of Dr. James T. McMahon before this subcommittee last June. According to his written testimony, of which I have a copy, Dr. McMahon stated that anesthesia given to the mother as part of dilation and extraction abortion procedure eliminates any pain to the fetus and that a medical coma is induced in the fetus causing, quote, "a neurologic fetal demise, or in lay terms, brain death," end quote.

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary, even life-saving, medical procedures totally unrelated to the birthing process due

to misinformation regarding the effect of anesthetics on the fetus. Annually, over 30,000 pregnant women are anesthetized for such necessary procedures. Although it is certainly true that some analgesic or anesthetic medication given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant women are routinely heavily sedated or anesthetized during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone brain death. In my medical judgment, it would be necessary, in order to achieve neurologic demise of the fetus in a partial-birth abortion, to anesthetize the mother to such a degree as to place her own health in serious jeopardy.

As you are aware, Mr. Chairman, I gave similar testimony to a Senate committee on November 17. That testimony received wide circulation in anesthesiology circles and to a lesser extent in the lay press. You may be interested in the fact that, since my appearance, not one single anesthesiologist or other physician has contacted me to dispute my stated conclusion. Indeed, two eminent obstetric anesthesiologists and one equally eminent pediatric anesthesiologist appear here with me today testifying on their own behalf and not as ASA representatives. I am pleased to note that their testimony reaches the same conclusions that I have expressed.

I thank you for your attention, and I would be happy to respond to your questions.

* * *

Mr. CANADY. Thank you, Dr. Ellison. Dr. Birnbach.

**Statement of David J. Birnbach, M.D., Director of Obstetric
Anesthesiology, St. Luke's-Roosevelt Hospital Center**

Dr. BIRNBACH. Mr. Chairman, members of the subcommittee, my name is David Birnbach, M.D., and I am presently director of obstetric anesthesiology at St. Luke's-Roosevelt Hospital Center, which is a teaching hospital of Columbia University College of Physicians and Surgeons in New York City. I am also president-elect of the Society for Obstetric Anesthesia and Perinatology, which is the society which represents my subspecialty.

I am here today to take issue with the previous testimony before committees of the Congress that suggest this issue because I am a practicing obstetric anesthesiologist. Since completing my anesthesiology and obstetric anesthesiology training at Harvard University, I've administered analgesia to more than 5,000 women in labor and anesthesia to over 1,000 women undergoing cesarean section.

I have also provided anesthesia to approximately 200 patients who were carrying fetuses of less than 30 weeks' gestation, and who needed

emergency, nonobstetric surgery during pregnancy. These operations have included appendectomies, gall bladder surgeries, orthopedic procedures, uterine and ovarian procedures including removal of malignant tumors, breast surgery, neurosurgery, and major cardiac surgery. The anesthetics which I have administered have included general, epidural, spinal, and local. The patients have included both healthy patients as well as very sick pregnant patients. Although I often use spinal and epidural anesthesia, I also administer general anesthesia, and, on occasion, I have needed to administer, quote, unquote, "huge doses of general anesthesia" in order to allow the surgeons to perform cardiac or neurosurgery.

In addition, I believe that I am especially qualified to discuss the effect of maternally-administered anesthesia on the fetus because I am one of only a handful of anesthesiologists who has administered anesthesia to a pregnant patient undergoing in utero fetal surgery which allowed me to watch the fetus as I administered general anesthesia to the mother. A review of the experiences that my associates and I had while administering general anesthesia to a mother while a surgeon operated on the fetus was published in the *Journal of Clinical Anesthesia*.

Safe doses of anesthesia to the mother certainly did not cause fetal demise when used for these operations. Despite my extensive experience with providing anesthesia to the pregnant patient, I have never witnessed a case of fetal demise that could be attributed to an anesthetic. Although some drugs which we administered to the mother may cross the placenta and affect the fetus, in my medical judgment, fetal demise is definitely not a consequence of a properly-administered anesthetic. In order to cause fetal demise, it would be necessary to give the mother dangerous and life-threatening doses of anesthesia. This is not the way we practice anesthesiology in the United States.

Mr. Chairman, I am deeply concerned that the previous congressional testimony and the widespread publicity that has been given this issue will cause unnecessary fear and anxiety in pregnant patients and may cause some to unnecessarily delay emergency surgery.

As an example, several newspapers have turned this into a quote, unquote, "a controversy" and have said that fetal demise occurs after anesthesia. Evidence that patients are still receiving this misinformation regarding fetal effects of anesthesia can be seen by review of an article that a pregnant patient brought into me on labor and delivery last week from *Marric Claire* magazine. And she highlighted a line that says, "the mother is put under general anesthetic which reaches the fetus through her bloodstream. By the time the cervix is sufficiently dilated, the fetus is overdosed on the anesthetic and is brain dead." Now this patient came in saying, "Is that the kind of anesthesia you're giving me?"

Despite the previous testimony of Dr. Ellison, I have yet to see an article in the lay press that states in no uncertain terms that anesthesia when used properly does not harm the fetus.

This supposed controversy regarding the effects of anesthesia on the fetus must be finally and definitely put to rest. There is absolutely no scientific or clinical evidence that a properly-administered, maternal anesthetic causes fetal demise. To the contrary, there are hundreds of scientific articles which demonstrate the fetal safety of currently used anesthetics.

In conclusion, I would like to say that I believe that I have a responsibility as a practicing obstetric anesthesiologist to refute any testimony that suggests that maternally-administered anesthesia causes fetal demise. Pregnant women must get the message that, should they need anesthesia for surgery or analgesia for labor, that they may do so without worrying about the effects on their unborn child.

Thank you. I'm happy to respond to your questions.

* * *

Mr. CANADY: Thank you, Dr. Birnbach. Dr. Chestnut.

Statement of David H. Chestnut, M.D., Chairman, Department of Anesthesiology, University of Alabama At Birmingham

Dr. CHESTNUT: Mr. Chairman, members of the subcommittee, my name is David Chestnut. I am professor and chair of the department of anesthesiology and also a professor of obstetrics and gynecology at the University of Alabama School of Medicine. I am grateful for the opportunity to testify this morning on the effects of anesthesia administered to a mother during a partial-birth abortion.

Some proponents of this procedure have stated that the fetus dies of an overdose of anesthesia given to the mother and that the anesthesia induces fetal brain death in a matter of minutes. This is nonsense. There is no scientific basis for these claims.

As many as 75,000 pregnant women undergo anesthesia and surgery each year in the United States. A large number of these procedures are performed during the second and third trimesters of pregnancy. The vast majority of these women subsequently deliver a healthy baby.

In his description of dilation and extraction for late second-trimester abortion, Dr. Martin Haskell stated that he administers 1 percent lidocaine as the standard anesthesia. The fetus is unaffected by clinical doses of local anesthetic administered to the mother. In the United States, most newborn babies are exposed to local anesthetic drugs during labor and delivery. These infants cannot be distinguished from newborn infants not exposed to

local anesthetics. Rational use of local anesthetic drugs does not affect the fetus.

Dr. Lewis Koplik stated that he gives the mother small doses of Versed and fentanyl during performance of second-trimester abortion. In the United States, general anesthesia is administered to approximately 20 percent of women who undergo cesarean section. Administration of anesthetic drugs in doses larger than those described by Dr. Koplik has little effect on the fetus. Some of these infants exhibit transient, mild somnolence at delivery, but by 5 minutes of life, these infants typically cannot be distinguished from those infants whose mothers did not receive general anesthesia.

Dr. Koplik suggested that Dr. McMahon administered larger doses of Versed and fentanyl. Dr. Mary Campbell stated that this regimen is the drug combination most frequently used for late-term D & X abortion.

My comments are sevenfold. One, it is unlikely that a physician who is not trained as an anesthesiologist would give such large dose of Versed and fentanyl to any patient.

Two, it is unlikely that any physician would give such large doses of Versed and fentanyl to any patient in an outpatient setting. Administration of these doses of Versed and fentanyl would place the mother at risk for respiratory arrest.

Three, administration of these large doses of Versed and fentanyl would not result in fetal death or fetal neurologic demise unless there was serious compromise of the mother's health. Stated another way, these doses of Versed and fentanyl would not kill the fetus unless the mother was killed or injured first.

Four, administration of these drugs may provide some degree of fetal pain relief, but the extent to which this renders any procedure pain free is unknown. Obstetricians observe fetal withdrawal responses, during performance of invasive procedures in utero. These responses suggest that the fetus is capable of experiencing pain even during the second trimester of pregnancy.

Five, Dr. Campbell stated that administration of large doses of Versed and fentanyl depress fetal respirations. This is irrelevant because the fetus does not depend on his or her respiratory efforts to maintain oxygenation.

Six, Dr. Campbell stated that administration of these doses of drugs preclude fetal respiration afterward. This need not affect neonatal outcome. After delivery, the physician provides respiratory support and reverses the narcotic effect with naloxone.

Seven, I am concerned regarding the suggestion that any physician might deliberately give any patient an overdose of anesthetic drugs. Such practice clearly would endanger the life of the mother.

In summary, these false claims regarding the effects of maternal anesthesia on the fetus may cause some pregnant women to delay necessary and even life-saving surgery during pregnancy. Further, these false claims may prompt other women to deny themselves adequate pain relief during labor and delivery.

Mr. Chairman, anesthesia during pregnancy is safe for the mother and the baby.

I will be happy to respond to your questions.

* * *

Mr. CANADY. Thank you, Doctor. Dr. Wright.

Statement of Jean A. Wright, M.D., Medical Director,
Egleston Children's Hospital, Emory University

Dr. WRIGHT. Mr. Chairman and members of the subcommittee, my name is Jean Wright, and I am an associate professor of pediatrics and anesthesiologist at Emory School of Medicine, and I've been a practicing physician since 1983. My testimony will focus on three parts. First, the developmental aspects of pain in the neonate. Second, the increased sensitivity of preterm infants to pain compared to term or older children. And, thirdly, the effects of maternally-administered anesthetics on these infants.

With respect to the first, very preterm neonates have the anatomy and functional, physiologic and chemical processes that they need in their brains responsible to mediate both pain and noxious stimuli. Anatomic studies have shown that the density of skin pain fibers are present in preterm and newborn infants and, in fact, may exceed the number of fibers of adult skin. These pain fibers begin around the mouth about the 7th week of gestation and are fully formed by 20 weeks of gestation.

Traditionally, lack of myelin, the coating around the nerve cell, has been used as an argument for stating why infants in this age group cannot feel pain. This has been proposed as an index of immaturity. However, we know that adults can perceive pain through nerves that are not myelinated, and more recent studies have shown that infants by 30 weeks of gestation have complete myelination up to and through the level of their brain.

Several types of scientific observation speak for the functional maturity of these infants' brains. The first is fetal and neonatal EEG patterns. Infants in this age group can respond both to visual and auditory stimulation. There are other brain waves that measure response to touch, pain, hot and cold, and these are documented in preterm infants up to—beginning at 26 weeks gestation.

Also, there are well-defined periods of sleep and wakefulness present in utero, present from 28 weeks of gestation onward. Ultrasound findings

have reported specific fetal movements in response to needle punctures in utero. Moreover, control studies of interuterine blood sampling and blood transfusions in fetuses between 20 and 34 weeks of gestation show that these infants release hormones that are consistent with perception of pain and were correlated with the duration of the painful stimulus.

Preterm infants who are born and delivered at 23 weeks of gestation show very highly specific and well-coordinated physiologic and behavioral responses to pain which is just like older infants.

My second point is there is increased sensitivity to pain in preterm infants. Contrary to previous teaching, current data now indicates that preterm neonates have greater pain sensitivity than term neonates or older infants. Several lines of scientific evidence support this, and I will review these briefly from the most basic to that which reflects my clinical practice.

First, in the study of pain reflexes, there are reflexes, one of which we call the cutaneous flexor response, which is a response that measures the connection between the distal pain fiber and the sensation in the brain. This is a well-described response and has been used to mark or parallel pain perception exactly.

Second, neurotransmitter substances cross from nerve to nerve, and these are present in high concentrations in these young infants.

Third, there are receptors for these transmitters in high density in the fetal brain.

Fourth, pain in the fetus and neonate can be measured by these hormones that I mentioned earlier. In studies of surgical procedures, these responses in preterm infants were three to five times those of adult patients undergoing similar types of surgery.

And, fifth, pain felt as a fetus or neonate can have a long-term health effect on the child's well being. Studies have shown that aggressive anesthesia is needed to decrease a stress response in preterm infants undergoing surgery, and, when done, improves their post-op clinical outcome.

Lastly, with respect to the effects of anesthesia on the fetus, as my colleagues have mentioned, local anesthetics rarely have any effect at all on the fetus. The mother's liver would clear these drugs as well as those given intravenously, and the concentration that reaches these babies does not achieve a therapeutic response. Mothers who underwent fetoscopy, their infants, when sampled for stress hormones, showed a much higher level when the mothers did not receive anesthesia. And these were infants of 16 to 20 weeks' gestation.

In conclusion, the scientific literature that I briefly reviewed and my own clinical practice has shown that the anatomic and functional processes that you need for the perception of pain are present in these infants who

would be considered for partial-birth abortion. Second, these infants are more sensitive to pain than term infants or older children would be if they were having the same procedure. And, third, current methods of providing maternal anesthesia during partial-birth abortions is unlikely to prevent the experience of pain and stress in these preterm infants prior to their delivery. Thank you. I'd be happy to entertain questions.

* * *

Mr. CANADY: Thank you, Doctor.

Let me just say that I think that the testimony that we've heard makes very clear what the facts are here. It's unfortunate that those who have disseminated the information that is contrary to the facts that we've heard here were unable to be here or unable to present any medical testimony in support of the information that they have disseminated.

Now, Dr. Birnbach and Dr. Ellison, you head the two organizations that represent anesthesiologists and obstetric anesthesiologists and perinatologists. Did Kate Michelman of the National Abortion Rights Action League, Mary Campbell of Planned Parenthood, Dr. Lewis Koplick, or any official from the National Abortion Federation, consult either one of you about the accuracy of their claims that anesthesia administered to a mother kills her unborn child?

Dr. ELLISON: After I testified in the Senate in November, I did receive a call from someone from the National Abortion Federation who explained to me in detail the anesthetic technique and asked, "Would that change my opinion?" Frankly, I said, "Not only did it not change my opinion, it really gave me cause for concern about the health of the mother." They're giving doses of drugs that are capable—in fact, I'm surprised that they are not routinely producing a general anesthetic state in patients who—in mothers—without an anesthesiologist present. Admittedly, there has apparently been no maternal mortality from Dr. McMahon's experience, but they are giving very large doses of drug, much more than I would recommend.

Mr. CANADY: Dr. Birnbach.

Dr. BIRNBACH: When the article that you mentioned came out in the *St. Louis Post-Dispatch*, I called them to ask them how they had gotten such misinformation, and they said that—as to suggest that they might retract that, because I had already heard from people in St. Louis that people were reading this and were alarmed. And they told me that this was a fact that they had received from Mary Campbell. And I, then, after several days of trying, did get in touch with Mary Campbell. But her fact sheet was already out at that point.

And I told her that there was no scientific basis for what she said on her fact sheet. As a practicing anesthesiologist, I have administered larger doses than the doses that she claimed that Dr. McMahon was giving. The

difference is that the patients that I administered the anesthesia to were asleep for 2 to 3 days and intubated on that dose, and the babies were fine. So that was my total contact with them.

Mr. CANADY. Well, are either of you aware of any action the individuals have taken to clear up the misinformation that they have disseminated?

Dr. ELLISON. I'm not.

Dr. BIRNBACH. No.

Mr. CANADY. Now at the risk of repeating some of the ground we've already covered, let me ask both of you, do you think that there is any anesthesiologist who would be able to defend the claim that anesthesia administered to a mother kills her unborn child?

Dr. ELLISON. Absolutely not.

Dr. BIRNBACH. There is no obstetric anesthesiologist who could even remotely come up with that because we administer anesthesia on a daily basis to women of all gestational ages without interfering with fetal development.

Mr. CANADY. Dr. Ellison, you have already touched on this, but let me ask Dr. Birnbach. In your professional opinion, would it be within accepted medical practice for a doctor who is not an anesthesiologist to administer the high doses of anesthesia that Dr. Koplick and Dr. Campbell claim Dr. McMahon administered?

Dr. BIRNBACH. Absolutely not. The doses that they are suggesting were given were 40 milligrams of midazolam, and that—which is an analgesic drug—is clearly enough to administer general anesthesia alone. But to that they added between 9,025 micrograms of fentanyl. That combination is probably enough to anesthetize five of my patients and keep them asleep for several hours. So, even if they were given incrementally over several hours, we are talking about massive doses of anesthetic that probably would put the mother's life at risk unless her respirations were taken care of by an anesthesiologist who was breathing for her.

Mr. CANADY. Dr. Chestnut, would you like to comment on that same question?

Dr. CHESTNUT. I agree with the statements made by both Dr. Ellison and Dr. Birnbach, and I am very skeptical that any physician would give those doses of drugs of Versed and fentanyl to any patient in an outpatient setting. And for any physician to do so safely would require the placement of an endotracheal tube, and would require the physician to support the ventilation and oxygenation of the patient for a prolonged period of time.

Mr. CANADY. Thank you, Mrs. Schroeder.

Mrs. SCHROEDER. Thank you, Mr. Chairman.

First of all, I'd like to ask, do any of you here support *Roe v. Wade*?

[No response.]

Mrs. SCHROEDER. None of you? Does anybody support *Roe v. Wade*?

[No response.]

Mrs. SCHROEDER. No, OK.

Dr. ELLISON. Excuse me. I'm not sure what your question—are you saying the Supreme Court decision?

Dr. ELLISON. Yes, the Supreme Court decision of *Roe v. Wade*.

Mrs. SCHROEDER. I am not opposed to that.

Mrs. SCHROEDER. OK.

Dr. BIRNBACH. And I support that personally. However, the question that I was called here for today was—

Mrs. SCHROEDER. I understand that.

Dr. BIRNBACH. It was not what is my opinion about *Roe v. Wade* but what is my opinion about anesthesia.

Mrs. SCHROEDER. Absolutely. Now the next question I have, do I take it by your appearing here that you support the bill? All of you would be supporters of this bill? I guess what I'm asking is—what I think I hear you saying is that there is no anesthesiologist or any practice that a recognized anesthesiologist could have that they could utilize in this type of procedure that would be humane. In other words, it almost sounds like you'll be moving a malpractice suit against any anesthesiologist that permitted or participated in a late-term abortion.

Dr. CHESTNUT. I think that's a misrepresentation of the testimony this morning. And I would also add to Dr. Birnbach's response that I have not read the bill and did not come here today prepared to comment on the bill one way or the other. But I stand by every word of the testimony that I have given regarding the effects of anesthesia on the mother and the fetus.

Mrs. SCHROEDER. No, I understand that, and I'm really not trying to be confrontational. I'm saying that if there were things that came out in this debate, that you think sent the wrong messages to women, I, too, would want to correct that. But I also want to make clear that you're not saying that there is no safe way, or there is no authorized way that a legitimate anesthesiologist could participate or deal with this type of procedure. You're not saying that. You're just saying that some of the things that you heard were wrong. Is that right?

Dr. ELLISON. Representative Schroeder, first of all, I'm here representing ASA, and I want to make it clear that they have taken no position on this or any other abortion procedure. We have members of our society that feel strongly on both sides. I'm sure.

In terms—what we're—what I believe all of us are concerned about is, we don't want pregnant women to defer necessary surgery out of fear that anesthesia is going to harm the fetus in any way.

Mrs. SCHROEDER. Absolutely.

Dr. ELLISON. And that is the extent of my testimony.

Mrs. SCHROEDER. And I believe you also testified that you do not believe that physicians should be sent to prison for having performed abortions.

Dr. ELLISON. That was in the question and answer section last

Mrs. SCHROEDER. And that was your testimony, too?

Dr. ELLISON. That's right.

Mrs. SCHROEDER. And that was this procedure. Let me ask you as doctors, when a doctor has a very difficult decision to make, aren't they obligated to use the procedure that has the greatest reduction of risk to the woman?

Dr. CHESTNUT. I would believe so.

Mrs. SCHROEDER. And you, would you believe so?

Dr. BIRNBACH. I would agree with that statement.

Mrs. SCHROEDER. And would you agree with that, too?

Dr. WRIGHT. That's right, although some of the anesthetic techniques that we've heard described do not sound like they protect the health of the woman.

Mrs. SCHROEDER. I'm trying to get to where the bottom line is, because, as I said, what I had hoped the hearing would be about is what the President's letter was about, saying that *Roe v. Wade* talks about the health and safety of the woman, and I'm trying to find out if that's in conflict with the standard that the medical society would have. And it would seem to me that if your patient is the woman and she comes in, and she's got a pregnancy that has gone terribly wrong or there is some critical health condition that has occurred—we have 100 percent agreement that the doctor should be focusing on his patient and what can be done to try and keep her health whole or keep her as healthy as possible. That would be the medical standard, right? So, the President's letter would be right on on that.

I also wanted to say that Dr. Campbell did testify fully in front of the Senate. I didn't put that in the record, but it is the full Senate record, and I think it is very, very important that if anybody has questions about that, they should look at that.

If this—

Mr. CANADY. The gentleman's time has expired. We're going to have a second round.

Mrs. SCHROEDER. OK, thank you.

Mr. CANADY. Mr. Hyde.

Mr. HYDE. I thank you, Mr. Chairman.

Dr. Wright, I was fascinated by your—everybody's testimony, but your's in particular, because you talked about—you say that current data

indicate that preterm neonates have greater pain sensitivity than term neonates or older age groups. You're talking about preborn babies, then that they feel pain.

Dr. WRIGHT. They feel pain, and they feel it more than a term neonate does. And we know that because those 24-, 26-, 28-weekers that are delivered and are in the neonatal intensive care unit are now subjects of studies over the last few years that have confirmed that both they can feel perceive pain, and their response is magnified.

Mr. HYDE. Now, Doctor, how in your professional opinion—how early following conception can that fetus begin to feel pain?

Dr. WRIGHT. Begin to feel pain, the earliest reference I made was 7 weeks because of the sensation that's on—

Mr. HYDE. Seven weeks.

Dr. WRIGHT. Seven weeks.

Mr. HYDE. The mother hardly knows she's pregnant then.

Dr. WRIGHT. That's correct. And by 20 weeks—

Mr. HYDE. That little fetus is feeling pain?

Dr. WRIGHT. That's right.

Mr. HYDE. And you know, we have movements in this country to do away with leg clamps on animals because they feel pain. Cruelty to animals is condemned. We've had people go and sleep on icebergs to be close to baby hump seals, save the whales. Now you're telling us that Dr. Nathanson, who composed a film called "The Silent Scream" referring to the feeling of pain by the unborn child, wasn't off the wall at all. They do feel pain?

Dr. WRIGHT. That's correct. And in response to that, just because we can't hear the cry doesn't mean that it's not there. And we can see it, as some of my colleagues have referenced by the fetoscopy procedure. We see it in the neonatal intensive unit. And, this procedure, if it was done on an animal in my institution, would not make it through the institutional review process. The animal would be more protected than this child is.

Mr. HYDE. Doctor, is there such a thing as a pain-free abortion for the fetus.

Dr. WRIGHT. No.

Mr. HYDE. I've just come across an astounding letter that was handed to me by counsel. I guess it's over on the table. It's from a Dr. Mitchell Cremin, assistant professor, director of family planning and family planning research at McGehee Women's Hospital in Pittsburgh. And I quote—and I'm going to ask each of you if you can validate this statement—I am the director of family planning and family planning research in the department of obstetrics, gynecology and reproductive sciences at the University of Pittsburgh. As a physician, I can assure you there is no such thing as pain to

a fetus. Plain and simple, pain does not exist to a fetus. Any doctor who states otherwise is flat out lying and twisting medical data."

Dr. ELLISON, would you agree with that?

Dr. ELLISON, I read that letter over there, and I find it inconceivable that any physician would make it—would attach his name to a letter like that.

Mr. HYDE, Dr. Birnbach.

Dr. BIRNBACH, Having administered anesthesia for fetal surgery, I know that on occasion we need to administer anesthesia directly to the fetus because even at these early ages the fetus moves away from the pain of the stimulation. So I cannot agree at all.

Mr. HYDE, Dr. Chestnut.

Dr. CHESTNUT, I agree with my colleagues and would also note that at the University of California at San Francisco, which is the leading center in the world for performance of fetal surgery, that even though the mother is receiving heavy, deep doses of general anesthesia, those physicians give additional anesthetic drugs directly to the fetus during surgery in order to make certain that the fetus does not experience pain during the procedure.

Dr. Wright.

Dr. WRIGHT, There is no science to substantiate that letter. I believe all of us submitted to you journal articles that have been reviewed by our peers—and I make particular reference to a landmark article in 1987 in *The New England Journal*, and their phrase was, "there is no doubt about cortical function and the perception of pain in children of this age." There's no science behind that.

Mr. HYDE, I ask—and thank you all—I ask unanimous consent that this letter from this Dr. Creinin be placed in the record.

Mr. CANADY, Without objection.

Mr. HYDE, Thank you.

* * *

Mr. CANADY, We are going to have a second round of questions now. In the course of your testimony, reference was made to a written statement that was submitted to the subcommittee by Dr. McMahon. And I want to read from that statement. This was submitted on June 23, 1995, and it's on page 5 of the letter that was submitted by Dr. McMahon. The paragraph I am going to read is somewhat ironically, in my view, under a bold heading, "Miscellaneous." It says, "The fetus feels no pain through the entire series of procedures. This is because the mother is given narcotic analgesia at a dose based upon her weight. The narcotic is passed, via the placenta, directly into the fetal bloodstream. Due to the enormous weight

difference, a medical coma is induced in the fetus. There is a neurological fetal demise. There is never a live birth."

Would any of the witnesses like to make any additional comments on that statement and the various elements in that statement?

Dr. ELLISON, I would comment that that seems to be the origin of the misconception that we're here to refute. I believe that Dr. McMahon's statement about their giving a dose 40 times what the fetus—but they're not giving it to the fetus. They are giving it to the mother. And only a very small fraction of that crosses that placenta barrier and is transmitted to the fetus.

Mr. CANADY, Doctor, do you have any idea what may have led Dr. McMahon to make this statement, what may have led to a misunderstanding that could have caused it?

Dr. ELLISON, A gross misconception on his part. I can't conceive of why he would say that.

Mr. CANADY, Dr. Birnbach.

Dr. BIRNBACH, I would have to agree. The mother is given a narcotic analgesia dose based on her weight. That's true, and I do that in practice every day—in cesarean section under general anesthesia, the baby is wide awake, despite the fact that we gave enormous doses of anesthesia to the mother. The anesthetic dose not all cross the placenta, and that that does get metabolized by the liver. Quite often the baby can be somewhat sleepy or wide awake. But there is no question of fetal demise.

Mr. CANADY, Let me yield to the gentlelady from Colorado, Mrs. Schroeder, do you believe that the statement that was contained in Dr. McMahon's testimony that we've been discussing was inaccurate?

Mrs. SCHROEDER, I want to say that I'm not a doctor, and I feel very uncomfortable—Congress sitting here deciding what dosage, and how you give it, and what was stated, and which doctor was—

Mr. CANADY, Of course, that's not, that's not really the question.

Mrs. SCHROEDER, But we're not trying doctors today. We're talking about a bill that's going to limit the choices doctors have. And I'm trying to say, we can always find things that we can pick away that somebody has said who was a witness for one side or the other, but the bottom line is: Why do we feel free to try doctors here? I mean—

Mr. CANADY, We're not trying any doctors. We're trying to get some facts out here that are important to the health of women. And you've heard the testimony from the doctors here today who believe that this myth about the impact of anesthesia on children in the womb is something that may cause women who need to have a surgical procedure to avoid having the treatment that they're trying because of the fear that they feel for the impact on their fetus. What they're trying to do is clear the air on that.

I understand that, regardless of what the facts are on this particular question, you will still oppose the bill, and that's the choice that you make. And I understand that there are other grounds on which that position can be taken, but I think that it is very important for us in the Congress, for us to clear up this misconception which is posing a threat to the health of women. And again, I can't—you have to speak for yourself.

Mrs. SCHROEDER. Well, if the gentleman will yield, I now feel like the gentleman has decided to try me. If the question is about pain and how much dosage you issue of anesthesiology, and so forth—I come from a family filled with anesthesiologists, and the last thing I'm going to do is sit up here and get involved in this because I know how tough to call it is. And I have great respect that they are not going to do something that is harmful. If the issue is about pain, I can tell you, as someone who's been through it, birth is painful. Birth is painful to the child. Fetal surgery is painful. Other forms are painful, if we're trying to find a pain—

Mr. CANADY. My time has expired. The gentlemanly from Colorado is recognized.

Mrs. SCHROEDER. I think the gentleman, I can't quite figure out where we're going with all of this. I think the bottom line—well, let me ask this question: Is there anything in anyone's training that would lead you to believe that one method of an abortion is less painful than another when it comes to late-term? So is it proper for this bill to ban one form of late-term abortion because this is more painful than any other term of late-term abortion procedure that is being used? You understand?

I mean, what you're testifying on is a bill that says that one form of late-term abortion is hereby criminal to perform. Is this one form so bad compared to any form of late-term abortion or so much more painful and act? I mean, that's what we're talking about here.

Dr. ELLISON. I have to pass on that in that I don't know what other types of late-term abortion there are. I think you're asking a group of anesthesiologists, and with the possible exception that Dr. Chesnut might know since he's trained in obstetrics also, we don't do this procedure. So I've never actually seen it done.

Mrs. SCHROEDER. I think it's done very rarely because, fortunately, very few people have to resort to it, thank goodness. But the question is, are there other forms that we don't know about? Now that we're going to become medical doctors, should we have Ob/Gyn's in here to tell us what the different forms are and why this one should be outlawed over any other? My next question is do Ob/Gyn's make these choices lightly?

Dr. ELLISON. I can't believe they would do that. They'd give the same careful consideration to the health of the mother that we do when we consider the anesthetic.

Mrs. SCHROEDER. I would certainly think so, too. And that's why I guess I'm so troubled by this.

In looking at the health of the mother, preserving her future reproductive capacity could also be a valid factor, wouldn't you think? Doesn't she have the right to continue to try for successful motherhood, or do you only get one shot at this?

Dr. ELLISON. Yes.

Mrs. SCHROEDER. You would agree with—that a doctor could reasonably take that into account and not think she was just being selfish?

Dr. ELLISON. Yes.

Mrs. SCHROEDER. Let me ask about pain, then. We've heard a lot about pain here, but I assume that when there's fetal surgery there's pain. Is that correct?

Dr. BIRNBACH. Yes, there is evidence that there is pain.

Mrs. SCHROEDER. And so what you do in that case is you directly administer the anesthesia to the fetus, right?

Dr. BIRNBACH. Either you administer more anesthetic to the mother or you administer anesthetic directly to the fetus, correct.

Mrs. SCHROEDER. And, of course, with birth there's pain.

Dr. BIRNBACH. Not if the patient has an analgesia on board, like an epidural.

Mrs. SCHROEDER. You mean for the patient. But there can be pain for both the mother and the child. Birth is—I mean, as I remember it—

Dr. BIRNBACH. Personally, I don't remember my birth. [Laughter.]

Mrs. SCHROEDER. I remember giving birth. I'm like you, I can't remember birth itself, but it is not exactly a pain-free experience. So, if the idea is we should ban anything that has pain, Congress should ban any procedure that has pain, then aren't we stepping into a real muddy field?

Mr. HYDE. My dentist would hate to hear you say that.

Mrs. SCHROEDER. That's right. I'd never go to one again.

Does anesthesia administered to the woman provide any pain relief to the fetus? Is that what you're saying, it does not?

Dr. CHESTNUT. What we have said—I think this is consistent with the other testimony this morning—is that, yes, these drugs do cross the placenta, and, in the case of large doses, may or may not provide partial pain relief. But the ability of any physician to predict the amount of pain relief provided to the fetus, that just doesn't exist in clinical practice. And, as Dr. Birnbach and I have both said, for that reason, at fetal surgery, surgeons give additional doses of drugs directly to the fetus, despite the fact

that the mother is already receiving general anesthesia, and I might add, a deep level of general anesthesia.

Mrs. SCHROEDER: I see my time has again expired, Mr. Chairman. Thank you.

Mr. CANADY: Mr. Hyde.

Mr. HYDE: Dr. Wright, it seems we're getting into pain, but anesthesia and pain are certainly linked, I guess. I'm trying to think of the methods of abortion, and we're going to ask you about pain. Dilatation and curettage, that's where they reach in with an instrument, a sharp instrument, and dismember the fetus and extract the fetus. Would you think, in your professional opinion, that fetus feels some pain in undergoing the process of dilatation and curettage?

Dr. WRIGHT: While the mother is only under local anesthesia?

Mr. HYDE: Yes.

Dr. WRIGHT: Yes.

Mr. HYDE: All right, then there's the salting-out method. That's where they inject a saline solution into the womb, and that literally scalds the unborn child, and finally the child is expelled. Or the fetus, to be as impersonal as we can, is expelled. Would you say that that fetus would feel pain while undergoing the salting-out process?

Dr. WRIGHT: I would believe so. I'm not an abortionist nor do I practice obstetrics anesthesia. But, based on the scientific evidence I gave you earlier about more pain fibers on the skin than on full term or on older children, yes.

Mr. HYDE: I should think scalding the unborn child in the womb would be painful.

Then there's the suction machine. They attach a machine, and it literally pulls the child to pieces out of there. One could assume that's a painful process for the unborn. Now we're going to focus—leave the autonomous woman for a second and focus on the child.

Then we have the partial-birth abortion where the child is almost totally extracted from the birth canal and the scissors goes in the back in the neck, and then they suck out the brains.

So we're talking about a lot of pain, I would think, based on your testimony and based on what I heard from the other gentlemen who are superior anesthesiologists. So I think it's an accomplishment if we could ever get a concession that the unborn child feels a hell of a lot of pain in this process, and maybe we ought to consider that in weighing the advisability of abortion as an answer to lots of problems.

I thank you, Mr. Chairman.

* * *

Mr. CANADY: The gentleman from Virginia.

Mr. GOODLATIE: I'd like to follow up on that same line of questioning but with the panel, and ask them to comment on the statements by another individual, Dr. Martin Haskell, who performs partial-birth abortions in Ohio and was asked in a Cincinnati medicine article whether the unborn child feels pain. He answered by saying, "Neurological pain and perception of pain are not the same. Abortion stimulates fibers, but the perception of pain, the memory of pain that we fear and dread, are not there. I'm not an expert, but my understanding is that fetal development is insufficient for consciousness. It's a lot like pets; we like to think they think like we do. We ascribe human-like feelings to them, but they are not capable of the same self-awareness we are. It's the same with fetuses. It's natural to project what we feel for babies to a 24-week-old fetus."

That's Dr. Haskell's statement. I would like to ask the panelists to give their opinion on that, perhaps starting with Dr. Wright.

Dr. WRIGHT: Well, I don't know of any scientific evidence that would back up his opinion, and that's what I would call it, his opinion. Pain is a multidimensional phenomenon. It has everything from reception of the pain, transmission of it. It's incorporated into your memory. In fact, pain, many experts say, by definition is important when it becomes remembered, or when we have memory of it. And we do know that these preterm infants have memory, and that they show it after delivery. We also know from studies in neonatal intensive care units that they have procedural memory. Because they cannot vocalize it or verbalize it in a way that says to us, "I have pain," like an adult patient can by pushing a button for a nurse in a hospital bed, we disregard that many times. We know from the studies that I mentioned earlier, the EEG studies, the potential studies, the wakefulness, their sleepiness, those all reflect a human that is capable of perceiving and responding to pain.

You know, I was thinking about this as you were reading that quote. Those of us who practice anesthesia, we frequently have signs up in our operating room, "Be careful what you say. Patients may be listening." The patient is anesthetized, but we know that people can bring in, perceive, integrate, and remember things even when under anesthesia.

Mr. GOODLATIE: Thank you. Anyone else care to comment on that quote? Dr. Chestnut.

Dr. CHESTNUT: I think that many of us have observed the response of infants born at 24 weeks' gestation in a neonatal intensive care unit, and the responses that they exhibit in response to procedures suggests that at that age they do experience pain.

Mr. GOODLATIE: Thank you. In a National Abortion Rights Action League press conference, Kate Michelman, the group's president, said, "The fetus undergoes demise before the procedure begins, and because of the

anesthesia, which is, you know, something like 50 to 100 times what a fetus can withstand because it's given according to the weight of the woman." That's her quote.

Then during a radio interview, Ms. Michelman said, "The other thing that I want to say is that they have, the other side, grossly distorted the procedure. The anesthesia that they give the woman already causes the demise of the fetus. That is that it is not true that they are born partially. That is a gross distortion. And it's really a disservice to the public to say this."

I ask the panelists, aren't Ms. Michelman's statements a distortion themselves, and isn't that a disservice to the public, to create that perception on the part of pregnant women and their children that they— isn't she promulgating a myth about anesthesia killing the unborn child?

Dr. ELLISON: I would agree. I think that this entire myth originating with McMahon, and being promulgated by, I guess, his adherents, is most unfortunate.

Dr. BIRNBACH: That's why we're here today. This myth is being promulgated, and it's being picked up in the lay press. And our patients are reading that, and there is no truth to that.

Mr. GOODLATTE: Thank you. Anyone else care to—

Dr. CHESTNUT: A gross distortion of reality and clinical medicine, and I wish I could ask you, if I were permitted to ask a question, and I know that I'm not, how often does this type of gross misinformation get presented to the Congress?

Mr. CANADY: Too often, too often.

Mr. GOODLATTE: Thank you, Mr. Chairman.

Mr. CANADY: We're going to go through, I think, just one more round of questions, I'd like to follow up on the comments about the reports in the press, and I'd like to ask particularly Dr. Ellison and Dr. Birnbach what your appraisal is of the way the press has handled the information related to anesthesia and partial-birth abortion.

Dr. ELLISON: I would say that if you would read in the press, for example what was said last November, you would wonder if I was in that hearing room. The quote that Dr. Birnbach made in the *Marie Claire* magazine, I was at the same table as Dr. Campbell when that statement was made, and no mention was made of the fact that I publicly disputed her claims. And—

Mr. CANADY: Or that you're the president of the American Society of Anesthesiologists?

Dr. ELLISON: Right.

Mr. CANADY: Dr. Birnbach.

Dr. BIRNBACH: If I were to put it in one word, it would be "irresponsible." And I have spoken to most of the people who've written those newspaper and magazine articles, and they are trying to push one side of this, and have latched onto the fact that maybe anesthesia does cause some problem because some doctors said so to the Senate. The fact that that doctor was not an anesthesiologist and had no knowledge about anesthesiology, they don't particularly care about.

So, I would think that the fact that, at this point, Dr. Ellison has testified, I have yet to see any major newspaper say, "Hey, it's OK out there. You can get an anesthetic if you need it. If you want analgesia for labor, since labor is painful, go ahead, it's safe for the baby." But plenty of magazines and newspapers still are latching on to this fetal demise theory.

Mr. CANADY: OK, thank you very much. I have a question for Dr. Chestnut. Doctor, you are both an anesthesiologist and an obstetrician, as we have noted already today. Nurse Brenda Shafer, who will be testifying on a later panel today, previously testified before the Senate Judiciary Committee that she witnessed Dr. Haskell perform a partial-birth abortion, and before he inserted scissors into the back of the baby's skull, and I quote: "The baby's little fingers were clasping and unclasping, and his little feet were kicking." Is this description consistent with a baby being delivered from the womb after the application of local anesthetic?

Dr. CHESTNUT: Yes, it is. What she has described is what I observed several times during vaginal breech deliveries, more often later in gestation. And in babies who might be delivered with the mother having received local or epidural anesthesia, that description would be consistent.

Mr. CANADY: Thank you, Dr. Chestnut, let me also ask you about this. Dr. Martin Haskell wrote a detailed description which he delivered at a medical conference of how to perform what he called a "dilation and extraction" abortion. He advocates the technique as a "quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia." In his description he states, "The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized, and grasped with a tenaculum. Lidocaine 1 percent with epinephrine, administered intracervically, is the standard anesthesia." What effect would this anesthesia have on the unborn child?

Dr. CHESTNUT: The anesthetic drug itself would be expected to have no effect on the infant. Occasionally during performance of a similar procedure called "paracervical block," the local anesthetic might interfere with blood flow to the placenta and oxygenation of the baby which could cause the baby's heart rate to drop. That would be in the minority of cases, and, even in those cases, the infant would be expected to recover.

Mr. CANADY: Thank you very much.

burdens on the abortion right in *Casey* which exceed any burden employed by using these procedures, as noted above, any burden of a ban on partial-birth abortions must be constitutionally permissible.

After viability, partial-birth abortion is not necessary to preserve maternal health. After viability, "the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."¹⁹⁵ Therefore, the test after viability is whether the partial-birth abortion procedure is necessary to preserve maternal life and health, not whether banning it poses an undue burden. Because there is an exception to the ban for preserving the mother's life, the issue becomes whether the partial-birth abortion procedure is necessary to preserve maternal health. Needless to say, the same arguments made here apply where it is asserted that a procedure banned by a partial-birth abortion statute is necessary for maternal health reasons.

The answer to whether a partial-birth abortion is necessary for maternal health is easily answered in the negative. Because there are industry-standard, alternate abortion methods available (which are well within the medical standard of care and have been described as safe to the mother), it cannot reasonably be asserted that the partial-birth abortion method is necessary to protect maternal health.

Also, both the state's compelling interest in preserving the unborn child's life after viability and the state's super-compelling interest in protecting partially-born human beings fully capable of drawing a breath and living if their head is delivered must be weighed against the mother's health interest in deciding whether a particular procedure is necessary. Any minor advantage the partial-birth abortion procedure might arguably have simply cannot outweigh the state's interests on the basis of being necessary to maternal health.

Partial-birth abortion is not safer for the mother than other abortion methods. The partial-birth abortion procedure is an undocumented and nonstandard procedure. Review of the medical literature employing standard medical computerized databases reveals no published case series, retrospective reviews or prospective studies of this procedure. According to Dr. Harlan Giles, however, the partial-birth abortion procedure is not new, but is "a resurrection of an old technique, going back to the early part of this century that, for health and safety reasons to the mother, plus the emergence of newer techniques in the 1960s and 1970s, has literally been abandoned in our practice of obstetrics and gynecology."¹⁹⁶ Dr. Giles stated

¹⁹⁵Casey, 305 U.S. at 879 (joint opinion; quotation marks and citation omitted; emphasis added).
¹⁹⁶1/1/8995 TR at 23 (testimony of Harlan Giles), Voinovich.

that the partial-birth abortion procedure is "essentially identical" to procedure used in the early 1900s to deliver a dead fetus, a craniotomy, which was later abandoned by the medical profession because it posed safety risks to the mother, including perforation of the uterus, injury to it, cervix and/or vagina, and the potential for complications and infections.¹⁹⁷

The safety of the partial-birth abortion procedure is untested and undocumented. For example, the anecdotal reports of Dr. Haskell and D. McMahon have not been substantiated by other investigators nor submitted to a peer-reviewed publication. Moreover, the reports have limited follow-up and scant data.¹⁹⁸ Follow-up is essential, as it is well-known that a woman who has undergone an abortion will often seek care for a complication another site rather than return to the scene of her fetal loss.¹⁹⁹

Dr. Haskell reported two complications per thousand in methods other than partial-birth abortion, and zero cases per thousand for partial-birth abortion.²⁰⁰ This difference is not statistically significant at these study population sizes.²⁰¹ If a statistical difference did exist, it would require seven thousand more cases or more complications to establish it.²⁰² Even if it were demonstrated that the non-partial-birth abortion procedure has, by Plaintiff Haskell's own testimony, a non-complication rate of 99.8%,²⁰³ Moreover, Dr. Giles stated concerning Dr. Haskell's asserted 0.0% complication rate with the partial-birth abortion procedure that "that is a statistic that is not keeping, as far as I'm aware, with my experience certainly or anyone else . . . the complication rate for most people is higher than that. That's very incredibly low complication rate overall."²⁰⁴ Dr. Haskell's assertions are not from a formalized study, subject to peer-review, and accepted by reputable, scholarly journal. In the scholarly medical literature, it must be reaffirmed, the partial-birth abortion procedure is undocumented. Again, this may be explained because a virtually identical procedure was previously abandoned due to health and safety risks to the mother.²⁰⁵

The partial-birth abortion procedure entails more risk than other abortion procedures because it requires internal podalic version, a technique that essentially has been abandoned by modern obstetric. "Despite numerous attempts to defend or condemn this procedure, there

¹⁹⁷Id. at 17-24.
¹⁹⁸1995 Senate Hearings, supra note 8, at 5.
¹⁹⁹1/1/3095 TR at 234, 280-83 (testimony of Harlan Giles), Voinovich.
²⁰⁰1/1/8995 TR at 149-51 (testimony of Martin Haskell), Voinovich.
²⁰¹1/1/3095 TR at 245 (testimony of Harlan Giles), Voinovich.
²⁰²1/1/8995 TR at 182 (testimony of Martin Haskell), Voinovich.
²⁰³1/1/3095 TR at 244-45 (testimony of Harlan Giles), Voinovich.
²⁰⁴Ver. 1/8995 TR at 17-24 (testimony of Harlan Giles), Voinovich.

and the instruments he used. I saw the baby move in the pan, and I asked another nurse and she said it was just "reflexes."

I have been a nurse for a long time and I have seen a lot of death—people maimed in automobile accidents, gunshot wounds, you name it. I have seen surgical procedures of every sort. But in all my professional years I had never witnessed anything like that.

The woman wanted to see her baby, so they cleaned the baby up and put it in a blanket and handed the baby to her. She cried the whole time. Looking down into the baby's face, she said, "Please forgive me. I am so sorry. I love you." I was crying, too. I couldn't take it. That baby boy had the most perfect angelic face you've ever seen.

I was present in the room during two more such procedures that day, but I think I was really in shock. I tried to pretend that I was somewhere else, to not think about what was happening. I just couldn't wait to get out of there. And after I left that day, I never went back. These last two procedures, by the way, involved healthy mothers with healthy babies.

I was very much affected by what I had seen.

Mr. CANADY. I'm sorry, the time has expired. If you could try to conclude as soon as possible—

Ms. SHAFER. Yes. And for a long time I still, and still do, had nightmares about what I saw that day. And that's when I wrote a letter to Congressman Tony Hall last July and told him about what I had seen.

Since I wrote that letter to Congressman Tony Hall, I have been the subject of some strange attacks on my credibility. These are addressed point by point in my written testimony. There are people who say I haven't seen what I've seen. I wish that was true. I wish I hadn't seen it, because I don't like being here to tell you today, but it is true, and what was done to that little boy and to other babies should not be allowed in this country.

* * *



Also as a preliminary matter, it is important to recall situations to which the statute does not apply. If the fetus is already dead, there is no state interest in protecting partially delivered human life, and the physician may use whatever procedures he desires, consistent with maternal safety. If the fetus has hydrocephalus (water on the brain), the fluid may be drained at this point without violating the statute, for the intent is not to kill the child (and many survive the procedure).

In weighing the burden on the woman at the point when the birth is partially complete and the head is not delivered, there are two degrees of burdens. First, in some cases, the burden on the woman is nil because "the cervix is floppy or loose," and the head simply comes out.¹⁷⁷ Because she has no right to a dead child and can readily be freed from the remaining and minimal burden of pregnancy (i.e., having the fetal head within her), she has no constitutionally-cognizable interest in having the physician hold the partially delivered child firmly in the birth canal to keep it from slipping out so as to kill the child before it is fully born and is indisputably a person.¹⁷⁸ Therefore, in such cases, there is no burden and the partial-birth abortion ban is clearly constitutional, even under the *Casey* analysis.

Second, in other cases, the aftercoming head will temporarily stop the delivery of the child with the head within the uterus, due to the head being larger than the not-yet-fully-dilated cervix. At this point, there are several ways to proceed to deliver the head, which were set out in the evidence of the Michigan case.¹⁷⁹

These options for proceeding to deliver the head of the yet-living, partially delivered child impose some level of burden on the mother, but it is the burden *undue*? The test is whether the burden is *substantial*, and it involves a balancing with the state's interest. If the state's interests (before viability) were the usual interests in protecting in fetal life and maternal health, a certain level of burden on the woman would yet be permissible under *Casey*. In *Casey*, the Supreme Court held that requiring the woman to wait for twenty-four hours after the prescribed informed-consent dialogue was not an undue burden even though it might cause the woman to make to two trips, experience greater cost, and suffer delay (perhaps longer than twenty-four hours).¹⁸⁰

So if the state's interest is as high as protecting a child in the midst of being born, as in the Texas parturition statute not reached in *Roe*, then the woman may be asked to bear a consequently higher burden. The Supreme

¹⁷⁷ 1995 Senate Hearings, *supra* note 8, at 80 (prepared statement of Pamela Smith, M.D.).
¹⁷⁸ *Id.* (Dr. Smith testified that often the abortionist has to keep a firm grip on the fetus to keep it from falling out.)

¹⁷⁹ *Id.*, e.g., 5/7/97 TR at 238-45 (testimony of Dr. Cook, Kelly
in *Casey*, 505 U.S. at 868-87).

Court has already said that once the state's interests in protecting unborn life reach the peak they do at viability, then the woman may constitutionally be asked to bear the burden of carrying that child to term (except to preserve maternal life or health). Therefore, there is some point at which women may be asked to bear the burden of childbearing because of the enormity of the state interest. The *Casey* joint opinion even noted the fairness of imposing the burden because the woman by allowing herself to reach that situation has constitutionally assumed the burden of carrying the child to term. Because of the constitutional implications of a partial-birth for personhood of the child, it is reasonable to say that a woman in such a situation may also be asked to bear the relatively smaller burden (than carrying a child from viability to term) of delivering the head of the living child.

Pregnancy complications never necessitate a partial-birth abortion and thus do not impose an undue burden. It is exceedingly unusual for a pregnant woman to have a disease that is so life-threatening that termination of a pregnancy is indicated. In fact, Alan Guttmacher, M.D., a founder of Planned Parenthood, so stated:

Two or three decades ago the common indications for legal abortion were serious disease of the heart, lung or kidney. In second position were intractable vomiting in early pregnancy and diabetes. Today, some of these diseases have been virtually eliminated as reasons for abortion and the others have been reduced to a status of unimportance. This change has come about as a result of the extraordinary advances in general medical care, such as miracle drugs against infection, the diuretics which free tissues of abnormally retained fluid and insulin to metabolize sugar. Today it is possible for almost any patient to be brought through pregnancy alive unless she suffers from a fatal illness such as cancer or leukemia and if so, abortion would be unlikely to prolong, much less save life.¹⁸¹

Of course medical science has advanced considerably since Dr. Guttmacher made his declaration in 1967. Statistics from countries such as Argentina, Ireland, or Italy, where abortion is illegal except to save the life of the mother, indicate that the rate of such conditions is one per one hundred thousand pregnancies.

There are complications of the late second and third trimesters of pregnancy that require termination of the pregnancy to protect the mother's life (e.g., severe preeclampsia). But when the unborn is viable, these conditions do not require the fetus to be killed in order to accomplish delivery (i.e., delivery, not abortion, is required). There are major

¹⁸¹ THE CASE FOR LEGALIZED ABORTION NEWS-9 (Alan F. Guttmacher ed., 1967).

cardiovascular diseases (e.g. pulmonary hypertension, and certain types of Marfan's syndrome) in which the pregnancy presents a definite threat to the mother's life. Again, once the fetus is viable, there is no evidence that terminating the pregnancy by abortion rather than delivery is beneficial to the mother.¹⁴⁷ In cases where there is a fetal malformation, it is exceedingly rare for the malformation itself to cause a threat to the mother's life.¹⁴⁸ The laws allow for intervention in these cases.

Partial-birth abortion is virtually never the preferred intervention for saving a mother's life, because it provides no additional benefit over safer methods of terminating a pregnancy (e.g., D&E in second trimester and medical induction in later gestation).

Indeed, the great majority of partial-birth abortions performed today are done for convenience. According to published reports concerning Dr. Haskell's work, 80% of his cases "are purely elective," i.e., had no medical indication, rather than unwanted pregnancies.¹⁴⁹

For example, Dr. McMahon's writings cite a number of indications for performing the partial-birth abortion procedure "for health reasons": cleft lip, two vessel cord (most commonly associated with a normal infant), too little or too much fluid (variations from the norm are not uncommon, and typically not associated with birth defects), exposure to a teratogen (a substance that can cause a birth defect, of which most have a low probability for effect), depression, minor maternal complications, and even a small pelvis.¹⁵⁰

Requiring a woman to choose an *alternat*, industry-standard procedure is not an *undue burden*. Where a woman chooses abortion during the time when a partial-birth abortion might be done, there are other, industry-standard abortion methods available.¹⁵¹ The proper analytical focus is the period between nineteen weeks of pregnancy and viability. Nineteen weeks is when Dr. Haskell said that the fetal tissues become more difficult to dismember in a standard D&E procedure due to the maturing of the fetus. Viability is when the standard changes from *undue burden* to a necessary standard.

Dr. Haskell set out the industry-standard alternatives in the monograph which ignited the partial-birth abortion controversy. He

¹⁴⁷11/13/95 TR at 248 (testimony of Harlan Giles), Venotich

¹⁴⁸11/13/95 TR at 241-42 (testimony of Harlan Giles), Venotich

¹⁴⁹See, supra note 14, at 22-23 (Letter from Barbara Bolten)

¹⁵⁰Partial-Birth Abortion, supra note 23, at 110-15.

¹⁵¹While the present authors do not condone these practices—believing that personhood should be recognized from conception—from a constitutional perspective these alternatives do not involve the killing of a human being, who is mostly (or the personhood line and so are constitutionally acceptable under the Supreme Court's abortion jurisprudence

mentioned induction methods and Dr. Hern's techniques for softening cervical tissues prior to doing a standard D&E during this period.

The evidence in the Michigan case showed that these other industry-standard methods are comparable in safety to the partial-birth abortion technique and well within the standard of care.¹⁵² Indeed, given the newness of the partial-birth abortion technique, the industry-standard techniques are the more established and widespread methods in the abortion service community. In the congressional hearings, concerns were raised about the safety of the partial-birth abortion method itself,¹⁵³ and even Dr. Warren Hern, author of a widely used textbook on abortion procedures entitled *Abortion Practice*, has voiced concern.¹⁵⁴

It is important to the analysis to note that the constitutionality of a partial-birth abortion ban is not determined by a balancing of the safety of abortion procedures. Professor Douglas Kmiec in his U.S. Senate testimony explained this well:

The constitutionality of this legislation does not depend on a comparison of the relative safety of abortion procedures. That is, the Casey exception for the health of the mother is not an entitlement to a specific abortion procedure, even if it were believed marginally safer [112 S.Ct. at 282]. That would ignore the interests of the child acknowledged in Casey [id. at 2816]. In other words, the issue is whether taking into account both the mother and the child's interests, the health of the mother is capable of being preserved following the legislative ban, and not whether a particular means of abortion remains available. Justice O'Connor, a member of the Casey plurality, made this point in her *Thornburgh* dissent. In particular, she concluded that a state statute which mandated an abortion method most likely to save a post-viability child should not be enjoined even as it posed some additional risk to the life of the mother. [476 U.S. at 830]. Since the unborn child's interest is more clearly articulated and re-stated in Casey, it cannot be seriously argued—as the opponents of this legislation do—that a partial-birth abortion method must be available because for some women the method poses fewer medical risks.¹⁵⁵

The *Thornburgh* decision to which Justice O'Connor dissented has been overruled by Casey and is clearly different in kind, as Professor Kmiec explained in his testimony concerning the federal partial-birth-abortion bill

¹⁵²See, e.g., 2/5/97 TR at 206-07 (testimony of Dr. Evans), Kelley.

¹⁵³1995 Senate Hearings, supra note 8, at 79 (prepared statement of Pamela Smith, M.D.).

¹⁵⁴Id. at 81 (quoting interview with Dr. Hern in Am. MED. NEWS, Nov. 20, 1995 ("I have very serious reservations about this procedure... You really can't defend it... I'm not going to do it.")).

¹⁵⁵1995 Senate Hearings, supra note 8, at 179 (prepared statement of Prof. Douglas Kmiec) (brackets in original).

burdens on the abortion right in *Casby* which exceed any burden employed by using these procedures, as noted above, any burden of a ban on partial-birth abortions must be constitutionally permissible.

After viability, partial-birth abortion is not necessary to preserve maternal health. After viability, "the State in promoting its interest in the potentiality of human life may, if it chooses, regulate and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."¹⁹⁵ Therefore, the test after viability is whether the partial-birth abortion procedure is necessary to preserve maternal life and health, not whether banning it poses an undue burden. Because there is an exception to the ban for preserving the mother's life, the issue becomes whether the partial-birth abortion procedure is necessary to preserve maternal health. Needless to say, the same arguments made here apply where it is asserted that a procedure banned by a partial-birth abortion statute is necessary previability for maternal health reasons.

The answer to whether a partial-birth abortion is necessary for maternal health is easily answered in the negative. Because there are industry-standard, alternate abortion methods available (which are well within the medical standard of care and have been described as safe to the mother), it cannot reasonably be asserted that the partial-birth abortion method is necessary to protect maternal health.

Also, both the state's compelling interest in preserving the unborn child's life after viability and the state's super-compelling interest in protecting partially-born human beings fully capable of drawing a breath and living if their head is delivered must be weighed against the mother's health interest in deciding whether a particular procedure is necessary. Any minor advantage the partial-birth abortion procedure might arguably have simply cannot outweigh the state's interests on the basis of being necessary to maternal health.

Partial-birth abortion is not safer for the mother than other abortion methods.

The partial-birth abortion procedure is an undocumented and nonstandard procedure. Review of the medical literature employing standard medical computerized databases reveals no published case series, retrospective reviews or prospective studies of this procedure. According to Dr. Harlan Giles, however, the partial-birth abortion procedure is not new, but is "a resurrection of an old technique, going back to the early part of this century that, for health and safety reasons to the mother, plus the emergence of newer techniques in the 1960s and 1970s, has literally been abandoned in our practice of obstetrics and gynecology."¹⁹⁶ Dr. Giles stated

¹⁹⁵Casby, 305 U.S. at 679 (quint opinion; quotation marks and citation omitted; emphasis added).

¹⁹⁶1/28/95 TR at 23 (testimony of Harlan Giles), Voinovich.

that the partial-birth abortion procedure is "essentially identical" to procedure used in the early 1900s to deliver a dead fetus, a craniotomy which was later abandoned by the medical profession because it pose safety risks to the mother, including perforation of the uterus, injury to it cervix and/or vagina, and the potential for complications and infections.¹⁹⁷ The safety of the partial-birth abortion procedure is untested, an undocumented. For example, the anecdotal reports of Dr. Haskell and D. McMahon have not been substantiated by other investigators nor submitte to a peer-reviewed publication. Moreover, the reports have limited follow-up and scant data.¹⁹⁸ Follow-up is essential, as it is well-known that a woman who has undergone an abortion will often seek care for a complication: another site rather than return to the scene of her fetal loss.¹⁹⁹

Dr. Haskell reported two complications per thousand in methods other than partial-birth abortion, and zero cases per thousand for partial-birth abortion.²⁰⁰ This difference is not statistically significant at these small population sizes.²⁰¹ If a statistical difference did exist, it would require sever thousand more cases or more complications to establish it.²⁰² Even if it were demonstrated that the non-partial-birth abortion procedure has, by Plaintiff Haskell's own testimony, a non-complication rate of 99.8%,²⁰³ Moreover, Dr. Giles stated concerning Dr. Haskell's asserted 0.0% complication rate with the partial-birth abortion procedure that "that is a statistic that is not keeping, as far as I'm aware, with my experience certainly or anyone else . . . the complication rate for most people is higher than that. That's very incredibly low complication rate overall."²⁰⁴ Dr. Haskell's assertions are not from a formalized study, subject to peer-review, and accepted by reputable, scholarly journal. In the scholarly medical literature, it must be reaffirmed, the partial-birth abortion procedure is undocumented. Again, this may be explained because a virtually identical procedure was previously abandoned due to health and safety risks to the mother.²⁰⁵

The partial-birth abortion procedure entails more risk than other abortion procedures because it requires internal podalic version, a technique that essentially has been abandoned by modern obstetric. "Despite numerous attempts to defend or condemn this procedure, there

¹⁹⁷*Id.* at 17-24.

¹⁹⁸1995 Senate Hearings, supra note 8, at 5.

¹⁹⁹1/13/95 TR at 234, 280-83 (testimony of Harlan Giles), Voinovich.

²⁰⁰1/28/95 TR at 149-51 (testimony of Martin Haskell), Voinovich.

²⁰¹1/13/95 TR at 245 (testimony of Harlan Giles), Voinovich.

²⁰²*Id.*

²⁰³1/28/95 TR at 182 (testimony of Martin Haskell), Voinovich.

²⁰⁴1/13/95 TR at 244-45 (testimony of Harlan Giles), Voinovich.

²⁰⁵Apr. 12/89/5 TR at 17-24 (testimony of Harlan Giles), Voinovich.

challenge rule is most clearly set out in the Salerno case, where the Supreme Court stated that it is not enough to show that a given law "might operate seeking an abortion must notify her spouse (with certain exceptions designed to avoid abusive situations) before obtaining an abortion. Id. The Casey complaint was a facial challenge, initiated before the law's provisions had taken effect. Id.

The Casey Court applied the Salerno facial challenge test when considering the twenty-four-hour waiting period. The majority upholding the twenty-four-hour waiting period consisted of Justices O'Connor, Kennedy, and Souter, *id.* at 2826 (joint opinion); and Chief Justice Rehnquist, joined by Justices White, Scalia, and Thomas, *id.* at 2868 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

While the Casey Court applied the facial challenge standard in considering the twenty-four-hour waiting period, a different majority set a different standard in its treatment of the spousal notice provision. The opinion, speaking also for Justices Blackmun and Stevens, applied the Salerno standard to the spousal notice provision. The majority of Pennsylvania's assertion that the spousal notice provision must be upheld because this was a facial challenge and less than one percent of the women seeking abortions would be even affected by the spousal notice provision, *id.* at 2892. The Court did not say that the facial challenge rule was inapplicable or altered, but rather "disagred[ed] with [Pennsylvania's] basic method of analysis." *Id.* The Court stated that the "controlling class" was not all women who wished to obtain abortions, but rather "married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions in the notice requirement." *Id.* at 2829-30. The Court held that the spousal notice provision was invalid because it would be an "undue burden" on a "large fraction" of these women.

Under the facial challenge analysis, if only a "large fraction" of this one percent of women would experience an undue burden, then the statute, not the constitutional application, because the Salerno standard rule requires that the statute, not the constitutional application, before succumbing to a facial challenge. As the Chief Justice Rehnquist noted in his dissent that the joint opinion opinion, the facial challenge standard of review, *id.* at 2870 & n.2. In other words, if the federal courts have struggled to determine the applicable standard in abortion cases. The following federal court decisions have rejected the view that Casey overruled the facial challenge doctrine in the field of abortion jurisprudence. *See, e.g.,* Janklow v. Planned Parenthood, 116 S. Ct. 1582 (1996); Fargo Women's Health Org. v. Schuler, 113 S. Ct. 1668 (1993); Ada v. Guam Society of Obstetricians & Gynecologists, 113 S. Ct. 633 (1992); Manning v. Hunt, 119 F.3d 254 (4th Cir. 1997); Planned Parenthood of the Blue Ridge v. Camblos, 116 F.3d 707 (4th Cir. 1997); Causeway Medical Suite v. Reynolds, 109 F.3d 1046 (5th Cir. 1997); Barnes v. Moore, 970 F.2d 12 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 656 (1992); Jane L. v. Bangert, 809 F. Supp. 865 (D. Utah 1992).

Other federal courts have accepted the Casey standard for abortion cases. *See, e.g.,* Women's Medical Professional Corporation v. Vonpovich, 130 F.3d 187 (6th Cir. 1997); *See also*, Bangert, 102 F.3d 1112 (10th Cir. 1996); *cert. denied*, Lewis v. Jett, 115 S. Ct. 453 (1997); Planned Parenthood, Sioux Falls Clinic v. Miller, 93 F.3d 952, 953 (8th Cir. 1995); Casey v. Planned Parenthood, 14 F.3d 668 (3rd Cir. 1994) (The Third Circuit has a footnote comment wholly unnecessary to the decision that states "it is not clear that the Supreme Court in Casey intended to overrule the facial challenge to pre-viability abortion laws." *Id.* at 663 n.21).

The Casey standard has not been applied at all in non-abortion cases. *See, e.g.,* Vaccio v. Quill, 117 S. Ct. 2203 (1997) (assisted suicide); Washington v. Glucksberg, 117 S. Ct. 2298 (1997) (assisted suicide); Anderson v. Edwards, 514 U.S. 143 (1995) (welfare benefits); Reno v. Flores, 507 U.S. 292 (1993) (deportation of aliens).

recently insufficient evidence to document its safety (Drew and associates, 991).¹⁹⁶ Williams Obstetrics does not include partial-birth abortion as a method of surgical abortion techniques.¹⁹⁷ The American College of Obstetricians and Gynecologists' discussion of the safety of abortion techniques does not even mention this procedure.¹⁹⁸

Generally, dilation and evacuation (D&E) and prostaglandin insertions are the most common and safest techniques for advanced pregnancy abortion.¹⁹⁹ But prostaglandin techniques often result in a live birth, causing many to add a step that will kill the fetus prior to delivery.²⁰⁰

Facial challenges should be dismissed because a ban is clearly constitutional in "a large fraction of the cases."

Facial challenges should be dismissed because a partial-birth abortion ban is clearly constitutional in "a large fraction of the cases."²⁰¹ The facial

¹⁹⁶ GARY CUNNINGHAM, ET AL., WILLIAMS OBSTETRICS 589 (19th ed. 1993).
¹⁹⁷ *Id.* at 680-83.

¹⁹⁸ American College of Obstetricians and Gynecologists, *Methods of Midtrimester Abortion* (ACOG Technical Bulletin No. 109, Oct. 1987).

¹⁹⁹ David A. Grimes & Kenneth F. Schulz, *Morbidity and Mortality from Second Trimester Abortions*, 30 J. REPRODUCTIVE MED. 305 (1985); W.M. HERN, *ABORTION PRACTICE* 122-37 (980); Warren M. Hern et al., *Outpatient Abortion for Fetal Anomaly and Fetal Death From 7-34 Menstrual Weeks' Gestation: Techniques and Clinical Management*, 81 OBSTETRICS & GYNECOLOGY 301 (1993).

²⁰⁰ Warren M. Hern, *Abortion Practice* 124 (1990); Warren M. Hern et al., *Outpatient Abortion for Fetal Anomaly and Fetal Death From 7-34 Menstrual Weeks' Gestation: Techniques and Clinical Management*, 81 OBSTETRICS & GYNECOLOGY 301 (1993).

²⁰¹ *Casey*, 505 U.S. 8, 895. The facial challenge rule was established by the United States Supreme Court in *United States v. Salerno*, 481 U.S. 739.

A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid. The fact that [an] Act might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid, since we have not recognized an "overbreadth" doctrine outside the limited context of the First Amendment. *Id.* at 745.

This facial challenge rule has also been employed in well-known abortion cases by the Supreme Court as recently as 1991 in the case of *Rust v. Sullivan*, 111 S. Ct. 1759 (1991). In *Rust*, the Supreme Court quoted and employed the Salerno analysis in rejecting a facial challenge to regulations prohibiting the use of public funds (in the Title X family planning program) for abortion counseling and referral, as well as activities advocating abortion as a method of family planning. *See* *Rust v. Sullivan*, 111 S. Ct. 1759 (1991). The Supreme Court also cited *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), which has contributed to some confusion in facial challenge suits. The *Casey* decision involved a challenge to the federal constitutionality of a Pennsylvania statute requiring train information to be communicated to a woman seeking an abortion 24 hours before it could consent to an abortion. 112 S. Ct. at 2803. It also required that a married woman