

ABORTION -

PARTIAL BIRTH

1996 - PRESENT



Abortion - partial birth -
legal

Memorandum



Subject

S.6, Banning "Partial-Birth" Abortions

Date

March 11, 1997

To

Andrew Foiss
Assistant Attorney General
Office of Legislative Affairs

From

Richard L. Shiffrin *RLS*
Deputy Assistant
Attorney General
Office of Legal Counsel

This memorandum sets forth the comments of the Office of Legal Counsel on the "Partial-Birth Abortion Ban Act of 1997," S.6, which would ban a particular method of performing an abortion.¹ The bill would criminalize performance of the procedure except where the procedure is "necessary to save the life of a mother" and "no other medical procedure would suffice for that purpose."

In our view, the bill, as currently drafted, suffers from at least two flaws, each of which is sufficient to render the bill unconstitutional. First, with regard to post-viability abortions, the bill does not contain an exception for performance of the procedure in order to preserve the woman's health. Second, with regard to pre-viability abortions, the bill is likely to impose a substantial obstacle to a woman's constitutional right to choose an abortion.

In Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992), the Supreme Court "confirm[ed] . . . the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health." See also id. at 879 (plurality) ("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.") (quoting Roe v. Wade, 410 U.S. 113, 164-65 (1973)). This means, first, that the government may not deny access to an abortion where necessary to preserve the life

¹ The procedure described by the bill appears to be a form of "dilation and extraction" abortion, sometimes abbreviated as "D&X." See Women's Medical Professional Corp. v. Voinovich, 911 F. Supp. 1051, 1065-67 (S.D. Ohio 1995).

of the woman or to preserve the health of the woman. It also means that the government may not regulate access to abortions in a manner that effectively "require[s] the mother to bear an increased medical risk" in order to serve a state interest. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 768-69 (1986) (citation omitted) (invalidating requirement that doctor use abortion procedure most protective of fetal life "unless . . . [that procedure] would present a significantly greater medical risk to the life or health of the pregnant woman" because that would require some degree of "trade-off" between woman's health and fetal survival). See also Jane L. v. Bangerter, 61 F.3d 1493, 1502-04 (10th Cir. 1995) (striking down provision that physician use abortion method that "'will give the unborn child the best chance of survival' unless that method would cause 'grave damage to the woman's medical health,'" because "Thornburgh's admonition that a woman's health must be the paramount concern remains vital in the wake of Casey") (citations omitted), sum. rev'd in part on other grounds sub nom. Leavitt v. Jane L., 116 S. Ct. 2068 (per curiam), and judgment reinstated in relevant part on remand, 102 F.3d 1112, 1114 n.1 (10th Cir. 1996). In short, even where survival of a viable fetus is at stake, the government may neither prohibit abortions without a health exception nor make them more dangerous to a woman's health.

The government's ability to regulate abortions in the pre-viability context is far more circumscribed. The Supreme Court held in Casey that government regulation before the fetus becomes viable is unconstitutional if it imposes an "undue burden" on a woman's ability to obtain an abortion. See, e.g., Casey, 505 U.S. at 895; id. at 877 (plurality). "Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." Id. at 846.² Under the approach taken in Casey, a regulation is unconstitutional on its face whenever, "in a large fraction of the cases in which [it] is

² As the plurality explained:

A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the 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. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.

Id. at 877.

relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." Id. at 895. This means that the constitutionality of a prohibition must be judged "by reference to those for whom it is an actual rather than an irrelevant restriction." Id. at 894-95.³ Applying that test here, the relevant group of cases should be limited to women who would have had their physicians perform the procedure at issue but for the prohibition in S.6. If, in a large fraction of these cases, the prohibition on the use of the procedure poses a substantial obstacle to the woman's election of an abortion, the prohibition is rendered unconstitutional.

Under S.6, physicians would face criminal prosecution for using this method of abortion even when they believed it was the safest procedure to use for a particular woman or [when it was the only procedure available in the woman's geographical area.⁴] The women for whom S.6 operates as a relevant prohibition, then, would be prevented from using this procedure where they would otherwise have chosen it, presumably, in consultation with their physicians as [the most medically appropriate method] for their situation. Therefore, it would appear that the bill is likely to impose an undue burden on not just a "large fraction" but most, if not all, women upon whom it operates as a relevant restriction. ever true?

³ Casey considered, among other things, the constitutionality of a provision allowing married women to obtain abortions only if their husbands had been notified, with certain exceptions, such as when, for example, the husband could not be located. The Court rejected the State's argument that the provision was not invalid on its face because only "one percent of the women seeking abortions who are married would choose not to notify their husbands of their plans." 505 U.S. at 894. The Court explained that the State had selected the wrong "controlling class" based on which to measure the impact of the restriction. The "real target is narrower . . . : it is 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 to the notice requirement." Id. at 895. Because for a "large fraction of the[se] cases" the notification requirement imposed a "substantial obstacle" to choosing an abortion, the Court held that it was facially invalid. Id.

⁴ In Women's Medical Professional Corp., the District Court concluded, after receiving sworn testimony from several physicians, that physicians were performing D&X abortions because this method appeared to pose less of a risk to a woman's health than any alternative procedure. 911 F. Supp. at 1070.



NATIONAL WOMEN'S LAW CENTER

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<i>As we discussed.</i>	

Draft

Language:

An abortion would be unlawful "when in the medical judgment of the attending physician the fetus is viable, unless it is necessary to save the life, ~~or of~~ prevent serious bodily injury to the woman, where serious bodily injury involves: (a) a substantial risk of death or (b) protracted loss or impairment of the function of a bodily member or organ [or system] [or mental faculty]."

Problems:

If "mental faculty" is deleted, it guarantees that a court will read that deletion as reflecting a clear Congressional intent to exclude mental health concerns, because the language on which this is modeled -- numerous federal statutes that have this definition of "serious bodily injury," or something very close to it -- invariably includes "mental faculty." See, e.g., 21 USC 802; 18 USC 1365; 18 USC 247; 18 USC 831; 33 USC 1319; 42 USC 6928; 18 USC 2246; plus many others that ~~cross~~ ~~reference~~ cross reference 18 USC 1365, such as 18 USC 43. See attached list

Even if impairment of a "mental faculty" is included, this language could be read very narrowly. First, it could be read only to cover mental health effects when they accompany physical health effects. Because the "mental faculty" language appears in the context of "serious bodily injury" ("where serious bodily injury involves . . . protracted loss or impairment of the function of a . . . mental faculty") it could be read to cover impairment of a mental faculty only when there is a "bodily" (i.e., physical) injury that also "involves" mental injury.

Second, there is caselaw construing "impairment of a mental faculty" very narrowly, under the statutes that include that language. See, e.g., United States v. Vasquez Rivera, 83 F.3d 542 (1st Cir. 1996) (rape victim who suffered extreme mental trauma from an ordeal that "had a devastating effect on her life" was held not to have suffered "protracted loss or impairment of the function of a . . . mental faculty" as required by 18 USC 1365); United States v. Yankton, 986 F.2d 1225 (8th Cir. 1993) (woman who endured a rape-induced pregnancy of twins, one of which died in utero and the other of which died three weeks after birth, was held not to have suffered "impairment of a function of a . . . mental faculty" under the federal Sentencing Guidelines even though her trauma had "life altering consequences"). There is thus no assurance that the mental trauma and life altering consequences of carrying an unwanted pregnancy to term and delivering a baby incompatible with sustained or cognitive life would be held to qualify as "impairment of a mental faculty" under the language under consideration.

This language does not include "extreme physical pain" as another category of "serious bodily injury," even though many of the statutory models cited ~~above~~ above do include this category. See, e.g., 18 USC 1365; 18 USC 247; 18 USC 831.

See attached.

The omission of this category will be construed as a deliberate decision by Congress to exclude it.

The language doesn't make clear that it applies when it is necessary in the judgment of the attending physician to save the woman's life or prevent serious bodily injury to her. Compare last year's Boxer amendment, which said "where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life or avert serious adverse health consequences"

The following federal statutes include the "mental faculty" language in their definitions of "serious bodily injury" like said definition in section 802 of the Drug Abuse Prevention and Control Act:

1. 18 USC §1365: Criminal Code: Tampering with Consumer Products:

(3)[T]he term "serious bodily injury" means bodily injury which involves--

- (A) a substantial risk of death;
- (B) extreme physical pain;
- (C) protracted and obvious disfigurement; or
- (D) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

18 USC §1365(g)(3).

2. The above definition of "serious bodily injury" which includes the "mental faculty" language has been incorporated by reference throughout the United States Criminal Code, Title 18 USC. Examples include:

- a. 8 USC §1324: Immigration and Nationality Deportation: Bringing in and Harboring Certain Aliens
- b. 18 USC §37: Aircraft and Motor Vehicles: Violence at International Airports
- c. 18 USC §43: Animal Enterprise Protection Act of 1992
- d. 18 USC §113: Assault with Maritime and Territorial Jurisdiction
- e. 18 USC §831: Prohibited Transactions Involving Nuclear Materials
- f. 18 USC §1153: Offense Committed with Indian Country
- g. 18 USC §1347: Mail Fraud: Health Care Fraud
- h. 18 USC §2119: Robbery and Burglary: Motor Vehicles
- i. 18 USC §2261A: Domestic Violence and Stalking: Interstate Stalking
- j. 18 USC §2332b: Terrorism: Acts of Terrorism Transcending National Boundaries

3. 18 USC §247: Civil Rights: Damage to Religious Property

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious

disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

4. 18 USC §1864: Hazardous or Injurious Devices on Federal Lands

(1)[T]he term "serious bodily injury" means bodily injury which involves--

- (A) a substantial risk of death;
- (B) extreme physical pain;
- (C) protracted and obvious disfigurement; and
- (D) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

5. 18 USC §2246: Sexual Abuse

(4)[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

18 USC §2246(4).

6. 18 USC Appx 1B1.1: Sentencing Guidelines for the United States Courts: Application Instructions

(j) "Serious bodily injury: means injury involving extreme physical pain or the impairment of a function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

7. 33 USC §1319: Water Pollution Prevention and Control: Enforcement

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

8. 42 USC §5106a: Child Abuse Prevention and Treatment and Adoption Reform: Grants for States

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

9. 42 USC §6928: Solid Waste Disposal: Federal Enforcement

The term "serious bodily injury" means--

- (A) bodily injury which involves a substantial risk of death;
- (B) unconsciousness;
- (C) extreme physical pain;
- (D) protracted and obvious disfigurement; or
- (E) protracted loss or impairment of the function of a bodily member, organ or mental faculty.

10. 42 USC §7413: Air Pollution Prevention and Control: Federal Enforcement

The term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

Abortion - partial birth -
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 Also - Ab - PB - medical
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April 2, 1997

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To: Regional Directors CWE Members

From: Lois Waldman

Re: Lobbying Against Bill Regulating Intact Dilation and
 Extraction Procedure ("Partial Birth Abortion")

INTRODUCTION

On March 20, the United States House of Representatives voted for the fourth time to ban an abortion procedure described by gynecologists as "intact dilation and extraction" and by abortion opponents as "partial birth" abortion. The issue now goes to the Senate. Senator Trent Lott, the Republican leader and abortion opponent, has announced that the measure will not be taken up until after the Congressional recess, which ends April 6, and perhaps not until late April so as to give, in Lott's words, time for a "little steam to build up." The Senate is still about seven votes shy of being able to override a Presidential veto. However, since the President's veto last session, there have been statements by a lobbyist for the National Coalition of Abortion Providers that he lied about the number of the D&E abortions and the circumstances under which they were performed.¹ These statements have played into the hands of anti-choice politicians, demonized this specific procedure and assisted the right-to-life forces in their effort to blur the distinction between pre- and post-viability abortions. In the House, for example, five legislators changed their votes this time, including some who were formerly considered firmly pro-choice, like Sue Kelly of New York and Christopher Shays of Connecticut. Further, the composition of the Senate has changed. It is vital that Senators be shored up to support the presidential veto that has been promised. A list of particular Senators who need our efforts is available on request. It is also important that efforts to enact similar bills in the various states be turned back. Currently, bills are pending in many states, including New York,

Arkansas, Illinois, Montana, Oklahoma and South Carolina, and prohibitions have already been enacted in Michigan, Mississippi, South Dakota, Alaska and Georgia.

In order to effectively argue against these bills with our legislators, we must understand both the medical and legal implications. The following is an attempt to set forth the medical and legal facts and to respond to the most commonly asked questions on the issue.

MEDICAL FACTS

Because doctors who perform abortions are reluctant to call attention to themselves or their procedures, information about the medical aspects of the procedures has not been readily available in the media. Recently, both in an article in *The New York Times* and in depositions in a case challenging the Michigan law on intact D&Es, doctors have spoken about the procedures used in late term abortions. The following facts have been set forth:

(1) Approximately 90% of abortions occur during the first trimester of pregnancy—that is, before the first 12 or 13 weeks. For these early abortions, physicians typically use suction curettage. In this procedure, the physician dilates the cervix and then removes the embryo or fetus and the other products of conception with a tube inserted into the uterus. The tube is attached to a vacuum generator.

(2) After the first trimester, when the fetus is often too large to remove simply by means of suction, physicians generally use one of two methods: D&E, which accounts for 95% of post-first trimester abortions, or induction, which accounts for 5% of such abortions.

(3) Late abortions are rare in and of themselves. Approximately 5% of abortions occur after 16 weeks. Only 1% or 15,000 of the 1.5 million abortions a year take place after 20 weeks of gestation. Most late abortions occur between 20 and 24 weeks. The rarity of these abortions give the lie to the impression created by the anti-choice forces that most abortions involve mature fetuses akin to born babies. These advanced pregnancies are ended by one of three basic methods.

(4) After fourteen weeks and throughout the early part of the second trimester, most physicians use a D&E procedure. At the outset of a D&E procedure, the physician dilates the cervix, typically over twelve to thirty-six hours, with multiple intracervical osmotic dilators made of either laminaria (seaweed) or a synthetic agent. When the cervix is sufficiently dilated, the physician, using a combination of forceps, suction curettage, and sharp curettage, disjoins and removes the fetus. Typically, the calvarium (skull) is too large to pass through the cervix whole, and so must be compressed. Sometimes, the physician uses suction to remove the contents of the calvarium before compressing it.

(5) For procedures later in the second trimester, some physicians use a variant of D&E, known as intact D&E or dilation and extraction (D&X). In the intact D&E, the physician dilates

the cervix and then removes the fetus from the uterus intact. To do so, the physician extracts the fetal body intact, feet first, until the cervix is obstructed by the aftercoming head, which is too large to pass through the cervix. Then, using a sharp instrument, the physician creates a small opening at the base of the fetal skull and evacuates the contents, allowing the skull to pass through the cervical opening.

(6) Aside from D&E, the other common method of post-first-trimester abortion is induction, which entails using medications to induce premature labor. There are several ways of inducing labor. One is to inject an agent such as oxytocin intravenously, continuously over many hours. A second method--instillation--involves injecting agents such as prostaglandins, prostaglandins and urea, or hypertonic saline into the amniotic sac. A third method involves introducing prostaglandins into the vagina or cervix. A fourth method entails intramuscular injection of prostaglandins.

(7) Inductions are not generally done before 16 weeks. Before that point, the uterus is relatively less responsive to labor-inducing medications, and any instillation procedure is technically more difficult and less successful.

D&E is said to be safer than induction, which involves the same complications as labor and delivery and is physiologically stressful to the woman, particularly for women with certain medical conditions such as cardiac ailments and active pelvic infections. D&E is said to entail lower rates of maternal health complications, including fever, endometritis, retained products of conception, hemorrhage and cervical injury. It also can be performed earlier, which, in view of the fact that delay increases abortion risks, is an advantage.

Intact D&E has certain advantages over standard D&E. For example, intact D&E may reduce the risk of uterine perforation because it dramatically reduces the insertion of sharp instruments into the uterus, and because the fetus passes through the birth canal intact. In a standard D&E, in which the physician disjoins the fetus, sharp instruments and sharp fetal fragments may damage the woman's tissues. An intact D&E reduces those risks. An intact D&E may also result in less blood loss and less trauma for some patients, and may take less operating time, thus reducing anesthesia needs. Intact D&E may also have some advantages when a physician needs an intact fetus for an autopsy to assess the risk of fetal anomaly.

It may be difficult for a physician to predict with certainty that an intact method will be most appropriate in a particular procedure. If, for example, the physician grabs the fetal foot first, and the fetus starts to pass intact, it may be safer and quicker to do an intact procedure.

Because an intact D&E may be the most appropriate method for some patients, the American College of Obstetricians and Gynecologists has taken the position that the physician's best medical judgment must govern the decision of which method to use, and that the state should not ban specific methods, including intact D&E.

Although the epidemiological and medical data bear on the assessment of the safety of various methods of pregnancy termination, the procedure that is generally statistically safest may not be the best procedure for a particular woman in light of her circumstances. When performing an abortion, the physician determines the most appropriate method for a particular patient based on many variables: any underlying health conditions the patient may have; the exact stage of pregnancy; the condition of the fetus; the position of the fetus; the skill and training of the physician; and the facilities available. For abortion to remain safe, the physician must retain the discretion to make this judgment.

LEGAL SITUATION

Under *Roe v. Wade* and the subsequent *People v. Casey*, which reaffirmed a woman's fundamental right to reproductive choice, the Supreme Court has held that states may outlaw abortions only after fetal viability, that is, when the fetus is capable of survival outside the womb. Even as to these post viability abortions, states must allow exceptions to protect the life and health of the mother. Health has been held to include psychological health. Though viability varies and it is to be decided by physicians, not the legislature, it becomes more common after 24 weeks.

Thus, with respect to the 500 or so intact D&E procedures performed after 24 weeks, if performed on a viable fetus and not to protect the life or health of the mother, such abortions are already illegal. Forty one states and the District of Columbia have passed laws banning abortion after viability.¹ Thus, the intact D&E prohibition is not needed. And to the extent that the proposed prohibition does not permit exceptions for the health of the mother, it would be unconstitutional.

With respect to abortion after 20 weeks but before viability, *Roe v. Wade* and *People v. Casey* hold that the state may regulate to protect maternal health and to promote its interest in the potential life of fetus. However it may not impose an undue burden on a woman seeking such an abortion. That is, the state may only impose restrictions which do not have the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion." In prior cases the Supreme Court has held that a woman and her physician--and not the government--must be able to determine the course of her medical treatment. In *Colautti v. Franklin*, the Justices found unconstitutional a state statute that required physicians performing abortions when a fetus is or may be viable to use the techniques most likely to

¹ Ban opponents in the House used the key concept of viability to unsuccessfully push an alternative measure that would have banned all post viability abortions except those needed to save a woman's life and health, but allow any procedure before viability. Senator Daschle is working on a similar compromise in the Senate.

result in a live birth. In rejecting the measure, the High Court explicitly recognized the "central role of the physician," both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out.

Similarly, efforts to ban a specific abortion method, whether before or after viability, have been found to impermissibly restrict a physician's ability to use the procedure that best suits the particular medical needs and circumstances of a patient. Both the Supreme Court and lower federal courts have invalidated state laws that prevented a woman and her physician from determining the method of abortion to be used. In *Planned Parenthood of Central Missouri v. Danforth*, the Justices struck down a ban on the use of saline amniocentesis after the first 12 weeks of pregnancy, in part because "it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed."

Even when the government exercises its authority to ban abortions after viability, the Supreme Court has made clear that the state may not make its interest in the fetus paramount to women's health or require a "trade-off" between a woman's health and fetal survival. In *Thornburgh v. American College of Obstetricians and Gynecologists*, the Justices invalidated a law requiring a physician performing a post-viability abortion to employ the abortion technique "which would provide the best opportunity for the unborn child to be aborted alive unless ... that technique would present a significantly greater medical risk to the life or health of the pregnant woman."

If it can be established, as the depositions by physicians in the Michigan case seek to do, that induction is not an equally safe alternative and thus there are no equally safe and available alternative methods of abortion in particular cases to the intact D&E and standard D&E procedures, then the Court would have to find that the prohibition on intact D&E was unconstitutional.

In fact, the only Federal case to consider a constitutional challenge to a state prohibition on intact D&E procedure enjoined the ban. It found that the procedure not only "appears to have the potential of being a safer procedure than other available abortion procedures" after the 19th week of pregnancy. *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051, 1070 (S.D. Ohio 1995). The court compared the D&X procedure to induction, hysterotomy and hysterectomy and found it safer.

The court in this case also found that the use of D&X in the late second trimester "appears to pose less risk to maternal health" than D&E "because it is less invasive—that is, it does not require sharp instruments to be inserted into the uterus with the same degree of risk of uterine and cervical lacerations.

However, although the current bills for the reasons listed above seem patently unconstitutional, we cannot rely on the long and arduous court procedures to eliminate the

threat to abortion rights. Difficult though it may be, these bans must be fought in the legislature.

STRATEGY AND COUNTER STRATEGY

The very effective strategy of the antiabortion forces has been to single out this particularly "unattractive procedure" and to suggest falsely that it is performed on fetuses at a very late stage and thus to spread the view that abortion is akin to "infanticide." The facts as we have shown are otherwise. By blurring the distinction between viable and pre-viable fetus they seek to move the legal prohibition backward in time and thus effectively undermine *Roe* and change the current law so as to ban almost all abortions after 20 weeks.

Pro-choice advocates recognize that not only are intact D&E procedures performed very late in pregnancy in cases of severe fetal anomalies or where the health of the mother is at risk but also on a substantial number of nonviable fetuses carried by often healthy women. However, the answer to this situation is not to ban this procedure but to recognize that most of these late term abortions involve teenagers who deny their pregnancies, victims of incest, drug users, women who are menopausal or have irregular periods and women who because of poverty or personal disorganization are unable to obtain an early abortion. The solution to these problems is improved contraception and, as one editorial writer has argued, to remove the barriers that keep women from getting early abortions--parental notification laws and lack of Medicaid funding--and to encourage access to promising new drugs that induce abortion very early in pregnancy.

While acknowledging that the procedure sought to be banned is gruesome, pro-choice advocates must argue that many medical procedures--open heart surgery, amputation, heart and liver transplants, etc.--may seem gruesome to the lay person, but for those whose lives and health are saved by it, "gruesome" is not the issue. Rather, the determination of which abortion procedure is best for a particular woman in a particular circumstance should not be determined by which procedure is aesthetically pleasing (no abortion procedure is that) but is best left to medical professionals in consultation with the patient and her family.

Until women have improved means to control their fertility, and this requires greater investment in contraceptive research, women must continue to argue that abortion must remain an option if women are to achieve true parity and participate equally in the economic and social life of the nation. And so long as abortion is legal, physicians must be permitted to use their best judgment in deciding the abortion method that is safest for the woman in a particular situation. In this connection, it must be noted that no major medical organization has supported legislation to ban the D&X procedure. In fact, numerous medical organizations--including the American College of Obstetricians and Gynecologists, the American Public Health Association,

Regional Directors/CWE Members
Partial Birth Abortion Lobbying
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and the American Medical Women's Association--oppose any such legislation. (I am enclosing one of their statements.)

Moreover, a lack of consensus in the medical community is not grounds for the legislature to step in and decide the issue. In such circumstances, individual trained and licensed doctors, not legislators, should be left to determine what medical procedures are appropriate.

drs

*Pachal Birth P. 1
Fitzsimmons*

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TO: Betsy Myers

FROM: Ron Fitzsimmons

DATE: February 25, 1997

NO. OF PAGES (incl. cover sheet): 7

Attached is the article that we discussed at the National Press Club a few weeks ago. It will not be officially available until the end of the week, but I wanted to send you a copy ahead of time.

I am in Florida visiting clinics today, but I will be back in the office after 1 PM tomorrow. Please feel free to call me at any time to discuss this or any other matter.

Medicine adds to debate on late-term abortion

ACOG draws fire for saying procedure 'may' be best option for some

By Diane M. Gianeili
AMNEWS STAFF

WASHINGTON — As Congress and state legislatures consider banning a procedure opponents call "partial birth" abortion, the medical community is conducting its own appraisal of this controversial late-term abortion procedure.

The American College of Obstetricians and Gynecologists weighed in with an opinion from its Executive Board in January, saying it could identify "no circumstances under which this procedure would be the only option to save the life of the mother or preserve the health of the woman."

It added, however, that the procedure, which ACOG called intact dilation and extraction (D&X) and others call intact dilation and evacuation (D&E), "may be

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Photo by Karen Ballard

'The pro-choice movement has lost a lot of credibility during this debate, not just with the general public, but with our pro-choice friends in Congress,' says Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers.

Abortion rights leader urges end to 'half truths'

By Diane M. Gianeili
AMNEWS STAFF

WASHINGTON — Breaking ranks with his colleagues in the abortion rights movement, the leader of one prominent abortion provider group is calling for a more truthful debate in the ongoing battle over whether to ban a controversial late-term abortion procedure.

In fact, Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, said he would rather not spend his political capital defending the procedure at all. There is precious little popular support for it, he says, and a federal ban would have almost no real-world impact on the physicians who perform late-term abortions or patients who seek them.

"The pro-choice movement has lost a lot of credibility during this debate, not just with the general public, but with

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ACOG

Continued from preceding page
he said, allowed them the chance to have another baby.

Opponents of the procedure assert, however, that the claim is without medical merit, and note that one of the five women at Clinton's veto ceremony had five miscarriages after her intact D&E. The procedure, opponents say, is potentially risky and actually contraindicated for fertility enhancement.

Late-term abortion options

A better option, they maintain, is to deliver the fetus by induction, using prostaglandin or pitocin to ripen the cervix and induce labor. Fetus demise can be induced beforehand.

Some also question the necessity of killing the fetus through brain suction or any other method if it has a condition incompatible with life and suggest it is "more humane" to have the physician induce labor and let the child die naturally.

Critics also say turning the fetus to a breech position can cause amniotic fluid embolism, placental abruption or uterine rupture.

And they maintain that the forcible dilation necessary to prepare the women's cervix for the procedure risks creating an "incompetent cervix," which could prevent a woman from carrying future pregnancies to term.

Diana Grossheim, from Huntington Beach, Calif., may be one of those women. Grossheim had an intact D&E in 1995. She now has an incompetent cervix.

When Grossheim's almost 21-week-old fetus died in utero, she said her physician told her she had two choices: labor, which was described as up to 48 hours of torture, or intact D&E, which her doctor described as "more merciful."

Grossheim said the procedure was "three days of pure hell" — both physical and mental.

She had to stay in a hotel and go back

Abortion leader

Continued from page 3
our pro-choice friends in Congress," Fitzsimmons said. "Even the White House is now questioning the accuracy of some of the information given to it on this issue."

He cited prominent abortion rights supporters such as the *Washington Post's* Richard Cohen, who took the movement to task for providing inaccurate information on the procedure. Those pressing to ban the method call it "partial birth" abortion, while those who perform it refer to it as "intact"

dilation and extraction (D&X) or dilation and evacuation (D&E).

What abortion rights supporters failed to acknowledge, Fitzsimmons said, is that the vast majority of these abortions are performed in the 20-plus week range on healthy fetuses and healthy mothers. "The abortion rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," he said.

He knows it, he says, because when the bill to ban it came down the pike, he called around until he found doctors who did them.

"I learned right away that this was being done for the most part in cases

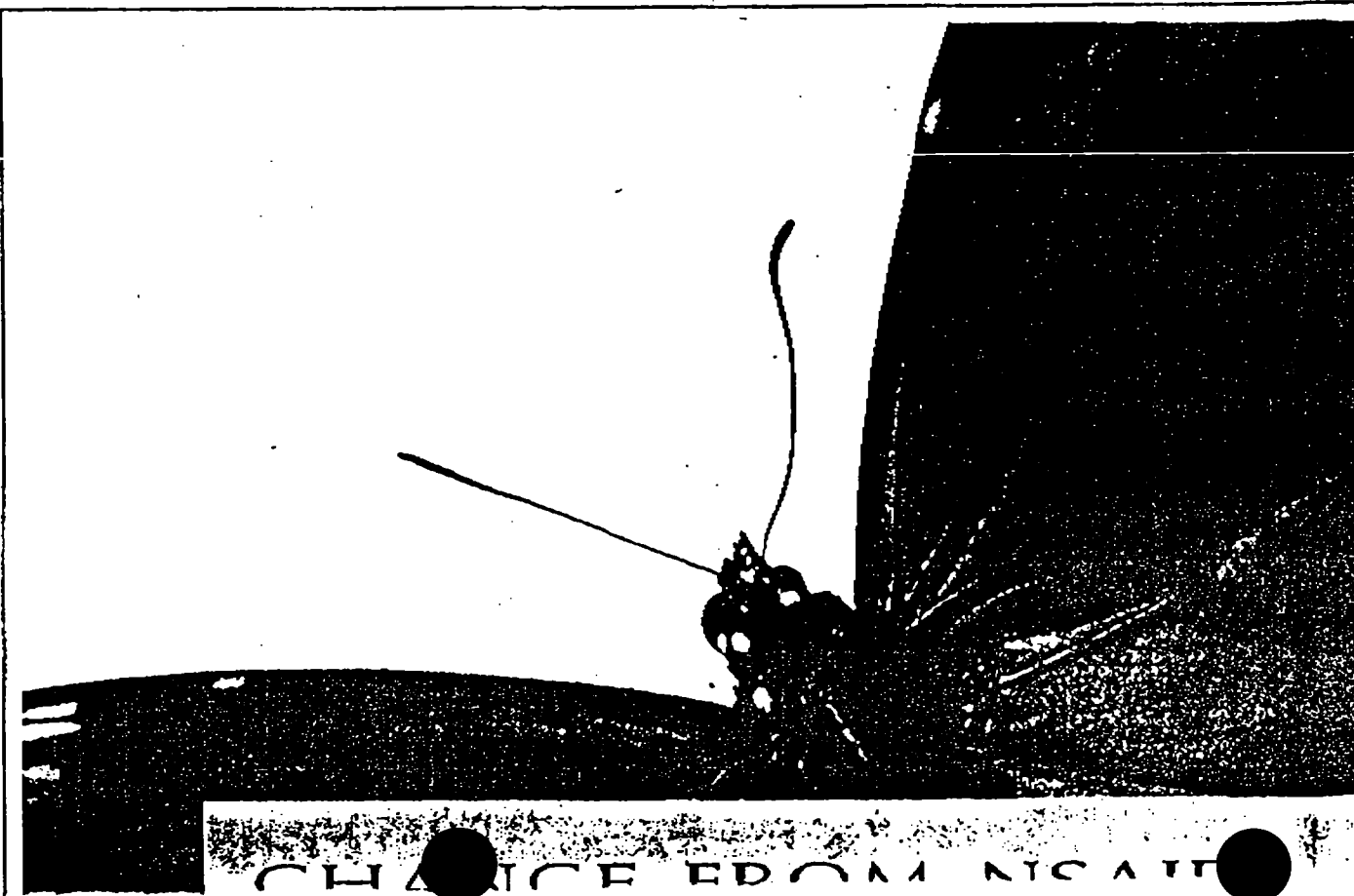
that did not involve those extreme circumstances," he said.

The National Abortion Federation's Vicki Saporta acknowledged that "the numbers are greater than we initially estimated."

As for the reasons, Saporta said, "Women have abortions pre-viability for reasons that they deem appropriate. And Congress should not be determining what are appropriate reasons in that period of time. Those decisions can only be made by women in consultation with their doctors."

Bill's reintroduction expected

Rep. Charles Canady (R, Fla.) is



CHANCE FROM NCAP

expected to reintroduce legislation this month to ban the procedure.

Those supporting the bill, which was also introduced in the Senate, inevitably evoke winces by graphically describing the procedure, which usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The physician then forces a sharp instrument into the base of the skull and uses suction to remove the brain. The procedure is usually done in the 20- to 24- week range, though some providers do them at later gestations.

Abortion rights activists tried to combat the images with those of their own,

showing the faces and telling the stories of particularly vulnerable women who have had the procedure. They have consistently claimed it is done only when the woman's life is at risk or the fetus has a condition incompatible with life. And the numbers are small, they said, only 500 to 600 a year.

Furthermore, they said, the fetus doesn't die violently from the trauma to the skull or the suctioning of the brain, but peacefully from the anesthesia given

to the mother before the extraction even begins.

The American Society of Anesthesiologists debunked the latter claim, calling it "entirely inaccurate."

And activists' claims about the numbers and reasons have been discredited by the very doctors who do the procedures. In published inter-

views with such newspapers as *American Medical News*, *The Washington Post* and *The Record*, a Bergen County, N.J.,

*'The real-world impact
[of a ban] on doctors and
patients is virtually nil,'
Fitzsimmons says.*

newspaper, doctors who use the technique acknowledged doing thousands of such procedures a year. They also said the majority are done on healthy fetuses and healthy women.

The New Jersey paper reported last fall that physicians at one facility perform an estimated 3,000 abortions a year on fetuses between 20 and 24 weeks, of which at least half are by intact D&E. One of the doctors was quoted as saying, "We have an occasional amnio abnormality, but it's a minuscule amount. Most are Medicaid patients ... and most are for elective, not medical reasons: people who didn't
See ABORTION LEADER, next page

Abortion leader

Continued from preceding page
realize, or didn't care, how far along they were."

A *Washington Post* investigation turned up similar findings.

'Spins and half-truths'

Fitzsimmons says it's time for his movement to back away from the "spins" and "half-truths." He does not think abortion rights advocates should ever apologize for performing the procedure, which is what he thinks they are doing by highlighting only the extreme

cases.

"I think we should tell them the truth, let them vote and move on," he said.

Charlotte Taft, the former director of a Dallas abortion clinic who provides abortion counseling near Santa Fe, N.M., is one of several abortion rights activists who share many of Fitzsimmons' concerns.

"We're in a culture where two of the most frightening things for Americans are sexuality and death. And here's abortion. It combines the two," Taft said.

She agrees with Fitzsimmons that a debate on the issue should be straightforward. "I think we should put it on

the table and say, 'OK, this is what we're talking about: When is it OK to end these lives? When is it not? Who's in charge? How do we do it?' These are hard questions, and yet if we don't face them in that kind of a responsible way, then we're still having the same conversations we were having 20 years ago."

Fitzsimmons thinks his colleagues in the movement shouldn't have taken on the fight in the first place. A better bet, he said, would have been "to roll over and play dead, the way the right-to-lifers do with rape and incest." Federal legislation barring Medicaid abortion funding makes exceptions to save the

life of the mother and in those two cases.

Fitzsimmons cites both political and practical reasons for ducking the fight. "We're fighting a bill that has the support of, what, 78% of the public? That tells me that we have a PR problem," he said, pointing out that several members of Congress who normally support abortion rights voted to ban the procedure the last time the measure was considered.

From a practical point of view, it also "wasn't worth going to the mat on. ... I don't recall talking to any doctor who said, 'Ron you've got to save us on this one. They can't outlaw this. It'd be terrible.' No one said that."

He added that "the real-world impact on doctors and patients is virtually nil." Doctors would continue to see the same patients, using an alternative abortion method.

In fact, many of them already do a variation on the intact D&E that would be completely legal, even if the bill to outlaw "partial birth" abortions passed. In that variation, the physician makes sure the fetus is dead before extracting it from the birth canal. The bill would ban only those procedures in which a live fetus is partially vaginally delivered.

Lee Carhart, MD, a Bellevue, Neb., physician, said last year that he had done about 5,000 intact D&Es, about 1,000 during the past two years. He induces fetal death by injecting digoxin or lidocaine into the fetal sac 72 hours before the fetus is extracted.

Damage control

Fitzsimmons also questions whether a ban on an abortion procedure would survive constitutional challenge. In any event, he concludes that the way the debate was fought by his side "did serious harm" to the image of abortion providers.

"When you're a doctor who does these abortions and 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? You know they're primarily done on healthy women and healthy fetuses, and it makes you feel like a dirty little abortionist with a dirty little secret."

Saporta says her group never intended to send this message to doctors.

"We believe that abortion providers are in fact maligned and we work 24 hours a day to try to make the public and others understand that these are heroes who are saving women's lives on a daily basis," she said.

When Fitzsimmons criticizes his movement for its handling of this issue, he points the finger at himself first. In November 1995, he was interviewed by "Nightline" and, in his own words, "lied," telling the reporter that women had these abortions only in the most extreme circumstances of life endangerment or fetal anomaly.

Although much of his interview landed on the cutting room floor, "it was not a shining moment for me personally," he said.

After that, he stayed out of the debate.

Don't get 'sidetracked' by specifics

While Fitzsimmons is one of the few abortion rights activists openly questioning how the debate played out, it is clear he was not alone in knowing the facts that surround the procedure.

At a National Abortion Federation meeting held in San Francisco last year, Kathryn Kohlbert, one of the chief architects of the movement's opposition
See ABORTION LEADER, facing page

Abortion leader

Continued from facing page
to the bill, discussed it candidly.

Kohlbert, vice president of the New York-based Center for Reproductive Law and Policy, urged those attending the session not to get "sidetracked" by their opponent's efforts to get them to discuss the specifics of the procedure.

"I urge incredible restraint here, to focus on your message and stick to it, because otherwise we'll get creamed,"

abortions, which are far fewer in number than those done in the late second trimester and more frequently done for reasons of fetal anomaly.

When the debate shifts back to "elective" abortions done in the 20- to 24-week range, the movement's response has been to assert that those abortions are completely legal and the fetuses are considered "pre-viable."

In keeping with this strategy, Sen. Thomas Daschle (D, S.D.), plans to introduce a bill banning third-trimester abortions. Clinton, who received an

troil both houses and therefore, the agenda.

And given the public reaction to the "partial birth" procedure — polls indicate a large majority want to ban it — some questions occur: Is the public reaction really to the procedure, or to late-term abortions in general? And does the public really make a distinction between late second- and third-trimester abortions?

Ethicists George Annas, a health law professor at Boston University, and Carol A. Tauer, PhD, a philosophy professor at the College of St. Catherine in St. Paul, Minn., say they think the public's intense reaction to the "partial birth" abortion issue is probably due more to the public's discomfort with late abortions in general, whether they occur in the second or third trimesters, rather than to just discomfort with a particular technique.

If Congress decided to pass a bill banning dismemberment or saline abortions, the public would probably react the same way, Dr. Tauer said. "The idea of a second-trimester fetus being dismembered in the womb sounds just about as bad."

Abortions don't have to occur in the third trimester to make people uncomfortable, Annas said. In fact, he said, most Americans see "a distinction between first-trimester and second-trimester abortions. The law doesn't, but people do. And rightfully so."

After 20 weeks or so, he added, the American public sees a baby.

"The American public's vision of this may be much clearer than [that of] the physicians involved," Annas said.

Regardless of procedure type, the public sees 'a distinction between first-trimester and second-trimester abortions,' an ethicist says. 'The law doesn't, but people do.'

Kohlbert told the group.

"If the debate is whether the fetus feels pain, we lose. If the debate in the public arena is what's the effect of anesthesia, we'll lose. If the debate is whether or not women ought to be entitled to late abortion, we probably will lose.

"But if the debate is on the circumstances of individual women ... and the government shouldn't be making those decisions, then I think we can win these fights," she said.

Public reaction

The abortion rights movement's newest strategy in fighting efforts to ban the procedure is to try to narrow the focus of the debate to third-trimester

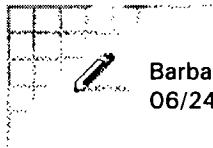
enormous amount of heat for vetoing the "partial birth" abortion ban, has already indicated he would support such a bill.

But critics counter that Daschle's proposed ban — with its "health" exception — would stop few, if any, abortions.

"The Clinton-Daschle proposal is constructed to protect pro-choice politicians, not to save any babies," said Douglas Johnson, legislative director of the National Right to Life Committee.

Given the broad, bipartisan congressional support for the bill to ban "partial birth" abortions last year, it's unlikely Daschle's proposal would diminish support for the bill this session — particularly when Republicans con-

Abortion - partial birth -
medical statements



Barbara D. Woolley
06/24/97 07:36:56 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Marjorie Tarmey/WHO/EOP

Subject: AMA Meeting - Late Term

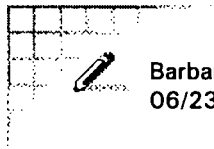
After 4 hours of debate and learning that former AMA CEO, Jim Todd had passed away, the AMA did adopt HR 1122 as policy. They adopted a resolution to work with Federal and State officials to address the criminal penalties issue. The AMA also agreed to work with ACOG and AMWA on issues of intent and vagueness. The vote was by voice vote and was not close.

Nancy Dickey, Chair, Board of Trustees, AMA, who lead the AMA review and recommended passage of HR 122, was elected at the meeting to become the first women President of AMA for 1998-1999.

Message Sent To:

Maria Echaveste/WHO/EOP
Ann F. Lewis/WHO/EOP
Jennifer L. Klein/OPD/EOP
Elena Kagan/OPD/EOP
Tracey E. Thornton/WHO/EOP
Janet Murguia/WHO/EOP
William P. Marshall/WHO/EOP
Robin Leeds/WHO/EOP

Abortion -
partial birth -
medical statements



Barbara D. Woolley
06/23/97 11:14:43 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Marjorie Tarmey/WHO/EOP

Subject: AMA/ACOG Joint Statement on HR 1122

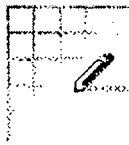
Today, AMA and ACOG released a joint statement on HR 1122. The statement highlights where the two organizations agree and disagree to assure that interested parties get a fair understanding of the exact nature of their disagreements.

They state that although they took different positions on the legislation they agree that clarity in definition is critical to any legislation prescribing the conduct of physicians, particularly when the penalties are criminal. If the application of the statute expands beyond what AMA believes is the intent, AMA and ACOG, will oppose such applications and will fully support any physician who is prosecuted.

Message Sent To:

Maria Echaveste/WHO/EOP
Tracey E. Thornton/WHO/EOP
Janet Murguia/WHO/EOP
Jennifer L. Klein/OPD/EOP
Ann F. Lewis/WHO/EOP
Elena Kagan/OPD/EOP
Robin Leeds/WHO/EOP

Abortion - partial birth -
medical ~~opinion~~
statements

 Barbara D. Woolley
07/21/97 06:47:54 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP, Elena Kagan/OPD/EOP, Maria Echaveste/WHO/EOP
cc: Marjorie Tarmey/WHO/EOP
Subject: American College of OBGYNs - Policy on Abortion - Update

ACOGs Executive Board recently met to reaffirm position.

"continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician."

ADAM - put birth -
med statement

American Medical Association

Physicians dedicated to the health of America



News Release

May 14, 1997

Statement is attributable to:

Nancy Dickey, MD
Chair
American Medical Association

LATE TERM ABORTION

"The American Medical Association Board of Trustees has forwarded to its House of Delegates for its consideration at AMA's Annual Meeting in June a report regarding late term abortions as requested by the House at its last meeting (December 1996). The report does not become AMA policy until approved by the House of Delegates. The report, which is based on the advice of an expert panel convened by the AMA and consisting of representatives from American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and AMA Councils on Ethics, Scientific Affairs and Legislation, reaffirms existing policy that abortion is a medical procedure subject to state laws and the standards of good medical practice.

"The report finds there is no 'identified situation' where intact dilatation and extraction or intact D&X (sometimes referred to as "partial birth abortion") is the 'only appropriate procedure' to induce abortion and it recommends against the use of the procedure except in unforeseen circumstances where it may be absolutely necessary.

"In addition, the report recommends that physicians not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies 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. Finally, the report calls on the medical profession, community organizations and the government to initiate more aggressive education efforts in order to reduce the demand for abortions generally.

"The report does not directly address any pending legislation regarding 'partial birth abortion.' The AMA does not support any legislative proposals at this time."

May 20, 1997

The Honorable Rick Santorum
United States Senate
Senate Russell 120
Washington, DC 20510

Dear Senator Santorum:

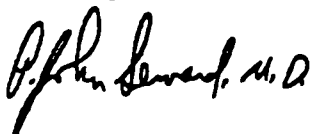
After months of intense deliberation, the American Medical Association (AMA) is writing to support HR 1122, "The Partial-Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122² now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,



P. John Seward, MD

*Amniotic fluid -
medical statement*

ADDENDUM TO THE REAFFIRMED 1993 ACOG POLICY ON ABORTION

The American College of Obstetricians and Gynecologists (ACOG) continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician.

Approved by the Executive Board
July 1997



ACOG *Statement of Policy*

As issued by the ACOG Executive Board

ACOG POLICY ON ABORTION

1. The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected.
2. The American College of Obstetricians and Gynecologists recognizes that the issue of support of or opposition to abortion is a matter of profound moral conviction to its members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions based on personal values or beliefs.
3. Termination of pregnancy before viability is a medical matter between the patient and physician, subject to the physician's clinical judgment, the

principles in their own practices and to support them at the community level.

Society also has a responsibility to support research leading to improved methods of contraception for men and women.

5. Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.

A pregnant woman should be fully informed in a balanced manner about all options, including raising

Abortion - Partial Birth -
Medical Statement



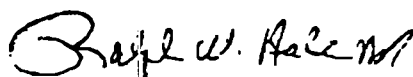
May 19, 1997

The Honorable Trent Lott
Senate Majority Leader
S-230 Capitol Building
Washington, DC 20510-7010

Dear Senator Lott:

In light of the slight modifications being proposed to HR 1122, the "Partial-Birth Abortion Ban Act of 1997," we wanted to take this opportunity to reiterate our opposition to this legislation. Our statement on this issue is attached.

Sincerely,


Ralph W. Hale, MD
Executive Director



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

NOT YET
POLICY

Atch -- part 4 -- the -- medical
statements --

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 age³

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-trimester²⁷

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>				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%
Totale	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>			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 38.0oC (100.4oF) 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.

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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.

MEDICAL ETHICS REGARDING ABORTION

Major 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 debar 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

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

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

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.

Asst. - J. L. Luth -
med. education

May 1997

TO: Delegates and Alternate Delegates
Executive Directors
State Medical Associations
National Medical Specialty Societies.

FROM: Nancy W. Dickey, MD
Chair, Board of Trustees

Included in this package is the Report of the Board of Trustees on Late-Term Abortion responding to Substitute Resolution 208. This report represents the cumulative work of many groups and individuals over the last several months. It should be evaluated as the science based treatise it was intended to be.

However, everyone is aware of the pending and peripherally related legislation. I am writing you this memorandum to share with you the thinking of the Board on this issue and to ask you to evaluate the legislative/political questions separately from, though very impacted by, the science issues.

Legislation addressing abortion procedures is currently pending in many state legislatures as well as the Congress. Action in the US Senate could come within the next two weeks. The Board's report on late-term abortion, developed by an expert panel, with representatives from AMA councils (Scientific Affairs, Ethical and Judicial Affairs, Medical Education, and Legislation), recognized medical specialty societies with expertise in this area (the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics), the AMA Board of Trustees and state medical associations, recommends severe restrictions on the use, at any time, of the abortion procedure known as intact dilation and extraction (intact D&X). In addition, the Report recommends that physicians "generally" not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because abortion is rarely necessary to preserve the life or health of the mother at this stage.

Generally, AMA policy calls for opposition to legislation controlling or criminalizing medical practice or procedures. However, AMA has supported legislation where the procedure(s) was narrowly defined, and not medically indicated such as prohibition of female genital mutilation.

For the AMA to support any legislation impacting medical decision-making the legislation would have to:

- Provide a formal role for medical peer determination (through the appropriate state medical licensing bodies or some similar process) in any enforcement proceedings under a bill.
- Retain for physicians the ability, using their best clinical judgment at the time, to use the procedure in an extraordinary circumstance where the patient would otherwise be seriously endangered.

- Use correct medical terminology so that it is clear on the face of the legislation what act is to be prohibited.

The AMA Board has determined that legislation regarding intact D&X would have to meet the above requirements to be supported. However, the strong concerns about intact D&X provided in the scientific report leave little basis for opposition if the legislative requirements were met. The widely debated, strongly supported, fast moving legislation in this area leads AMA to urge Congressional leaders on both sides of the debate to move forward and develop legislation consistent with these views.

Abortion - partial birth -
medical statements



AMERICAN MEDICAL WOMEN'S ASSOCIATION

For Immediate Release

Contact: Anne Pritchett
703-838-0500

Statement of the American Medical Women's Association on Abortion Legislation in the 105th Congress

Alexandria, VA (May 20, 1997)—The American Medical Women's Association, "is committed to protecting the reproductive rights of American women and has opposed any legislative intervention for medical and or surgical care decisions," says current AMWA President Debra R. Judelson, MD. This week, AMWA reiterated its opposition to H.R. 1122 and S. 6, which seek to ban a particular medical procedure.

It is the opinion of AMWA's Executive Committee that legislative efforts to regulate abortion have been flawed. Concerns in the following areas have prevented AMWA from taking a position on recent legislative efforts focusing on abortion in the 105th Congress.

- AMWA is gravely concerned with governmental attempts to legislate medical decisionmaking through measures that [do not protect a woman's physical and mental health, including future fertility,] or fail to consider other pertinent issues, such as fetal abnormalities. Physicians and their patients base their decisions on the best available information at the time, often in emergency situations. AMWA strongly opposes governmental efforts to interfere with physician-patient autonomy.

- It is irresponsible to legislate a particular test of viability without recognition that viability cannot always be reliably determined. Length of gestation is not the sole measure of viability because fetal dating is an inexact science.

- AMWA resolutely opposes the levying of civil and criminal penalties for care provided in the best interest of the patient. AMWA strongly supports the principle that

Representing Women in Medicine Since 1915

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AMWA is a 501(c)(3) non-profit organization. <http://www.amwa-doc.org>

medical care decisions be left to the judgment of a woman and her physician without fear of civil action or criminal prosecution.

Any forthcoming legislation will be carefully reviewed by AMWA based on the criteria outlined above, and AMWA will seek to ensure that there is no further erosion of the constitutionally protected rights guaranteed by *Roe v. Wade*. Says AMWA President Debra R. Judelson, MD, "AMWA firmly believes that physicians, not the President or Congress, should determine appropriate medical options. We cannot and will not support any measures that seek to undermine the ability of physicians to make medical decisions."

AMWA has long supported a woman's right to determine whether to continue or terminate her pregnancy without government restrictions placed on her physician's medical judgment and without spousal or parental interference.

Founded in 1915, the American Medical Women's Association represents more than 10,000 women physicians and medical students and is dedicated to furthering the professional and personal development of its members and promoting women's health.



Abortion - partial birth -
medical statements

May 13, 1997

The Honorable Thomas A. Daschle
509 Hart Senate Office Building
Washington, DC 20510

Dear Senator Daschle:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing 38,000 physicians dedicated to improving women's health. I am endorsing the legislative language of your substitute amendment to HR 1122. Although it does not take a position on the findings enumerated in your proposal, ACOG believes that by banning abortions on viable fetuses except when continuing the pregnancy threatens a woman's life or risks serious injury to her health, your substitute legislative language provides a meaningful ban while assuring women's health is protected.

ACOG believes this amendment is preferable to HR 1122 for the following reasons:

- It provides a meaningful ban, while allowing an exception when it is necessary for a woman's health. This preserves the ability of physicians to make judgments about individual patients, an issue of critical importance to physicians.
- The amendment does not dictate to physicians which abortion procedures can or cannot be performed.

In conclusion, ACOG supports your amendment and urges the Senate to adopt this language as an alternative to HR 1122.

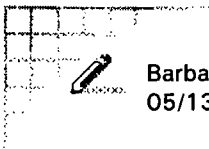
Sincerely,

Ralph W. Hale, M.D.

Ralph W. Hale, MD
Executive Director

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
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202/638-5577

Abortion -
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medical statements



Barbara D. Woolley
05/13/97 12:48:28 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: ACOG Position

ACOG is endorsing the legislative language of Daschle's substitute amendment preferable to HR.1122. I have a copy of the letter.

* It provides a meaningful ban, while allowing an exception when it is necessary for a women's health. It preserves the ability of physicians to make judgements about individual patients.

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Message Sent To:

Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Tracey E. Thornton/WHO/EOP
Maria Echaveste/WHO/EOP
John Podesta/WHO/EOP
Robyn Leeds/WHO/EOP
William P. Marshall/WHO/EOP

*blender
bubma*

1. Antenna

2.

*Abortion - partial birth -
medical statements*

May 1997

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Executive Directors
State Medical Associations
National Medical Specialty Societies.

FROM: Nancy W. Dickey, MD
Chair, Board of Trustees

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The AMA Board has determined that legislation regarding intact D&X would have to meet the above requirements to be supported. However, the strong concerns about intact D&X provided in the scientific report leave little basis for opposition if the legislative requirements were met. The widely debated, strongly supported, fast moving legislation in this area leads AMA to urge Congressional leaders on both sides of the debate to move forward and develop legislation consistent with these views.

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;

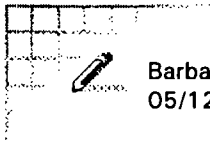
abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;

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.

Abortion -
partial birth -
medical statements



Barbara D. Woolley
05/12/97 07:04:23 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

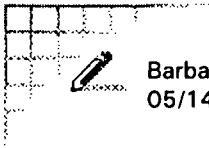
Subject: AMA Report - Late Term

AMA's Board of Trustees quietly released to selected Members of Congress today a new study reviewing the scientific literature on abortion and making 5 recommendations.

The following are highlights.

- * AMA reaffirms current policy regarding abortion: the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgement, the patient's informed consent.
- * The term 'partial birth abortion' is not a medical term and won't be used by the AMA. They will use the term "intact dilatation and extraction."
- * 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 D&X procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgement, acting within standards of good medical practice and in the best interest of the patient.
- * The viability of the fetus and the time when viability is achieved may vary with each pregnancy.
- * That abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery/
- * The AMA will work with ACOG, AAP to develop clinical guidelines for induced abortions after the 22nd week of gestation.
- * AMA urges CDC and state health dept to develop expanded, ongoing data surveillance systems of induced abortions.
- * AMA will work with appropriate medical specialty societies, government agencies, private foundation, and other interested groups to educate the public regarding pregnancy prevention strategies.

Abuse - partial birth -
medical statements



Barbara D. Woolley
05/14/97 02:06:13 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: AMA - Late Term, Daschle

AMA has put out a statement saying they do not support any legislative proposal at this time.

Message Sent To:

Tracey E. Thornton/WHO/EOP
Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Maria Echaveste/WHO/EOP
William P. Marshall/WHO/EOP
John Podesta/WHO/EOP
Ann F. Lewis/WHO/EOP

Send this as an alternative.

Abortion - partial birth -
Official statement,



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 20, 1997
(House)

STATEMENT OF ADMINISTRATION POLICY

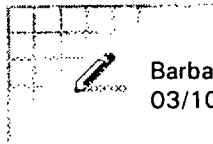
(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 1122 - Partial-Birth Abortion Ban Act of 1997 (Solomon (R) NY)

H.R. 1122 contains the same serious flaws as H.R. 1833, an identical bill that was passed during the 104th Congress and vetoed by the President on April 10, 1996.

The President will veto H.R. 1122 for the reasons he expressed in his veto message of April 10, 1996, which is attached.

*Partial Birth
Abortion -
ACOG*



Barbara D. Woolley
03/10/97 01:23:40 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: American College of OBGYN's - Partial Birth

ACOG's position statement on this issue has not changed. According to ACOG, "The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous." This is after the Catholic Bishops letter/statement today.

Message Sent To:

Maria Echaveste/WHO/EOP
John L. Hilley/WHO/EOP
Elizabeth A. Myers/WHO/EOP
Elena Kagan/OPD/EOP
FOLEY_M @ A1 @ CD @ LNGTWY
John P. Hart/WHO/EOP
Todd Stern/WHO/EOP
Pauline M. Abernathy/OPD/EOP
Peter G. Jacoby/WHO/EOP
Sylvia M. Mathews/WHO/EOP
Tracey E. Thornton/WHO/EOP

JAN-29-97 THU 03:28 PM

File
Abortion -
Partial birth - P. 02
Do Medical
statements



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 "Dilation and Extraction (D&X)". Planned Parenthood, for example, calls them D&X abortions, while the National Abortion Federation prefers Intact D&E, so there is no agreement, even among proponents of this procedure, as to what to call it. Indeed, in its January, 1996 newsletter, ACOG then referred to it as "intact dialation (sic) and evacuation." Your new coinage would seem to be a combination of these various "names" floating about, but to what end is not clear. What is clear is that none of these terms, including your own "Intact D&X" can be found in any of the standard medical textbooks or databases.

FOUNDING MEMBERS

Hon. T. 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,
Valley Hospital, OH

Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn
Medical Center,
LL
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
Medicine

L. DeCook, M.D.
Fellow, American College of
Obstetricians & Gynecologists

William Stalter, M.D.
Clinical Associate Professor,
Obstetrics & Gynecology
Wright State University, OH

Dennis Cavanagh, M.D.
Professor, Ob/Gyn
University of South Florida
College of Medicine, Tampa
FACOG

South Washington Street
#230
Alexandria, VA 22314
(703) 683-5004

Communications Counsel:
Tina Schmitt

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.

-- 03:29 PM

P. 04

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.

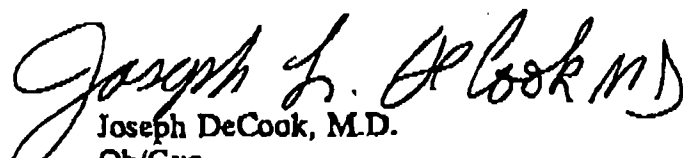
In truth, this statement is the product of a panel -- whose membership ACOG has not made public -- that was working behind closed doors and with no real participation from ACOG's membership itself. In crafting this statement, ACOG simply ignored its own members. There is the danger that in issuing this 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*.

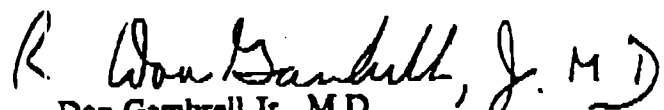
In conclusion, this statement clearly does *not* represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of the partial-birth abortion method. We ask you to provide the medical data, re all other relevant materials which could possibly have led to such an assertion, and you also make available the names of those on the select panel who arrived at this conclusion. We would also ask that the leadership of ACOG officially withdraw the statement until the matter at issue -- partial-birth abortion -- has been subject to open discussion among the members of ACOG and those doctors in relation who have significant knowledge regarding this issue. We look forward to your response.

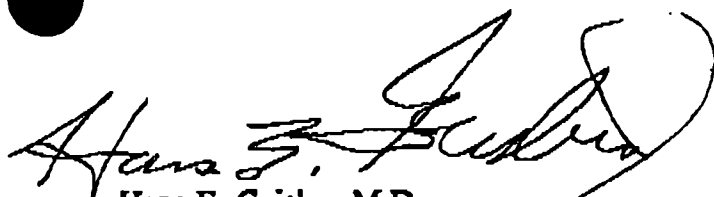
Sincerely:


Denis Cavanagh, M.D.
Professor of Ob/Gyn
Director, Division of Ob/Gyn
University of South Florida
College of Medicine
FACOG

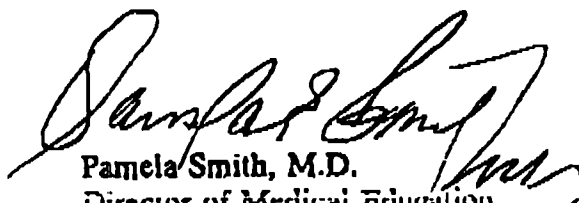

Curtis Cook, M.D.
Maternal-Fetal Medicine
Michigan State College
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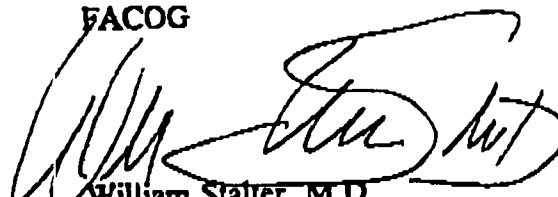

Joseph DeCook, M.D.
Ob/Gyn
FACOG

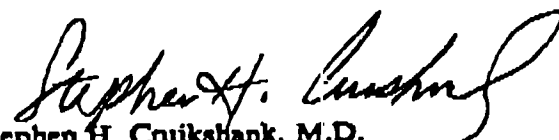

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Stephen H. Cruikshank, M.D.
Nicholas J. Thompson Professor and Chairman
Department of Obstetrics and Gynecology
Wright State University, OH

JAN-29-97 THU 03:30 PM

P.06

CC:

Vicki L. Seltzer, M.D.
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Dale L. Taylor, M.D.
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Daniel A. Chester, M.D.
Thomas F. Purdon, M.D.
William J. Peters, M.D.
Vivian M. Dickerson, M.D.
W. Gordon Peacock, M.D.
John D. Nash, Capt, MC USN
Nathana L. Lurvey, M.D.
Sarah S. Brown, MPH
American Medical Association (AMA) Task Force on "Intact Dilatation and
Extraction" [Partial-Birth] Abortion

Hypocritic Oath

le. How do you find a doctor who says there's no need to worry about smoking? Answer: Consult the American Medical Association.

In 1964, when the Federal Trade Commission proposed that cigarette packages carry health warnings, the A.M.A. broke with the American Cancer Society and other public health groups to oppose the plan. Why? The A.M.A. was violently opposed to the creation of Medicare — which it saw as a threat to physicians' bank accounts — and needed the support of tobacco-state Congressmen to derail it.

The secret A.M.A.-tobacco interests quid pro quo — which did slow the arrival of both Medicare (by one year) and health warnings in cigarette ads (by five-plus years) — was first reported by the muckraking Washington columnist Jack Anderson, who called it "the weirdest lobbying alliance in legislative history." Though the A.M.A. denied the story at the time, it has since been confirmed by Howard Wolinsky and Tom Brune of The Chicago Sun-Times, who provide a full account in their 1994 book, "The Serpent on the Staff."

Last week, history repeated itself. On the eve of the Senate's vote on "partial birth" abortion, the A.M.A. — which only five days earlier issued a report backing a doctor's discretion in choosing the safest abortion procedure for a patient, did an abrupt about-face. Suddenly it endorsed Senator Rick Santorum's "partial birth" ban — once the Senator made a few small changes designed to protect doctors, not women. As in 1964, the A.M.A. not only contradicted its own medical judgment but broke with other public-health organizations — this time the American College of Obstetricians and Gynecologists, the American Medical Women's Association and the American Nurses Association.

Why? Once again a journalist rakes in a clue. In this week's Modern Healthcare magazine, Jonathan Gardner reports that on the same day — May 19 — that the A.M.A. announced its "partial birth" switcheroo, its executive vice president, P. John Seward, sent an eight-page letter to Newt Gingrich (a copy of which I've now seen) that amounts to a Christmas list of requests in the latest battle over Medicare. Under the budget deal, Congress is squeezing Medicare spending by \$115 billion over five years, and, needless to say, Dr. Seward has a detailed plan to

stall or minimize any cuts that might come from physicians' hides.

As it did when caught in bed with Big Tobacco, the A.M.A. has vehemently denied any quid pro quo for its Medicare deathbed conversion on "partial birth" abortion: "Our positions on public health issues are done one at a time. There's an absolutely compelling need to look at things in isolation," said its spokesman to Modern Healthcare.

But equally compelling is the additional recent evidence suggesting that the A.M.A.'s priority is not public health but the wooing of the cur-

The A.M.A.'s bad medicine.

rent Congressional leadership, which it regards as its meal ticket in Medicare reform. In the 1995 debate over Medicare cuts, the A.M.A. was also caught by journalists in the act of making behind-closed-door sweetheart deals with Speaker Gingrich. In 1996, the A.M.A.'s campaign contributions overwhelmingly favored G.O.P. candidates.

That the A.M.A., like any labor union, should lobby intensely to bolster its members' incomes is hardly unexpected. What makes its last-minute effort to sway the abortion debate so noxious is that both it and its Congressional benefactors pretended that the A.M.A. board was handing down a principled medical judgment about women's health rather than just playing political pool. As Mr. Wolinsky and Mr. Brune detail in their book on the A.M.A., its position on abortion has always shifted "with the political winds as it suited the organization's purposes." The A.M.A. is pro-doctors' choice above all.

Such is the anguish among A.M.A. members that the board action could yet be rescinded when the association's full House of Delegates meets in June. Nor was the A.M.A. able to swing a veto-proof margin for the Santorum bill. But the organization's hardball Washington tactics nonetheless leave other drive-by casualties — kids who might have been educated earlier about the dangers of smoking in the 1960's, the elderly who might not get a fair economic shake in Medicare reform today. □

Foreign Affairs

THOMAS L. FRIEDMAN

Put Up, Shut Up, Hang Up

WASHINGTON

As the Arab-Israeli peace process continues sliding downhill, American officials say they may soon have to opt for one of two extremes: either "The Plan" or "The Phone Number." Either the President lays down, publicly, exactly what steps the U.S. believes Israelis and Palestinians must take to get the process back on track, or he gives them both the White House phone number, 202-456-1414, and tells them to call when they're serious. As one top White House official put it: "Either we step forward or we step backward, but where we are now is not working."

The temptation to walk is great. It would leave Yasir Arafat and Benjamin Netanyahu both standing stark naked before their own publics, without any U.S. mediators to hide behind or blame. But such strategic neglect would come at a price the U.S. may not want to pay. Here's why:

Mr. Arafat is not and has never been a democrat. He is at heart a typical Arab autocrat, for whom corruption, censorship and abuse of political opponents come naturally. Yet as a result of the Oslo process, Mr. Arafat has also presided over the creation of a Palestinian parliament, in the freest election ever in the Arab world. Palestinian elites were hopeful that as Mr. Arafat shifted the basis of his authority from leader of an armed struggle to leader of a peace process bringing Palestinians land and prosperity, he would be willing to — indeed would have to — tolerate more democracy within Palestinian life. In Jordan, too, King Hussein began fostering a freely elected Parliament and freer press to broaden his legitimacy for making peace with Israel and reforming Jordan's economy.

With the collapse of the Oslo process these baby steps toward democratization are being quashed, and

Mr. Arafat and King Hussein are reverting to form. This is, in part, because both men had made huge bets on Oslo. As it crumbles, they're increasingly politically exposed. Their critics are now out in full force, declaring, "I told you this would never work." And so their natural inclination is to silence all critics before they become a serious political challenge.

Mr. Arafat's outrageous arrest of one of the finest Palestinian journalists, Daoud Kuttab, is a good example. Mr. Kuttab's sin was that his infant Palestinian educational television station, a direct outgrowth of the peace process and the only real competitor to Mr. Arafat's official station, was broadcasting debates of the Palestinian legislature, another outgrowth of the peace process. The Palestinian legislators often criticize Mr. Arafat's rule. When things were going well he was ready to ignore much of it, but with his peace strategy in shambles he sees this sort of criticism as a more serious threat and so he arrests Mr. Kuttab. (He finally released him Tuesday.) In Jordan, King Hussein, also feeling besieged, has been clamping down on the press and tightening rules for who can run for office.

Mr. Netanyahu loves to lecture the Arab states about how they must become democracies. But he is trying to score propaganda points. Because Bibi is utterly blind to the relationship between the peace process and the process of internal change in the Arab world, Yitzhak Rabin chose not to build in Jerusalem because King Hussein wrote him and said such a move would badly undercut the King at home. With Bibi, King Hussein comes to Israel, asks him not to build in Jerusalem, and Bibi announces — at a joint news conference with the King — that he is going ahead anyway. Hello?

It would be absurd to suggest that the peace process is a cure-all for Arab politics. Democratization will only come to the Arab world after fundamental changes in Arab political culture. But the peace process helps promote internal changes, opens Arab societies and business to more outside contacts and puts some power in the hands of Arab democrats, like Daoud Kuttab. That is exactly why Syria's Hafez al-Assad fears the peace process. It's also why fledgling Arab democrats in Palestine or Jordan will be much worse off without it.

Which is also why, as much as I'd love to stick Mr. Arafat and Mr. Netanyahu with the phone number, that would be too easy on them. They might never dial the phone. The U.S. needs to come up with a clear-cut plan that engages every Israeli and Palestinian, presents them with some real choices and, ideally, enlists their pressure to move forward. □

The New York Times

THURSDAY, MAY 29, 1997

The peace process and Arab democrats.

Stop the Ticket Scalpers

Every frustrated theater, sports or music fan is familiar with the problem. After a huge buildup, tickets go on sale for a big game or entertainment event and are almost immediately sold out. Then suddenly it seems as if every broker, scalper or entrepreneur with an 800 number has seats available, but at several times the price of the original ticket. There ought to be a law preventing so many tickets ending up in the hands of price-gouging ticket agents, you say. Well, there is. The problem is that it is rarely enforced. Now the New York State Legislature is giving some thought to tightening the law and stiffening the penalties for scalping. Its efforts are welcome.

At first it looked as if the Legislature would adopt an approach that would only make the ticket-scalping problem worse. Republicans in the State Senate wanted to deregulate the resale of tickets altogether. Current law limits scalper markups to a cap of \$5 or 10 percent, whichever is greater, beyond the face value of any ticket. But Republicans argued that since this regulatory cap is widely ignored, getting rid of it entirely might at least encourage more brokers to enter the business and drive ticket prices down by free competition.

Theater owners and many other sponsors of entertainment events are strongly opposed to removing the ceilings on prices altogether. They argue that doing so would only unleash higher prices, turn off customers and encourage more scalpers into the business of buying up more tickets for themselves. As a result of the pressure from theaters and sponsors of sporting and other entertainment events, the idea of outright deregulation has been scrapped in Albany. Instead the debate is focused on where to set the new cap.

The ceiling ought to be fixed at a reasonable rate for ticket brokers, perhaps 30 percent above the face value of the ticket, without the possibility of

special charges added on beyond that. The new law should also contain stiff fines for anyone found guilty of charging more than the cap. Since many ticket brokers have moved out of the state to New Jersey and other parts of the region, the Attorney General or some other law enforcement authority should be given the power to require that all sellers in the secondary market register in New York, and then punish anyone who tries to sell a ticket to a New York event for an exorbitant price.

Some Democrats in Albany want another provision requiring Madison Square Garden and other places to disclose to the public how many of their tickets are held back from public sale. Three years ago, many fans were outraged that shows like Barney the dinosaur at Radio City Music Hall, and the Barbra Streisand concert at the garden, were sold out within minutes, at least partly because the people who put on those shows kept back large numbers of tickets for themselves.

Gov. George Pataki, Mayor Rudolph Giuliani and the Republicans in the Legislature, however, oppose the disclosure provision as an onerous burden on producers and promoters. Surely disclosure is a reasonable requirement in a regulated industry, though it should not be allowed to block passage of a bill placing a more realistic ceiling on ticket prices.

No matter what happens in Albany, the problem of exorbitant prices for the hottest tickets is not likely to go away. As long as there are people with money and the desire to get a ticket for a big game or hot show at the last minute, they will find the way to pay for it. But the Legislature should do what it can to prevent the problem from getting worse. The current law expires at the end of May and will be replaced by an old set of restrictions that will be even less likely to be enforced. It makes the most sense to ease the curbs somewhat and then enforce them aggressively.

Mr. de Klerk's Siege Mentality

When he served as South Africa's last white President, F. W. de Klerk could be a man of vision and pragmatism. He saw that apartheid was collapsing, and recognized that a negotiated transition was the only way to salvage some power for whites. He freed Nelson Mandela from jail and managed a transition to majority rule.

This month, however, Mr. de Klerk seems to have put his blinders back on. In dealing with his nation's Truth and Reconciliation Commission and with the future of his own National Party, he has retreated to narrow and unrealistic decisions. He is damaging his own reputation, the fortunes of his party and the chance that South Africans can live together in peace.

Earlier this month, Mr. de Klerk disbanded a National Party task force charged with redesigning the party. It was led by Roelf Meyer, the leader of the party's young generation and once Mr. de Klerk's most trusted lieutenant. Mr. Meyer won the respect of many black South Africans when he and Cyril Ramaphosa of the African National Congress led the teams negotiating the details of the transitional constitution. Mr. de Klerk set up the task force to help make the party into a conservative alternative to the A.N.C. for voters of all races.

Mr. Meyer feels that the party, which now enjoys the support of only 14 percent of South Africans, is doomed unless it is reconstituted with a mostly black leadership. He is certainly right, but the party hard-liners did not appreciate this view. They persuaded Mr. de Klerk to close down the task force. Mr. Meyer then resigned from the party to start a new political movement.

Also this month, Mr. de Klerk announced that

the National Party would no longer cooperate with the country's Truth Commission. His statement came after commission leaders questioned his testimony that he knew nothing about apartheid-era atrocities. Archbishop Desmond Tutu, who heads the commission, said that he himself had come to Mr. de Klerk when he was President with information about police brutality.

The National Party's withdrawal will probably not block the commission's quest to uncover the truth about apartheid-era crimes. The commission retains subpoena power, and those who have applied for amnesty for their crimes cannot turn back. The change will mean the National Party will no longer participate in party testimony, where it had provided little of value anyway. But the withdrawal will hurt the commission symbolically, fueling the erroneous but widespread feeling among whites that it is targeting the apartheid-era governments.

Mr. de Klerk's decisions show he has not yet come to grips with the consequences of the process he set in motion. His father was one of apartheid's architects, and he apparently cannot bring himself to admit that its top leaders knew of the crimes that were necessary to prop up minority rule. People who know him say he is bitter, feeling that blacks and particularly Mr. Mandela owe him gratitude he is not receiving.

South Africa needs a full accounting of the past, and a political system where parties are divided by ideology, not race. Mr. de Klerk's siege mentality is a setback to both goals. He would do his reputation, and his country, a service if he either returned to the leadership qualities that marked his presidency or got out of politics altogether.

The New York Times

THURSDAY, MAY 29, 1997

"We believe there are more than enough members still undecided on this issue to make the difference," Santorum said.

Those publicly uncommitted include Senate Democratic leader Tom Daschle, whose attempt at a compromise failed last week, and Democratic Sens. Tom Harkin of Iowa, Dale Bumpers of Arkansas and Robert C. Byrd of West Virginia and GOP Sen. Susan Collins of Maine. Santorum declined to identify others. Daschle's office declined comment on the AMA's change in position.

Clinton vetoed a similar bill last year and has promised to do so again because the measure doesn't provide an exemption when women's health is at risk a requirement laid down by the Supreme Court.

The immediate impact of the AMA's decision was unclear, although the bill's supporters previously had been heartened by Daschle's surprise announcement late last week that he might vote for the ban.

Daschle had tried unsuccessfully to fashion a compromise by proposing a ban on a variety of late-term abortions instead of the so-called "partial birth" procedure. But his proposal also would have permitted a broad range of health exceptions. He has said a case can be made that "this abhorrent procedure has to be stopped, regardless of the circumstances."

Santorum said the changes are designed to shelter doctors from overzealous prosecution. Any doctor accused of performing an illegal procedure would have the right to a review by a state medical board before trial. The bill also narrowly defines the proposed outlawed procedure to assure a permissible procedure is not banned.

The bill is H.R. 1122.
APNP-05-20-97 1145EDT

Date: 05/20/97 Time: 11:31

AGOP amends abortion bill slightly, wins AMA endorsement

WASHINGTON (AP) Republican sponsors of legislation to ban a late-term abortion procedure hope a few changes to the bill that won an endorsement from the American Medical Association will swing enough votes their way to overcome a presidential veto.

Still hunting for the necessary votes in the Senate, lawmakers agreed Monday to minor changes in the bill and received a stamp of approval from the nation's largest medical group in return. The Senate approved the amendments today without objection and planned to vote this afternoon on the bill.

The AMA, which had declined to endorse the measure last week and remained neutral, voted Monday to support the ban on what abortion opponents call "partial birth" abortions.

"We think that with the AMA endorsing it in the last 24 hours there is some churning, some potential movement," Senate Majority Leader Trent Lott said today. "We hope the president will consider the modifications that were made."

"I think this gives our effort ... a real boost," said Rep. Charles Canady, R-Fla., who sponsored the original bill almost two years ago in the House. "I think we're within sight of a veto-proof majority."

In a statement, the AMA said its board decided to support the bill because it has been "significantly changed" to meet the organization's own criteria for abortion legislation.

Sponsors said the measure, among other changes, now protects doctors from prosecution when they are intending to deliver a baby but are forced to resort to the abortion procedure to save the mother's life.

"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," AMA executive vice president P. John Seward wrote in a letter to Sen. Rick Santorum, R-Pa., sponsor of the bill.

Seward said the bill "now meets both those tests."

The National Right to Life Committee welcomed the AMA endorsement, but Kate Michelman, president of the National Abortion and Reproductive Rights Action League, accused the group of opening the door to "politicians' intrusion into doctors' professional decision-making."

The endorsement, she said in an interview, will leave doctors vulnerable to "political whims while sacrificing the health of women and the privacy and the sanctity of the doctor-patient relationship."

The American College of Obstetricians and Gynecologists, the leading medical organization in women's health care, continues to oppose the bill on grounds it is "inappropriate, ill-advised and dangerous" for lawmakers to meddle in medical decision-making.

If the Senate approves the amended bill, the House would have to agree to the changes before the measure could be sent to President Clinton for an expected veto.

The House earlier passed the ban, which provides exceptions only when the mother's life is at risk, by a veto-proof margin of 295-136.

Santorum told reporters he had 62 solid votes in support of the bill and that odds of winning a veto-proof majority were improving. Overriding a veto requires 67 votes if all senators are present.

of the year.

The current debate also ignores the fact that most abortions could be prevented with better contraception. The range of contraceptives available in America is much smaller than in most of Western Europe; education is scanty; access is harder and more expensive. Unsurprisingly, the rate of unintended pregnancies is far lower in Europe. Many insurance companies and managed-care organisations will pay for abortions, but few cover the cost of contraceptives. When will some enterprising politician take up that cause?

Car insurance

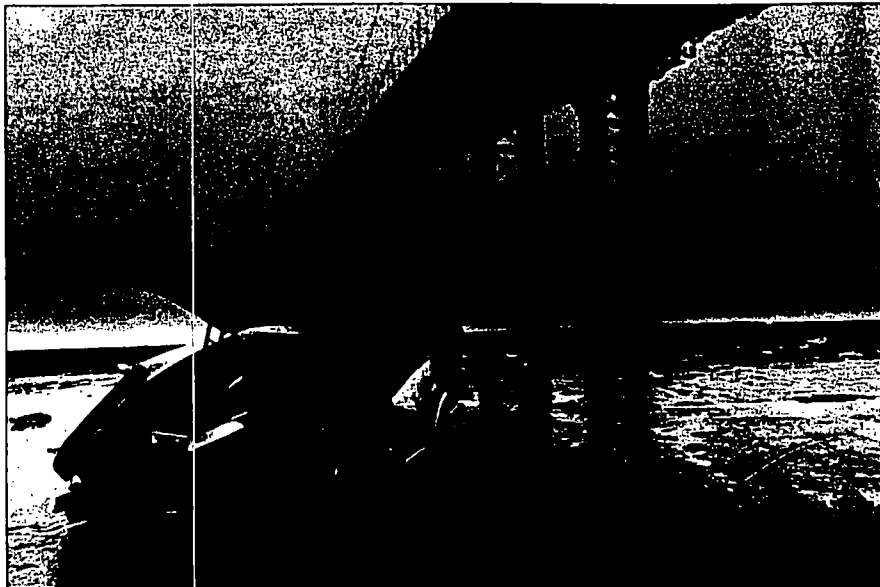
Auto-da-fé

NEW YORK

BACK in the 1980s, the life expectancy of a Chevrolet Corvette parked on one of New York's meaner streets was rumoured to be less than 30 minutes. Cars are a little less vulnerable these days. A mere 59,440 were stolen in the city last year, down from a peak of 146,925 in 1990 (see chart). Oddly, the car-insurance premiums paid by New Yorkers have yet to reflect this hefty decline. The State Insurance Department estimates that the annual premium for a 35-year-old male rose by an average of 47% between 1994 and 1996—a period in which vehicle theft fell by 38%. So, in an election-year defence of the man in the driving seat, Mayor Rudolph Giuliani aims to set motorists on the road to a refund.

Fittingly for the man who, as a prosecutor, busted Michael Milken, the mayor is filing suit against seven of America's biggest car-insurance firms, among them State Farm, Aetna, Allstate and GEICO. The lawsuit, which aims to force insurers to cut New York's comprehensive rates by as much as half, is being brought alongside a class-action suit filed on behalf of motorists who hold comprehensive policies (as opposed to basic car insurance, which does not cover theft). Around 80% of the claims made on comprehensive policies in New York are the result of theft—so, reasoned the mayor's task-force on insurance rates, which was formed last September, when theft declines, rates ought to follow suit.

Mr Giuliani claims that the city's lawsuit is the first of its kind, but it is by no means the only attempt by state or local authorities to curb soaring car-insurance rates. Two years ago, in the wake of a successful anti-



Last exit to Brooklyn

car-theft drive in Houston—and subsequent lobbying by the city's mayor—the Texas Department of Insurance cut “benchmark” car-insurance rates by one-third. Such an outcome would be impossible in New York, however, according to a report produced by Mr Giuliani's task-force. It is highly critical of the State Insurance Department's pro-insurer stance on rate regulation.

Several states have also introduced—or are drafting—legislation that would reduce car-insurance rates for drivers agreeing to a “no-fault” policy that restricts their right to sue (and ability to be sued) for the “pain and suffering” caused by a car accident. Insurers claim that the increasing incidence of such lawsuits, which are often frivolous, is the main reason why all types of vehicle premiums have risen in recent years. The Auto Choice Reform Act, a bill introduced last month by a bipartisan group of senators (among them Daniel Patrick Moynihan and Mitch McConnell), would allow nationwide use of no-fault policies—and save drivers up to \$45 billion a year, according to the Joint Economic Committee of Congress.

Unsurprisingly, Mr Giuliani supports such legislation, which is unlikely to become law any time soon. But what are the chances that his own attack on insurance rates will succeed? Testifying before the mayor's task-force, the car insurers maintained that the average cost of each claim had risen sharply during the 1990s—by 69% in the four years to 1995, according to Allstate—and that this had more than off-

set the effect of declining theft. But such an argument is specious: to offset New York's 60% reduction in theft this decade, the average cost of each claim would have to have soared by 150%. Nor did insurers explain why, despite their boast that comprehensive rates have been cut in New York in recent years, the average car-insurance premium is higher than ever.

Using the insurance industry's own definition of what represents “excellent profitability” as a guide, Mr Giuliani's task-force calculates that car insurers in New York city made windfall (ie, excess) profits of well over \$40m in each of the past two years alone—and it is these that the mayor intends to recoup for car owners.

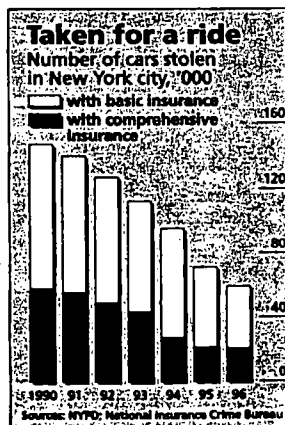
Mr Giuliani may not be fighting solo for long. In Chicago—where car theft has fallen by 30% since 1990—consumer-affairs agencies have already contacted New York officials to seek advice on launching their own attack on insurers; authorities in other cities where car theft has fallen sharply, such as Dallas and San Diego, are watching closely. Insurers, naturally, view New York's lawsuit as no more than an irritant. But that is what tobacco companies used to think about anybody who sued them, too.

California politics

An eerie silence

SAN FRANCISCO

THESE are strange days in California politics: so strange, that people are calling them the “dark time”. Malign astrological influences? No; it is simply that no money is being collected for or against candidates in next year's elections. Indeed, no money is even being sought. In normal



Not slashing manpower

2003: QDR:

ns	10	10	10
ns	11/1	11/1	11/1
ns	73	52	50
ns	128	131	116
ns	13	13	12
ns	202	187	187
ns	3	3	3
ns	1,450	1,420	1,360
ns	900	890	835
ns	800	720	640

Proposed: On current plan

has created a task force to by December, on how to im-
munity further.

es two groups of people
defence contractors are de-
t a single equipment pro-
cancelled. So are the ser-
who like to buy lots of current
generally dislike radical

two groups of disgruntled
s for the revolution in
think it ridiculously expen-
cal, to stick to the policy
e to fight two wars at once. They
ig programmes and forces
AD on unmanned aircraft and
re. "We should be prepared to
short-term risks, now that no su-
reatens, in order to prepare for
allenges," says Andrew
t, director of the Centre for Stra-
udgetary Assessments, a think-
ld we go ahead with so many
s for fighters when their for-
aircraft carriers—would
le to missile attack?" he asks.

sulking group, those who
ke the Department of Defence
nt, are dismayed that, although
ays the right things, he has pro-
modest changes. Since 1989 the
active military personnel has
%, but the number of bases has
1%. Eric Pages, of Business Exec-
utional Security, a consultancy,
t more aggressive base closures,
n and outsourcing could save
-30 billion a year. "The DOD
s its core business of war," he
of its 650,000 staff performing
functions could be replaced by
ractors."

ir to Mr Cohen, he knows—as a

former senator—how hard it will be to get
even the QDR's limited proposals past Con-
gress. Senator Strom Thurmond and Repre-
sentative Floyd
ised to resist ba:
plan could easil:
pork. Similarly,
fighter program
army divisions
would face heav
vice chiefs and c

A careful re-
impression ha-
have been more
at least, is set a
reforms. And th
gress has set up:
independent experts (including Mr Krep-
inevich), to assess the QDR and provide an
alternative view by the end of the year.

Abortion

From mother to child

WASHINGTON, DC

HAS the earth moved in the abortion
debate? On May 20th, after two
weeks of acrimonious and sanctimonious
rhetoric, the Senate voted 64-36 in favour
of a bill proposed by Rick Santorum, a Re-
publican from Pennsylvania. The San-
torum bill would outlaw a medical proce-
dure which the bill calls "partial-birth
abortion" unless a woman's life—not
merely her health—is at risk.

The day before, the American Medical
Association changed its long tradition of
neutrality on abortion legislation, support-
ing the bill after technical changes were
made to narrow the definition of the proce-
dure and to protect doctors from liability.
However, the American College of Obstetri-
cians and Gynaecologists, which represents
the doctors who are actually involved, op-
posed the bill, calling it "ill-advised and
dangerous".

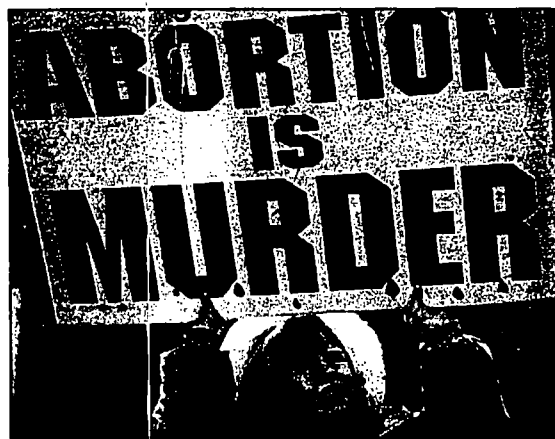
Both sides of the debate
were hampered by lack of
hard data, and both were dis-
ingenuous. The National Co-
alition of Abortion Providers
argued that the procedure in
question was very rare; but
their executive director later
announced that it was per-
formed far more often than he
had said, and usually on
healthy mothers with healthy
fetuses. On the other side, the
Santorum bill itself is a dis-
ingenuous piece of legisla-
tion. In medical parlance,
"partial-birth abortion" has

THE PRESIDENT HAS SEEN
no meaning; the term is an invention of the
anti-abortion movement. The rhetoric and
images have all been about one method of
abortion, known technically as intact dila-
tion and extraction. But the wording of the
bill is vague, and would actually apply to
other methods of abortion that are used in
the second trimester (12-24 weeks), before
the fetus is viable, and are therefore pro-
tected under law.

Taken as a whole, the 24 years since Roe
v. Wade, when the Supreme Court decided
that abortion was a constitutional right,
have actually seen an increasing number of
restrictions on it. But the change has hap-
pened gradually. The most recent moves,
the recurring debates over late-term abor-
tions, are an attempt to alter attitudes more
radically, by shifting the focus of the argu-
ment away from the health of the mother to
that of the developing child.

The tension in all thinking about abor-
tion is between the health and well-being of
the mother and that of the fetus. As a preg-
nancy progresses, this balance changes,
and current American law already
recognises this. Late-term abortions of any
kind are relatively rare. In a given year, just
1% of all abortions in America take place af-
ter 20 weeks; fewer than 600 are thought to
happen after 26 weeks, and at that stage are
almost always because of severe fetal ab-
normalities. As Mr Santorum has admitted,
his bill would do nothing to reduce the to-
tal number of abortions in America.

Yet that is not his point. By shifting the
attention from mother to child, the anti-
abortion lobby hopes to increase the dis-
comfort that most Americans to some de-
gree feel about abortion. With the
politicians, this approach is succeeding. In
each of the previous two votes on this issue
in the Senate, the vote has inched upwards.
With the public, however, little has
changed. Belief in the right to an abortion
remains stronger than distaste for it. Efforts
to restrict earlier abortions will be more dif-
ficult. In any case, RU486, the so-called
abortion pill for use early in pregnancy, is
likely to be available in America by the end



Should Congress agree?

Abortion - partial birth - press. and
Women's Issues - contraceptive

JIM NICHOLSON / JOE ANDREW

Question from Republicans: Will Al Gore continue to support the barbaric practice of partial-birth abortion?

Jim Nicholson, Republican chairman: By an overwhelming, bipartisan vote (287-141) last week, the House of Representatives passed, for the third time in five years, a ban on the barbaric practice of partial-birth abortion, in which a full-term unborn child is almost fully removed from the mother's womb — feet-first — leaving his head still inside the womb, so that birth has not yet legally occurred — and then has its brains vacuumed out. Similar legislation passed the Senate last September, by a similarly overwhelming 63-34 bipartisan majority.

Will Al Gore, proclaimed by President Clinton as the "most influential vice president in history," use his influence to stop the president from vetoing the bill again — or will he continue to side with Mr. Clinton and the most extreme pro-abortion advocates? I predict Joe is not going to answer these questions. Instead, he's going to argue that this particular abortion procedure is rarely used, and then only in cases of lethal danger to the mother. And he'll attempt to shift the argument to some irrelevant and strange notion of a woman's "right to choose" — never finishing that sentence by saying to choose what — rather than deal with the hard facts of this heinous practice. That makes sense, because defending a Clinton veto of this legislation is getting tougher and tougher.

In truth, this procedure is not rare; nor is it ever medically necessary. Ron Fitzsimmons, a leading abortion-rights advocate who once defended the practice, confessed in 1995 that he "lied through his teeth" about the frequency of the practice. And the American Medical Association has said the procedure is never medically necessary.

Sen. Daniel Patrick Moynihan, New York Democrat, years ago likened partial birth abortion to infanticide, and literally scores of

Partial birth abortion revisited

pro-choice Democrats — and pro-choice Republicans — agreed, and cast their votes to end this grisly practice. Even Minority Leader Dick Gephardt voted with the

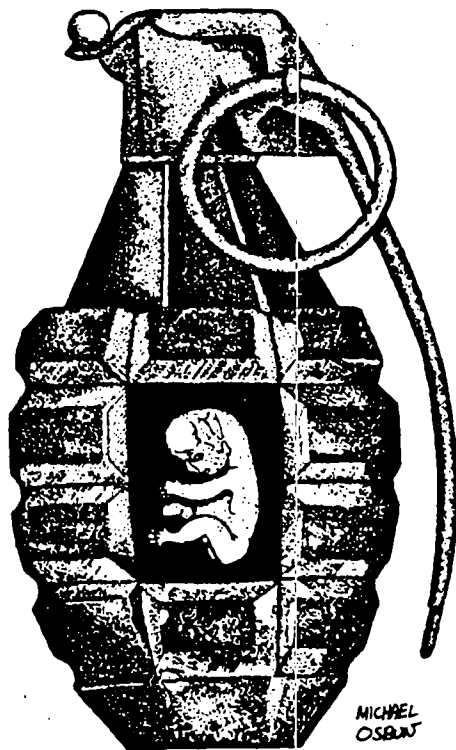


Illustration by Michael Osburn / Los Angeles Times Syndicate

Republican majority to ban it.

Joe Andrew, national Democratic chairman: Republicans, so good at exploiting sensitive topics for political gain, have been less successful in proposing solutions. Most Americans agree that abortion should be safe, legal, and rare and that the fewer women who face unintended pregnancies, the better. That's why Democrats on both

sides of the choice debate and some moderate Republicans want to improve women's access to contraception, but extreme Republicans are blocking them at every step.

One-half of all pregnancies in America are unintended. If contraception were a part of basic health care, families could avoid unintended pregnancy, thus reducing the need for abortion.

Many private insurers, on which three-quarters of American women rely, cover prescription drugs, but many don't cover prescription contraceptives. So, one way to reduce unintended pregnancies is to pass the bipartisan Equity in Prescription Contraceptive Coverage Act, which would make insurers cover prescription contraceptives, and help expand uninsured women's access to health care that includes contraceptive coverage. The world's largest employer-sponsored health insurance plan — which covers federal employees — provides such coverage.

Sound like common sense? It is. But, Republicans have blocked this bill, just as they blocked a real Patients' Bill of Rights. Republicans in Congress and George W. Bush have stood with the HMOs that fund their campaigns and against Americans who need better health care.

With his Texas record, it's no wonder that Mr. Bush continues to stand in the hospital door, blocking access to quality health care for those who need it most. Sadly, Texas ranks 50th among states for insuring women, 49th in insuring children and 48th for its teen pregnancy rate.

Calm, rational solutions have been missing in the debate over a woman's right to choose. When women face unintended pregnancies, Republicans would rather have an issue than solve a problem. The proof? Last week Jim criticized the first lady for her position on this issue. He neglected to point out that his candidate in the New York Senate race, Republican Rudy Giuliani, holds the exact same position. But you didn't hear Jim hurl insults at him.

Jim Nicholson is chairman of the Republican National Committee. Joe Andrew is national chairman of the Democratic National Committee.

Mode: 1 tale follows in steps of Augustine

E.L. Doctorow, a successful and respected novelist who is nevertheless an even more versatile and stylish writer than his critics commonly acknowledge, is probably doomed to be remembered as the author of "Ragtime" (1975), a vivid, smartly paced historical fiction that won prizes and spawned both a likewise popular (though critically suspect) film and a highly praised Broadway musical.

Mr. Doctorow has often aimed high, as may be seen in his 1971 reimagining of the ordeal and legacy of convicted atomic spies Julius and Ethel Rosenberg ("The Book of Daniel") and in such deft fusions of revisionist reminiscence and keen moral inquiry as the later novels "Loon Lake" (1980), "World's Fair" (1985), and "Billy Bathgate" (1989), each of which plays artful variations on the social and (particularly) criminal history of what is clearly Mr. Doctorow's chosen fictional territory: New York City, in all its grime and glory, then and now.

With "City of God" the writer reaches a new level, indicated by this novel's acknowledged source: St. Augustine's classic eponymous 4th-century Christian apologia (addressed to those who had accused the faith of conspiring to destroy the Roman Empire). The religious dimensions of Mr. Doctorow's similarly (and differently) sprawling work are revealed early on, in an introductory discursive meditation on the physical universe's "profound, disastrous, hopeless, infinitude" elsewhere described as "this stately vast rush of cosmosity." Here is persuasive evidence, to a mind already inclined to skepticism, of a deity indifferent, if not inimical to human concerns.

That meditation is one of numerous entries made in an all-purpose notebook faithfully kept by Everett, a writer — and, just possibly, a surrogate for E[lgar]. L. Doctorow — who seeks a subject for his next novel.

The novel's plot gears up with a puzzling act of vandalism: the theft, late in the year 1999, of a huge brass cross from St. Timothy's Episcopal Church on Manhattan's East Side, and its inexplicable reappearance on the roof of the Synagogue of Evolutionary Judaism, across town and as far as may be imagined from the (somewhat solid) environs of "St. Tim's."

Thomas Pemberton, rector of St. Timothy's, immediately guesses that "something momentous... [has been] announced." But no explanation for the mysterious act is forthcoming, even when "Pem" (a comparatively freethinking relic from the 1960s, who wryly labels himself "Divinity Detective") shares his hunches, as well as his bafflement with the synagogue's energetic young Rabbi Joshua Gruen and Joshua's wife Sarah Blumenthal (who is herself a rabbi).

The book exfoliates, both intriguingly and annoyingly, as Pem relates his experiences to his old friend Everett, whose inchoate speculations about the subject thus offered him are then juxtaposed against an often bewildering array of imperfectly related other matters.

The Gruens' lives become interwoven with Pem's when Joshua travels to Lithuania, in search of a manuscript long hidden in the Vilnius ghetto, which (according to Sarah's father, a Holocaust survivor) documents Nazi atrocities. Joshua is savagely beaten, and in the aftermath of his misadventure Sarah and Pem draw closer together.

Thomas Pemberton's unconventional exercise of his calling is unflatteringly compared to the importu-

CITY OF GOD
By E.L. Doctorow
Random House, \$25, 272 pages
REVIEWED BY
BRUCE ALLEN

nate apostasy of California's "notorious" Bishop James Pike (who had denied the divinity of Jesus), in nicely varied conversations with Pem's own disapproving bishop.

Everett's inconsistent efforts to arrange and make sense of stories told him by both Pem and Sarah must share space in the writer's busy mind with the aforementioned expressions of religious uncertainty and concern, as well as his musings about an unsatisfying adulterous affair, the temptations offered by Hollywood — Everett's conversation with "B," a conflicted, and self-important film director shows Mr. Doctorow's impressive gift for subtle satire — and cleverly spaced analyses of the lyrics of such representative American popular songs as "Me and My Shadow" and "Good Night Sweetheart" (offered by the fictional "Midrash Jazz Quartet," and, in one case, by the late Frank Sinatra).

More substantial light is shed on the novel's dense air of inquiry by Everett's detailed memories of his father's World War I combat experiences and his brother's near-thing survival of the subsequent world war (much of which is presented in skillfully handled free verse).

And the legacy of division and contention inherited from those wars that all but destroyed European civilization are potently contradicted in (presumably fictional) excerpts from the diary of Ludwig Wittgenstein, the philosopher-mathematician who devoted himself, not to received, and hence officially sanctioned, wisdom, but to "the world as we find it, and whose quiet defense of the mind's potential for creative as well as destructive acts ("European or not, a few of us have done some good") in effect points the way to the novel's affirmative and conciliatory, if not fully satisfactory, conclusion.

Mr. Doctorow ends the book with Thomas Pemberton's conversion to Judaism: a fulfillment of the act of union so to speak, in relation to which the novel has, since its initial expostulations and ruminations, been simultaneously advancing and retreating. Its coda is a restrained envisioning of "the modern city of consolidated institutions"; an image of accommodation and intermingling that suggests, almost as explicitly as does an otherwise very different contemporary novel, Salman Rushdie's defiantly "multicultural" "The Moor's Last Sigh," that the solution to the problem of our manifestly irreconcilable ethnic and religious differences may be the simple action of ignoring, and, if possible, thus obliterating them.

Many readers will find the novel's resolution ingenuous, but it seems to me honestly earned, and surprisingly convincing. Mr. Doctorow's challenging analysis of the concluding millennium's spiritual failings and confusions lacks the clarity of a linear narrative featuring firmly drawn characters involved in convincing interaction, but offers in its stead something rarer, more unsettling, and commendably suggestive: a credibly tangled viewing of the world as we find it, despair of it and struggle to make of it something that satisfies body, mind and soul.

Bruce Allen is a writer living in Maine.

The Washington Times
SUNDAY, APRIL 16, 2000

Abortion - partial birth -
legislative

Cynthia Dillard 09/18/98 11:06:21 AM

Record Type: Record

To: Nicole R. Rabner/WHO/EOP, Laura Emmett/WHO/EOP, Elena Kagan/OPD/EOP

cc:

Subject: partial birth abortion

The Senate sustained the President's veto, 64-36. Didn't lose any more votes this time around.

Abortion-partial birth-
legislative

Cynthia Dillard 09/17/98 10:52:03
AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: abortion

In case you don't already know, the Senate has 4 hours of debate on Partial Birth bill, and then they will vote tomorrow. Durbin is introducing a substitute amendment which will include the Daschle language from last year in addition to a provision requiring a women to get a second opinion (ie, a second doctor must certify that the procedure is necessary to protect a woman's life or from greivous harm). I don't think Durbin has decided yet whether or not to bring it up for a vote. I'll keep you posted.

Message Sent To:

Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Neera Tanden/WHO/EOP
Laura Emmett/WHO/EOP
Peter G. Jacoby/WHO/EOP

Abortion - partial birth -
uninhabited

 Cynthia Dailard
07/23/98 04:41:34 PM

Record Type: Record

To: Laura Emmett/WHO/EOP, Jennifer L. Klein/OPD/EOP, Neera Tanden/WHO/EOP

cc:

Subject: House override quickie analysis

----- Forwarded by Cynthia Dailard/OPD/EOP on 07/23/98 04:45 PM -----



clare_coleman @ ppfa.org
07/23/98 04:52:45 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: House override quickie analysis

Veto override vote analysis

October 8, 1997 final 295-133 6 absences
July 23, 1998 final 296-132 7 absences

New members since October 8, 1997, vote and how they voted:

Mary Bono	-	replaced Sonny Bono	-
Robert Brady	missed the vote	Tom Foglietta	-
Lois Capps	+	Walter Capps	+
Vito Fossella	-	Susan Molinari	-
Barbara Lee	+	Ron Dellums	+
Gregory Meeks	+ spoke on floor	Floyd Flake	-
Heather Wilson	-	Steve Schiff	-

Missed the vote, but were with us in the past:

Ford
Lewis (GA)
Markey
Serrano

Missed the last vote, but were with us today:

Hilliard
Payne

Members Voting Against the Rule, Against the Tabling of the Hoyer Motion to Recommit, In Support of the Frank Motion to Recommit and In Support of Final Passage of HR1122, the "Partial-Birth Abortion Ban Act."

T. Barrett (D-WI)
Bonior (D-MI)
Boyd (D-FL)
Davis (D-FL)
Etheridge (D-NC)
Flake (D-NY)
Gephardt (D-MO)
Hinojosa (D-TX)
J. Johnson (D-WI)
P. Kennedy (D-RI)
Kind (D-WI)

Lampson (D-TX)
Maloney (D-CT)
Minge (D-MN)
J. Moran (D-VA)
Pomeroy (D-ND)
Reyes (D-TX)
Sandlin (D-TX)
Shays (R-CT)
Spratt (D-SC)
Strickland (D-OH)

Members Voting Against the Tabling of the Hoyer Motion to Recommit, In Support of the Frank Motion to Recommit and In Support of Final Passage of HR1122, the "Partial-Birth Abortion Ban Act."

T. Barrett (D-WI)
Bonior (D-MI)
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Hinojosa (D-TX)
Jefferson (D-LA)
J. Johnson (D-WI)
P. Kennedy (D-RI)
Kind (D-WI)

Klecza (D-WI)
Lampson (D-TX)
Maloney (D-CT)
Minge (D-MN)
J. Moran (D-VA)
Pomeroy (D-ND)
Reyes (D-TX)
Sandlin (D-TX)
Shays (R-CT)
Spratt (D-SC)
Strickland (D-OH)

Members Voting In Support of the Frank Motion to Recommit and In Support of Final Passage of HR1122, the "Partial-Birth Abortion Ban Act."

T. Barrett (D-WI)
Bonior (D-MI)
Boyd (D-FL)
Castle (R-DE)
Davis (D-FL)
Etheridge (D-NC)
Flake (D-NY)
Frelinghuysen (R-NJ)
Gephardt (D-MO)
Gilchrest (R-MD)
Hinojosa (D-TX)
Houghton (R-NY)
Jefferson (D-LA)
J. Johnson (D-WI)
Kelly (R-NY)
P. Kennedy (D-RI)
Kind (D-WI)

Klecza (D-WI)
Klug (R-WI)
Lampson (D-TX)
Maloney (D-CT)
Minge (D-MN)
Moakley (D-MA)
J. Moran (D-VA)
Neal (D-MA)
Obey (D-WI)
Pomeroy (D-ND)
Ramstad (R-MN)
Reyes (D-TX)
Sandlin (D-TX)
Shays (R-CT)
Spratt (D-SC)
Strickland (D-OH)

Abortion - partial birth -
legislative

05/08/97 18:49

Q 002

DRAFT -- NOT FOR DISTRIBUTION

Findings

- (1) As the Supreme Court recognized in Roe v. Wade, the government has an "important and legitimate interest in preserving and protecting the health of the pregnant woman . . . and has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes compelling";
 - (2) In delineating at what point the government's interest in fetal life becomes "compelling," Roe v. Wade held that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability," a conclusion reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey;
 - (3) Planned Parenthood v. Casey also reiterated Roe's holding that the government's interest in potential life becomes compelling with fetal viability, stating that "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";
 - (4) According to the Supreme Court, viability "is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman";
 - (5) The Supreme Court has thus indicated that it is constitutional for Congress to ban abortions occurring after viability so long as the ban does not apply when a woman's life or health faces a serious threat;
 - (6) Even when it is necessary to terminate a pregnancy to save the life or health of the mother, every medically appropriate measure should be taken to protect a viable fetus so long as the mother's health is not put at greater risk;
 - (7) It is well established that women may suffer serious health conditions during pregnancy, such as breast cancer, preeclampsia, uterine rupture or non-Hodgkin's lymphoma, among others, that may require the pregnancy to be terminated;
 - (8) While such situations are rare, not only would it be unconstitutional but it would be unconscionable for Congress to ban abortions in such cases, forcing women to endure severe damage to their health and, in some cases, risk early death;
 - (9) In cases where the mother's health is not at such high risk, however, it is appropriate for Congress to assert its "compelling interest" in fetal life by prohibiting abortions after fetal viability;
 - (10) While many States have banned abortions of viable fetuses, in some States it continues to be legal for a healthy woman to abort a viable fetus;
 - (11) As a result, women seeking abortions may travel between the States to take advantage of differing State laws;
 - (12) To prevent abortions of viable fetuses not necessitated by severe medical complications, Congress must act to make such abortions illegal in all States;
- (more)

08/08/97 10:48

000

DRAFT -- NOT FOR DISTRIBUTION

(13) Congress finds that abortion of a viable fetus should be prohibited throughout the United States, unless a woman's life or health is threatened and that, even when it is necessary to terminate the pregnancy, every measure should be taken, consistent with the goals of protecting the mother's life and health, to preserve the life and health of the fetus.

Prohibition of Post-Viability Abortions

(a) In General. It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health.

"Grievous injury" shall be defined as:

- (a) a severely debilitating disease or impairment specifically caused by the pregnancy; or
- (b) an inability to provide necessary treatment for a life-threatening condition.

(b) "Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.

Penalties

(a) Action by Attorney General: the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (a), the court shall order the suspension or revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall order the revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$250,000, or both.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section; and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

(more)

Penalties

(a) Action by Attorney General. The Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (), the court shall notify the State medical licensing authority in order to effect the suspension or revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall notify the State medical licensing authority in order to effect the revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding \$250,000, or both.

(3) Hearing on penalties: The State medical licensing authority shall be given notification of and an opportunity to be heard at a hearing to determine penalties under this Title.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section, as well as the State medical licensing board or other appropriate State agency, and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

Regulations

In the certification to be submitted under subsection (), the physician shall certify that, in his or her best medical judgment, an abortion was medically necessary pursuant to subsection (), and describe the medical indications supporting his or her judgment.

The Department of Health and Human Services shall establish regulations for certification by the physician under subsection (), unless the State has its own certification procedure for abortions after fetal viability.

In addition, Department of Health and Human Services shall establish regulations to ensure the confidentiality of all information submitted pursuant to certification by the physician, as required by subsection ().

Each State shall ensure that the State medical licensing authority develops regulations to effect the revocation or suspension of respondent's medical license under subsection (), or the State shall be subject to loss of funding under title XVIII.

Rule of Construction

Nothing in this chapter shall be construed to prohibit State or local governments from regulating, restricting, or prohibiting post-viability abortions to the extent permitted by the Constitution of the United States.

Abortion - partial
birth - legislative

Bipartisan Alternative to S. 6/H.R. 1122

S. 6, the Partial Birth Abortion Ban, would outlaw the procedure physicians call dilatation and extraction (D&X) at any stage of pregnancy -- with no exception for the health of the mother -- but allow other, sometimes more dangerous abortion procedures to be used in its place.

The bipartisan alternative to S. 6 would ban all abortions after fetal viability (when the fetus can sustain survivability outside the womb with or without life support) unless the mother's life or health is truly endangered. The health exception to the comprehensive ban is being written to cover only very rare situations (1) that arise from complications of the pregnancy itself, such as serious heart damage (cardiomyopathy), severe hypertension (preeclampsia); dangerous aggravation of pre-existing conditions, such as complications from diabetes (blindness, amputation); and, as in the cases of some women carrying severely deformed fetuses, uterine rupture and other injuries; or (2) where termination of the pregnancy is necessary to allow medically necessary treatment of life-threatening conditions, including aggressive cancers (acute leukemia or breast cancer).

Constitutional Parameters Limiting Government Restriction of Abortion

Right To Terminate Pregnancy Prior To Viability: Roe v. Wade held that the Constitution protects "a woman's decision whether or not to terminate her pregnancy." This holding was reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey, in which the Supreme Court held that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy."

Viability Defined: According to the Court, "viability is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." Although the actual point of viability varies with each case, it is generally reached between the 23rd and the 28th week.

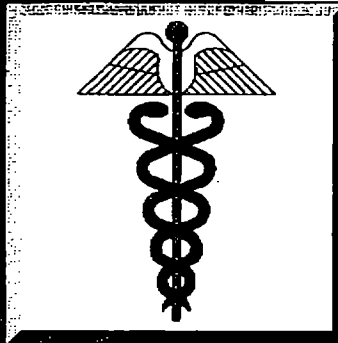
Government May Ban Abortion After Viability: In Casey, the Supreme Court reiterated Roe's determination that after viability, the State may ban abortion. Many states have done so, and post-viability abortions comprise less than 0.5% of all abortions (99% occur in the first 20 weeks).

Ban Must Have An Exception When A Woman's Life Or Health Is At Risk: According to Roe and Casey, although the State has a legitimate interest in preserving potential life, and may promote this interest by prohibiting abortion once the fetus attains viability, it may not do so when preventing an abortion would endanger the life or health of the mother. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

Would S. 6 prevent abortions? No. S. 6 would not stop a single abortion; it would merely result in abortion by a different method, such as induction, hysterotomy (pre-term c-section), or dilatation and evacuation (D&E) -- all of which pose a greater risk to the mother's health in certain cases.

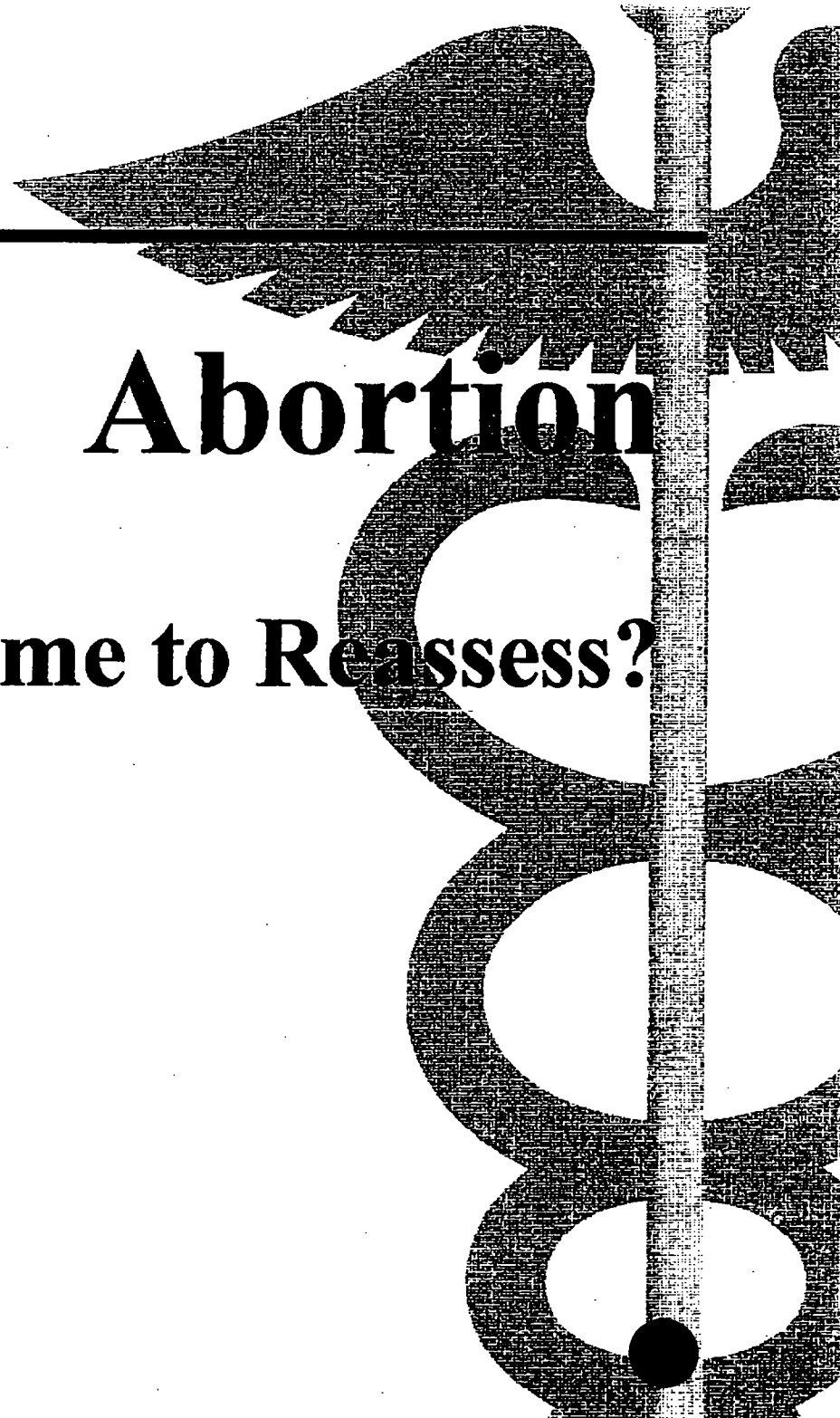
Can S. 6 become permanent law? No. Even if Congress overrides a Presidential veto, S. 6 is clearly unconstitutional, so it will be struck down by the courts and have no ultimate effect.

Can something be done to stop unnecessary abortions of viable fetuses? Yes. Congress can pass the bipartisan, comprehensive post-viability abortion ban with a narrow life and health exception that will outlaw these very late-term abortions. This will actually reduce the number of abortions in this country without putting women at unacceptable risk. This ban would be constitutional, and the President would sign it.



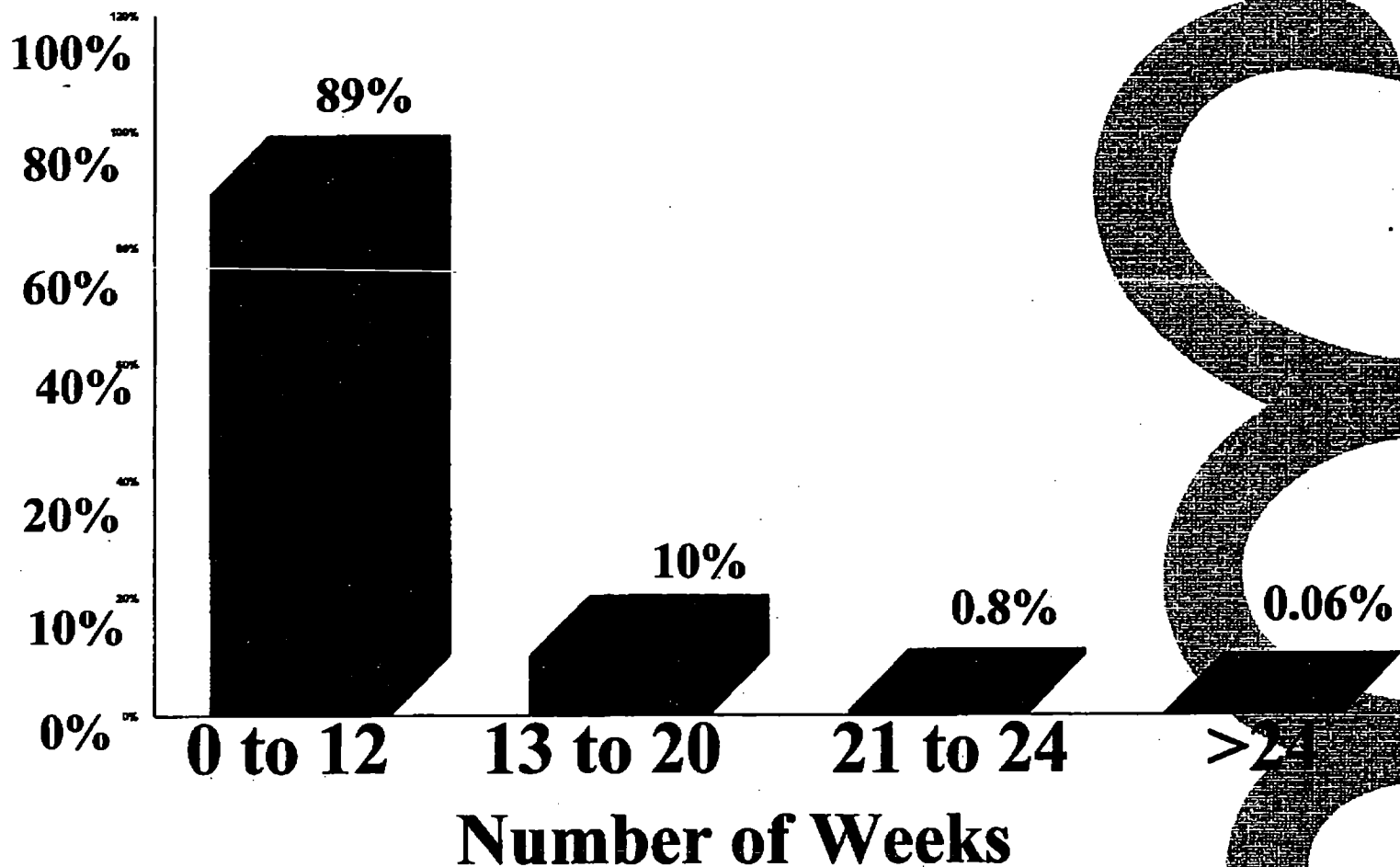
Abortion

Time to Reassess?



05/08/97 17:30 003

Truth When Abortions Occur



Source: The Alan Guttmacher Institute



The Real Issue

**When, and under what
circumstances, should the
government restrict abortion?**



Truth: the Constitution

Roe v. Wade (1973): protects *"a woman's decision whether or not to terminate her pregnancy."*

Colautti v. Franklin (1979): *"a fetus is considered viable if it is potentially able to live outside the womb, albeit with artificial aid."*

Planned Parenthood v. Casey (1992): prohibits restrictions that place *"a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus."*

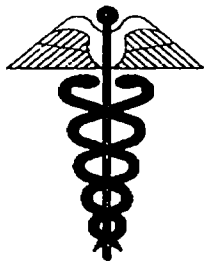


Truth: the Science

Viability:

- ▶ Ability to sustain survivability outside the womb, with or without life support.
- ▶ Usually 23-28 weeks.
- ▶ Determined by physician on a case-by-case basis.

Key Questions Posed by S. 6/H.R. 1122



- ▶ Should just one, or all, post-viability abortion procedures be banned?
- ▶ Should a mother's health be protected throughout pregnancy?
- ▶ Should a woman's Constitutional right to choose before viability be preserved?



Two Approaches

S. 6/H.R. 1122

- ▶ Bans only one procedure; allows others in its place.
- ▶ Violates a woman's Constitutional right to have her health protected.
- ▶ Violates a woman's Constitutional right to choose before viability.●

The Alternative

- ▶ Bans all post-viability abortions
- ▶ Preserves exceptions for life & health of the mother. (narrowly defined)
- ▶ Protects a woman's Constitutional right to choose before viability.●



Viability

99% of abortions are performed within the first 20 weeks.



0

Right to Choose
Constitutionally protected.

Viability

(23-28 weeks)

40

S. 6/H.R. 1122: bans D&X
and all other
procedures



Post-Viability

S. 6/H.R. 1122

- ▶ Bans only:
Dilatation & Extraction
(D&X or "Intact D&E")
- ▶ No exception to protect
health of the mother.

The Alternative

- ▶ Bans all:
Dilatation & Evacuation (D&E)
Dilatation & Extraction (D&X)
Induction
Hysterotomy
Hysterectomy
- ▶ Preserves exception
for health of the mother.
(narrowly defined)

National Right to Life on Alternatives to D&X:

S. 6

(source: NRL Web Page as of 5/1/97)

no ban

D&E "...may cause cervical laceration.
Bleeding...may be profuse."

no ban

Induction [with prostaglandins]
"...risks...cervical trauma, infection,
hemorrhage...cardiac arrest and rupture
of the uterus....Death is not unheard of."

no ban

Hysterotomy (C-section) "...highest risk
to the health of the mother...potential for
rupture during subsequent
pregnancies..."

banned

D&X No Maternal health risks cited



Who Should Decide...

- ...Which Procedure is Medically Appropriate in an Individual Case?

**A Woman
and her Doctor.**

or

The Government.



Health Consequences: the Constitution

Roe v. Wade (1973): protects a mother's health throughout pregnancy.

Planned Parenthood v. Danforth (1975): Cannot force "*a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.*"

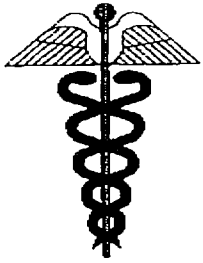
Thornburgh v. American College of Ob/Gyns (1986): Cannot force a mother "*to bear an increased medical risk to save her viable fetus.*"

Health Consequences Physicians say...



American College of Obstetricians & Gynecologists

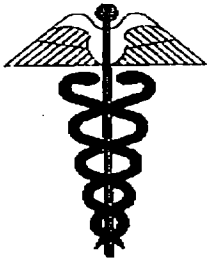
"An intact D&X may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."



Complications Caused by the Pregnancy

- ▶ **Primary pulmonary hypertension:** *Sudden death or intractable congestive heart failure. Maternal mortality approaches 50%. (this or other complications occur in 10 to 40% of patients with chronic hypertension)*
- ▶ **Preeclampsia:** *Severe hypertension & accompanying renal/kidney or liver failure. (5 to 10% of pregnancies)*
- ▶ **Cardiomyopathy:** *Occurs late in pregnancy in women with no history of heart disease as "a distinct, well-described syndrome of cardiac failure."*

When Pregnancy Complicates Treatment



- ▶ **Cancers:** (1 in 1000 pregnancies)
Pregnancy depresses mother's immune system; radiation and chemotherapy are harmful to fetus.
- ▶ **Lymphoma:** 50% cure rate with immediate treatment; likely death in 6 months if delayed; radiation & chemotherapy risk fetal mutation.
- ▶ **Breast Cancer:** (1 in 3000 pregnancies)
Increased estrogen and lactose production during pregnancy accelerates cancer; immune system depressed.

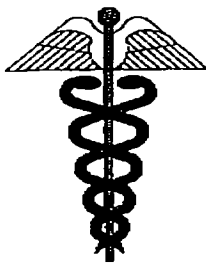


Health Exception

It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health. "Grievous injury" shall be defined as:

- (a) a severely debilitating disease or impairment specifically caused by the pregnancy; or
- (b) an inability to provide necessary treatment for a life-threatening condition.

"Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.



Who Should Decide...

► ...When Medical Risks are Serious Enough?

**A Woman
and her Doctor.**

or

The Government.



S. 6/H.R. 1122

- ▶ **Clearly Unconstitutional.**
- ▶ **Doesn't Stop a Single Abortion.**

The Alternative



- ▶ **Before Viability:** A woman's Constitutional right to choose is protected.
- ▶ **After Viability:** All procedures banned with exceptions only when the life or health of a mother are seriously threatened.

Albin Partial Birth - Legislation
05/06/97 18:49

RECEIVED

002

DRAFT - NOT FOR DISTRIBUTION

Findings

- (1) As the Supreme Court recognized in Roe v. Wade, the government has an "important and legitimate interest in preserving and protecting the health of the pregnant woman . . . and has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grow in substantiality as the woman approaches term and, at a point during pregnancy, each becomes compelling";
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 - (7) It is well established that women may suffer serious health conditions during pregnancy, such as breast cancer, preeclampsia, uterine rupture or non-Hodgkin's lymphoma, among others, that may require the pregnancy to be terminated;
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- (more)

08/08/97 18:49

003

DRAFT -- NOT FOR DISTRIBUTION

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Prohibition of Post-Viability Abortions

(a) In General. It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health.

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- (a) a severely debilitating disease or impairment specifically caused by the pregnancy; or
- (b) an inability to provide necessary treatment for a life-threatening condition.

(b) "Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.

Penalties

(a) Action by Attorney General: the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (a), the court shall order the suspension or revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall order the revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$250,000, or both.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section, and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

(more)

08/08/87 12:22

002

Penalties

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(b) **Relief.**

(1) **First offense:** In any action under subparagraph (), the court shall notify the State medical licensing authority in order to effect the suspension or revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

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(3) **Hearing on penalties:** The State medical licensing authority shall be given notification of and an opportunity to be heard at a hearing to determine penalties under this title.

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Regulations

In the certification to be submitted under subsection (), the physician shall certify that, in his or her best medical judgment, an abortion was medically necessary pursuant to subsection (), and describe the medical indications supporting his or her judgment.

The Department of Health and Human Services shall establish regulations for certification by the physician under subsection (), unless the State has its own certification procedure for abortions after fetal viability.

In addition, Department of Health and Human Services shall establish regulations to ensure the confidentiality of all information submitted pursuant to certification by the physician, as required by subsection ().

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Each State shall ensure that the State medical licensing authority develops regulations to effect the revocation or suspension of respondent's medical license under subsection O, or the State shall be subject to loss of funding under title XVIII.

Rule of Construction

Nothing in this chapter shall be construed to prohibit State or local governments from regulating, restricting, or prohibiting post-viability abortions to the extent permitted by the Constitution of the United States.

Abortion - partial birth -
legislative

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DRAFT -- NOT FOR DISTRIBUTION

Findings

- (1) As the Supreme Court recognized in Roe v. Wade, the government has an "important and legitimate interest in preserving and protecting the health of the pregnant woman . . . and has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes compelling";
 - (2) In delineating at what point the government's interest in fetal life becomes "compelling," Roe v. Wade held that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability," a conclusion reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey;
 - (3) Planned Parenthood v. Casey also reiterated Roe's holding that the government's interest in potential life becomes compelling with fetal viability, stating that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even prescribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother";
 - (4) According to the Supreme Court, viability "is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman";
 - (5) The Supreme Court has thus indicated that it is constitutional for Congress to ban abortions occurring after viability so long as the ban does not apply when a woman's life or health faces a serious threat;
 - (6) Even when it is necessary to terminate a pregnancy to save the life or health of the mother, every medically appropriate measure should be taken to protect a viable fetus so long as the mother's health is not put at greater risk;
 - (7) It is well established that women may suffer serious health conditions during pregnancy, such as breast cancer, preeclampsia, uterine rupture or non-Hodgkin's lymphoma, among others, that may require the pregnancy to be terminated;
 - (8) While such situations are rare, not only would it be unconstitutional but it would be unconscionable for Congress to ban abortions in such cases, forcing women to endure severe damage to their health and, in some cases, risk early death;
 - (9) In cases where the mother's health is not at such high risk, however, it is appropriate for Congress to assert its "compelling interest" in fetal life by prohibiting abortions after fetal viability;
 - (10) While many States have banned abortions of viable fetuses, in some States it continues to be legal for a healthy woman to abort a viable fetus;
 - (11) As a result, women seeking abortions may travel between the States to take advantage of differing State laws;
 - (12) To prevent abortions of viable fetuses not necessitated by severe medical complications, Congress must act to make such abortions illegal in all States;
- (more)

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(13) Congress finds that abortion of a viable fetus should be prohibited throughout the United States, unless a woman's life or health is threatened and that, even when it is necessary to terminate the pregnancy, every measure should be taken, consistent with the goals of protecting the mother's life and health, to preserve the life and health of the fetus.

Prohibition of Post-Viability Abortions

(a) In General. It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health.

"Grievous injury" shall be defined as:

- (a) a severely debilitating disease or impairment specifically caused by the pregnancy; or
- (b) an inability to provide necessary treatment for a life-threatening condition.

(b) "Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.

Penalties

(a) Action by Attorney General: the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (.), the court shall order the suspension or revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall order the revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding \$250,000, or both.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section; and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

(more)

Penalties

(a) Action by Attorney General. The Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (), the court shall notify the State medical licensing authority in order to effect the suspension or revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding \$100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall notify the State medical licensing authority in order to effect the revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding \$250,000, or both.

(3) Hearing on penalties: The State medical licensing authority shall be given notification of and an opportunity to be heard at a hearing to determine penalties under this Title.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section, as well as the State medical licensing board or other appropriate State agency, and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

Regulations

In the certification to be submitted under subsection (), the physician shall certify that, in his or her best medical judgment, an abortion was medically necessary pursuant to subsection (), and describe the medical indications supporting his or her judgment.

The Department of Health and Human Services shall establish regulations for certification by the physician under subsection (), unless the State has its own certification procedure for abortions after fetal viability.

In addition, Department of Health and Human Services shall establish regulations to ensure the confidentiality of all information submitted pursuant to certification by the physician, as required by subsection ().

Each State shall ensure that the State medical licensing authority develops regulations to effect the revocation or suspension of respondent's medical license under subsection (), or the State shall be subject to loss of funding under title XVIII.

Rule of Construction

Nothing in this chapter shall be construed to prohibit State or local governments from regulating, restricting, or prohibiting post-viability abortions to the extent permitted by the Constitution of the United States.

II

105TH CONGRESS
1ST SESSION**S. 481**

To prohibit certain abortions.

IN THE SENATE OF THE UNITED STATES

MARCH 19, 1997

Mrs. FEINSTEIN (for herself, Mrs. BOXER, and Ms. MOSELEY-BRAIN) introduced the following bill; which was read twice and referred to the Committee on the Judiciary

A BILL

To prohibit certain abortions.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Post-Viability Abortion
5 Restriction Act".

6 **SEC. 2. PROHIBITION ON CERTAIN ABORTIONS.**

7 (a) IN GENERAL.—It shall be unlawful, in or affect-
8 ing interstate or foreign commerce, knowingly to perform
9 an abortion after the fetus has become viable.

10 (b) EXCEPTION.—This section does not apply if, in
11 the medical judgment of the attending physician, the abor-

2

1 tion is necessary to preserve the life of the woman or to
2 avert serious adverse health consequences to the woman.

3 (c) CIVIL PENALTY.—A physician who violates this
4 section shall be subject to a civil penalty not to exceed
5 \$10,000. The civil penalty provided by this subsection is
6 the exclusive remedy for a violation of this section.

○

Health - partial birth -
legislative

10: Hena
JF: Tracey 5/1/97

Record Type: Record

To:

cc:

Subject: Late-term

Daschle met with about 24 Senators in his office last night to talk through his alternative. Attached is updated materials including more info on mental health (Daschle let Members see the language but did not let them take copies). I understand they spent quite a bit of time talking about how they could possibly draw a narrow mental health exception and the talks were quite inconclusive. The sense was that there was general uneasiness -- even among some of the pro-choicers -- with the mental health language. Members are concerned that they are going to vulnerable to chargers that the standard to not tight enough and conditions like mild depression could be covered. They're gonna keep talking next week.

POTUS may get asked about this at the Senate retreat.

Message Sent To: _____

AGENDA
Late-Term Abortion Meeting
April 30, 1997

I. Problems with S. 6/H.R. 1122

- Unconstitutional
- No health exception
- Ineffective

II. Goals of Alternative

- Constitutionality
- Protection of women's health
- Effectiveness

III. Health Definition

IV. Penalties

V. Schedule and Floor Strategy

- After Supplemental Appropriations bill
- Message/Participation
- Amendments

Bipartisan Alternative to S. 6/H.R. 1122

S. 6, the Partial Birth Abortion Ban, would outlaw the procedure physicians call dilatation and extraction (D&X) at any stage of pregnancy -- with no exception for the health of the mother -- but allow other, sometimes more dangerous abortion procedures to be used in its place.

The bipartisan alternative to S. 6 would ban all abortions after fetal viability (when the fetus can sustain survivability outside the womb with or without life support) unless the mother's life or health is truly endangered. The health exception to the comprehensive ban is being written to cover only very rare situations (1) that arise from complications of the pregnancy itself, such as serious heart damage (cardiomyopathy), severe hypertension (preeclampsia); dangerous aggravation of pre-existing conditions, such as complications from diabetes (blindness, amputation); and, as in the cases of some women carrying severely deformed fetuses, uterine rupture and other injuries; or (2) where termination of the pregnancy is necessary to allow medically necessary treatment of life-threatening conditions, including aggressive cancers (acute leukemia or breast cancer).

Constitutional Parameters Limiting Government Restriction of Abortion

Right To Terminate Pregnancy Prior To Viability: Roe v. Wade held that the Constitution protects "a woman's decision whether or not to terminate her pregnancy." This holding was reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey, in which the Supreme Court held that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy."

Viability Defined: According to the Court, "viability is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." Although the actual point of viability varies with each case, it is generally reached between the 23rd and the 28th week.

Government May Ban Abortion After Viability: In Casey, the Supreme Court reiterated Roe's determination that after viability, the State may ban abortion. Many states have done so, and post-viability abortions comprise less than 0.5% of all abortions (99% occur in the first 20 weeks).

Ban Must Have An Exception When A Woman's Life Or Health Is At Risk: According to Roe and Casey, although the State has a legitimate interest in preserving potential life, and may promote this interest by prohibiting abortion once the fetus attains viability, it may not do so when preventing an abortion would endanger the life or health of the mother. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

Would S. 6 prevent abortions? No. S. 6 would not stop a single abortion; it would merely result in abortion by a different method, such as induction, hysterotomy (pre-term c-section), or dilatation and evacuation (D&E) -- all of which pose a greater risk to the mother's health in certain cases.

Can S. 6 become permanent law? No. Even if Congress overrides a Presidential veto, S. 6 is clearly unconstitutional, so it will be struck down by the courts and have no ultimate effect.

Can something be done to stop unnecessary abortions of viable fetuses? Yes. Congress can pass the bipartisan, comprehensive post-viability abortion ban with a narrow life and health exception that will outlaw these very late-term abortions. This will actually reduce the number of abortions in this country without putting women at unacceptable risk. This ban would be constitutional, and the President would sign it.

Memorandum

Re: Constitutional Issues Involved in Drafting Health Exception to Late Term Abortion Ban

To follow up on your meeting yesterday, we wanted to address more precisely the constitutional problems associated with a pre-viability restriction on abortion and on limiting the health exception to physical health alone.

Is it constitutional to ban one procedure before viability?

No. There are two reasons why a ban on a procedure before viability would be unconstitutional. First, before viability, the States may restrict abortions only when the purpose of the restrictions is to protect the health of the mother (or to "inform the choice") and may not impose restrictions that are intended simply as an obstacle to getting an abortion. Second, limiting a woman's access to one type of procedure could force the woman to risk her health, since in some cases that procedure may be the safest.

Restrictions Before Viability -- Only for Informed Choice & Women's Health: The Supreme Court made it extremely clear in Planned Parenthood of Southeastern Pennsylvania v. Casey, that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy." In Casey, the court held that prior to viability, restrictions on abortion must not constitute an "undue burden" on a woman's right to terminate her pregnancy. An undue burden is one that has "the purpose or the effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."

Regulations that have been upheld under the Casey formulation include informed consent provisions and parental notification and have been characterized by the Court as not intended to burden the right but intended to inform the choice. A ban on a procedure could not be characterized as intended to do anything but limit the right to seek abortions. In addition, criminalizing a procedure used prior to viability, particularly since there are strong similarities between various procedures, would likely have a chilling effect on doctors who perform abortions. Such a chilling effect also could be seen by the Court as burdening a woman's constitutional right to choose to abort a nonviable fetus.

Under the Supreme Court's jurisprudence, blocking a woman's access to what a doctor might believe to be the safest abortion procedure would pose an undue burden to the right to choose to terminate a pregnancy.

Restricting Access to One Procedure Could Harm Women's Health: The Supreme Court has stated repeatedly that maternal health cannot be compromised in favor of the fetus. In Colautti v. Franklin, the Supreme Court criticized a Pennsylvania statute, which provided that a physician must employ an "abortion technique . . . that . . . would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary . . . to preserve the life or health of the mother." The Court found the provision very "problematic." The Court noted that the provision "does not clearly specify . . . that the woman's life and health must always prevail over the fetus's life and health when they conflict," and also found that the term "necessary" meant "that a particular technique must be indispensable to the woman's life or health -- not merely desirable -- before it may be adopted." The Court stated that the statute's ambiguity concerning "whether it requires the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival" posed "[s]erious . . . constitutional difficulties."

More recently, in Thornburgh v. American College of Obstetricians and Gynecologists, the Court struck down a statute that "failed to require that maternal health be the physician's paramount consideration" and forced her to "bear an increased medical risk in order to save her viable fetus."

While people differ over whether the so-called "partial birth" procedure is sometimes necessary to protect a woman's life or health, mainstream gynecologists and obstetricians would agree that it may often be the most appropriate or safest procedure among those available. The American College of Obstetricians and Gynecologists (ACOG) recently issued a position statement, stating that it could not establish that the procedure "would be the only option to save the life or preserve the health of a woman." According to ACOG, "[a]n 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 fact that mainstream gynecologists and obstetricians believe there are times when the procedure would best protect a woman's life or health, would make a ban on a specific procedure unconstitutional, as it could have a detrimental impact on women's health.

Would it be unconstitutional to ban post-viability abortions for mental health reasons?

Yes. First, it is clear that, even after viability, women must be allowed access to abortion to protect their health. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

While the Supreme Court has never been faced directly with the breadth of the health exception after viability, the Court has indicated that it considers mental health to be an integral part of health. For example, in Casey, the Court stated that "[i]t cannot be questioned that psychological well-being is a facet of health." Similarly, in United States v. Vuitch, the Court noted that "the general usage and modern understanding of the word 'health' . . . includes psychological as well as physical well-being."

Following the Supreme Court's lead, the Third Circuit in American College of Obstetricians & Gynecologists v. Thornburgh stated that Pennsylvania's abortion law would have been unconstitutional if it had declared that "potential psychological or emotional impact on the mother" could not be considered a medical risk to the mother.

Even more recently, the District Court for the Southern District of Ohio became the first court in the nation to face post-viability health definitions head on. In the context of a facial challenge (that is, challenging the statute as unconstitutional not just in a particular case but for all or most applications), the court struck down the ban because the court believed that the statute did not make an exception for abortions necessary for mental or emotional health reasons. Women's Medical Professional Corp. v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995).

Based on these precedents, it is very likely that the Court would rule that an exception drafted to cover only physical health problems is unconstitutional.

MEMORANDUM

Re: Mental health conditions and pregnancy

Upon a review of psychiatric journals and after discussions with the American Psychiatric Association, as well as independent psychiatrists, it appears that we were correct in our initial determination that the health definition would only cover extremely rare cases. Pregnancy may prohibit successful treatment of, or seriously worsen, some psychiatric diseases, such as schizophrenia and manic depression psychoses. For these reasons, it appears a mental health inclusion is necessary in order to comprehensively protect women's health.

Difficulty of treating Psychiatric Disease during Pregnancy

According to the American Academy of Family Physicians, approximately 16 percent of pregnancies are accompanied by some type of psychiatric dysfunction. Most of these women do not experience severe depression or psychosis, but some may require anti-depressant medication. Often, such medication is not prescribed for pregnant women because of the risk of teratogenic (developmental malformations) effects on the fetus. In some cases, depriving the woman of medication may lead to suicide or total functional breakdown.

It should be noted that for many women with serious psychiatric conditions (such as suicidal tendencies), abortion would not provide successful treatment. However, in extreme situations where a woman does not respond to aggressive treatment, pregnancy termination may be necessary to avoid a severe psychotic break. Obstetrics manuals list such cases as indications for pregnancy termination.

Suggested Mental Health Response

When discussing the health exception, we should continue to refer to the severity standard, and we can correctly point out that this excludes almost all psychiatric conditions. In addition, it is important to note that the debate over mental health parity highlighted the connection between many mental illnesses and their physical manifestations or causes. Even though we may not be able to anticipate the types of serious psychiatric conditions that may require pregnancy termination for treatment, we should not exclude mental health as a category simply because it is perceived as "less serious" than physical health. The following is a reprint of the suggested response to questions about the inclusion of mental health:

Mental illness, when diagnosed as a psychiatric disease, is not ruled out in this definition. However, mild depression or other less-than-severe conditions are not covered by this definition, just as a minor illness or other mild "physical" conditions are not covered. And remember that the Senate voted just last year to insist on equitable health coverage for mental illness, based largely on the fact that mental illnesses are diseases of the brain and can be just as serious as "physical" conditions.

Our exception turns on the severity, not the type, of condition dealt with by a woman late in pregnancy. These severe conditions fall under the two categories in our definition (either a disease or impairment caused by the pregnancy, or inability to treat a life-threatening condition). We are providing legal guidelines for physicians to supplement their existing understanding of medical indications for pregnancy termination. It is the physicians themselves who must make the ultimate determination about which conditions and circumstances meet that severity standard.

It may well be that the exception for mental illness or psychiatric disease will never be used. If at all, it would be an extremely rare case, and it should be noted that in the case of most psychiatric diseases, treatment could be administered without the need for pregnancy termination.

In the end, no matter how tight we make this definition, some will always argue that it's too loose — that there's a loophole that women and doctors could use to allow unnecessary abortions. But don't forget to counterbalance that concern with consideration for protecting the women for whom termination of pregnancy is truly a medical necessity. And don't forget there are certain constitutional parameters within which we must operate. Excluding mental health categorically would almost certainly make the law unconstitutional, and I am not willing to arbitrarily rule out coverage of diseases that could, in fact, put women at unacceptable risk.

This should not be considered an exhaustive list of serious maternal health conditions. These are merely examples of conditions listed in obstetrical textbooks as possible medical indications for pregnancy termination.

Disease or Impairment Caused by Pregnancy

Preeclampsia (with accompanying renal, kidney, or liver failure)

onset of severe hypertension during pregnancy

"Preeclampsia often occurs early and with increased severity. Deterioration of maternal renal function or uncontrolled hypertension is an indication for pregnancy termination." Preeclampsia occurs in 5-10% of pregnancies and is severe in less than 1%. Eclampsia (complication characterized by seizures) occurs in approximately 0.1% of pregnancies.

Peripartal cardiomyopathy

heart failure in late pregnancy

"Characterized by its occurrence...in women with no previous history of heart disease and in whom no specific [origin] of heart failure can be found, peripartal cardiomyopathy is a distinct, well-described syndrome of cardiac failure in late pregnancy."

Pregnancy-aggravated hypertension

acceleration of existing hypertension

"Maternal indications include organ failure such as renal failure, seizures associated with the development of eclampsia [progression from hypertension/preeclampsia characterized by seizures and can result in cerebral hemorrhage], and uncontrollable hypertension."* Complications develop in 10-40% of patients with chronic hypertension.

Primary pulmonary hypertension

complication of existing hypertension (abnormally high blood pressure)

"The natural course of the disease terminates either by sudden death or by the development of intractable congestive heart failure resistant to therapy. Maternal mortality with primary pulmonary hypertension approaches 50%."

Amniotic fluid embolism

results from a mass of amniotic fluid in the maternal circulation

Typically caused by invasive third-trimester obstetric procedures or by blunt abdominal trauma. Amniotic fluid lodges in the circulation system and leads to respiratory failure and cardiovascular collapse, shock, or coma.*

Sources:

* Clinical Manual of Obstetrics, ed. David Shaver and Frank Ling (University of Tennessee College of Medicine), Sharon Phelan (University of Alabama Department of Obstetrics and Gynecology), and Charles Beckmann (University of Wisconsin Department of Obstetrics and Gynecology)

• Manual of Obstetrics: Diagnosis and Therapy, ed. Kenneth Niswander and Arthur Evans, University of California, Davis, School of Medicine

Life-Threatening Conditions Requiring Immediate Treatment

Bone Marrow Failure

severe form of anemia

"The role of pregnancy termination [in bone marrow failure treatment] is unclear. Therapeutic abortion is inconsistently associated with remission. It may be necessary, however, in order to treat the patient with anabolic steroids."* Additionally, "bone marrow transplant has become the treatment of choice. Termination of the pregnancy would be necessary if a suitable donor could not be found."* It should be noted that bone marrow transplant is also a treatment for other conditions such as leukemia.

Cardiac Arrest

heart failure

Most incidents of cardiac arrest are secondary to other acute events, such as anesthetic complications, trauma, or shock. According to several obstetrics manuals, pregnancy termination -- whether by delivery or abortion -- is often recommended.* CPR can generally be expected to generate only 30 percent of normal cardiac output, and during pregnancy the uterus obstructs this cardiac output even further.

Cancer

Cancer complicates approximately 1 out of every 1000 pregnancies. Issues that must be addressed in pregnancies affected by cancer include the effect of pregnancy on the malignancy, the need for pregnancy termination, and the timing of therapy. Radiation and chemotherapy may be contraindicated during pregnancy due to documented risks of fetal mutation. Additionally, pregnancy inhibits a woman's ability to fight off cancer because the immune system is often depressed, and her nutritional intake is divided between herself and the fetus.

Lymphoma

cancer of the lymphatic system

"High-grade Non-Hodgkin's lymphoma is a rapidly progressive disease with a median survival of six months. Since cure rates approach 50%, it is imperative therapy not be delayed."* In this situation, delay of therapy could mean the loss of an opportunity to cure the mother. Because both radiation and chemotherapy present mutation risks for the fetus, termination of the pregnancy is suggested in order to begin treatment for lymphoma.

Breast Cancer

especially breast cancer diagnosed during pregnancy

"Factors in pregnancy that could adversely affect this malignancy include...increased estrogen and prolactin stimulation [both factors that exacerbate breast cancer], and depression of the immune system."* The frequency of breast cancer in pregnancy is second only to cancer of the cervix, occurring in 1 out of every 3,000 pregnancies. In addition, adequate nutrition is a serious problem.

Sources:

* Clinical Manual of Obstetrics, ed. David Shaver and Frank Ling (University of Tennessee College of Medicine), Sharon Phelan (University of Alabama Department of Obstetrics and Gynecology), and Charles Beckmann (University of Wisconsin Department of Obstetrics and Gynecology)

* Manual of Obstetrics: Diagnosis and Therapy, ed. Kenneth Niswander and Arthur Evans, University of California, Davis, School of Medicine

Elana -

I did not imagine it - Barney made fairly clear references to difference between banning all procedures vs one procedure during debate on the rule + general debate (attached). He also opined that the Pres might sign the Bill with his amendment included (also attached).

See also Rep Barnett's note re change in the bill on the floor re life endangerment as a result of the pregnancy itself -

MCF

to the process. However, my determination to ban this gruesome, immoral process is stronger. Vote "yes" on the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Wisconsin [Mr. BARRETT].

Mr. BARRETT of Wisconsin. Mr. Speaker, I rise in opposition to this rule. This is a bill that I supported last year and I will probably support it again this year, but I am deeply troubled by what the Committee on Rules did.

The Committee on Rules said that a woman whose life is threatened by the pregnancy itself should die. The original bill said we are not going to do that; if my wife is going to die because of the pregnancy, we are not going to let that happen. This bill says, let the woman die, and that is wrong.

The Committee on Rules abused this process. We should go back to the original language in this bill that was put in as it was introduced. There is no woman in this country that should die because of the pregnancy itself. This bill should be changed.

Every person in this room knows that there is not a woman in this country that should die because her life is threatened by her pregnancy. That is an outrage, and this bill originally recognized that there was a problem with that. It originally realized that this is a spot where this bill was vulnerable last year, so it corrected it. Now they are back to playing politics.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes and 15 seconds to the gentleman from New York [Mr. NADLER].

(Mr. NADLER asked and was given permission to revise and extend his remarks.)

Mr. NADLER. Mr. Speaker, I am outraged that the leadership of this House has once again decided to play politics with women's lives. This bill values abusive fathers more than women's lives. This bill, as reported here, eliminated amendments made by the committee that would have helped save some women.

Let me explain how this bill works. A woman becomes pregnant. While she is pregnant, the father of the fetus rapes her. He then beats her to a pulp. He throws her down the stairs, he batters her. He then disappears from the scene and abandons her.

This woman, who is now severely traumatized, who is physically injured by the battering, whose doctor tells her that because of her injuries, carrying the pregnancy to term will probably result in permanent, severe physical injury, perhaps permanent paralysis, for life, decides to have an abortion. The doctor tells her the safest method of abortion is the so-called, what some people call the partial-birth abortion. It is the safest method. Other methods might kill her, might increase the chance of paralysis, but this, he says, is the safest method.

This bill says, First, she cannot have that abortion that way. If she does, the

doctor is criminally liable. The bill also says that the father of the child, of the fetus, who raped her, who abused her, who abandoned her, now can sue her and her doctor for damages. The abusive father is entitled to damages. In fact, he is even entitled to money for physical and emotional damages that he has suffered.

This is ludicrous. It is an outrage. It is disgusting. Not only does this bill intrude, infringe, and violate the constitutional right to choose, but it rewards abusive fathers. It rewards rapists.

The committee's amendment that would have said that a father who beats the woman, who abuses her, who abandons her, cannot sue her for damages, was eliminated in proceedings by the Committee on Rules. This is shameful. I urge the House to reject this bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, it seems very clear to me that we have people who would prefer an issue to a bill that could become law. I offered an amendment in committee that would have provided an exception to the ban in cases where it was necessary to use this procedure to avoid serious adverse physical health consequences to the mother.

Now, people on the other side have argued that health is too broad. I do not agree with that. I find the health concept important. But I also understand the health concept, including mental health, is most directly relevant when we are talking about whether or not to have an abortion.

This bill does not say you cannot have an abortion; it says you may not use this particular procedure. Where we are talking about a ban on a specific procedure, then physical issues become more prominent, because the mental question generally is as to whether or not an abortion is permitted.

Here is what the majority is insisting upon. A doctor believes he can show that it is necessary under the wording of this bill to use this procedure for a woman who has established her right to an abortion, because otherwise there would be severe physical adverse health consequences, and the majority says no. The majority says even if avoiding this procedure will subject the woman to severe adverse physical health consequences, as long as she is not going to die, but if she is severely physically damaged, then they cannot use this procedure. And the chairman of the full committee, with the intellectual honesty he brings to the issue, said if it is a choice between the woman incurring serious physical health damage and the life of the fetus, then the woman's health must give way.

The chairman of the committee made that explicit when he opposed the amendment, and that is the choice that

the Members are not being allowed to make. I am not being allowed to offer an amendment that would have provided an exception to severe physical adverse health consequences. I think that bespeaks an interest on the part of some in an issue and not a law.

Ms. SLAUGHTER. Mr. Speaker, I yield 1½ minutes to the gentleman from New York [Mrs. LOWEY].

(Mrs. LOWEY asked and was given permission to revise and extend her remarks.)

Mrs. LOWEY. Mr. Speaker, I rise in strong opposition to this closed rule.

Mr. Speaker, this is a difficult issue. That is why I had hoped that we could work with the GOP leadership to reach consensus on this legislation. We have repeatedly tried to compromise with the Republican leadership to write a bill that the President could support. As my colleagues know, the President has said very clearly that he will sign this legislation if it contains a narrow exception to protect those few women who need this procedure to preserve their health. I personally asked the leadership to work with us, to craft a narrow health exception to the bill. They were unwilling.

The GOP leadership was also unwilling to allow a vote on the bipartisan Hoyer-Greenwood substitute. That legislation would have banned all late-term abortions, except those performed to save the life or preserve the health of the pregnant woman.

The President will veto the bill in its current form. He has made that very clear. So rather than work with us to send the President a bill that he will sign, the Republican leadership would rather pass legislation that he will veto.

Let us be clear. This vote today is about the value of women's health. The President said that he will not sign a bill unless it protects women's health, and the GOP leadership will not go along. I am sorry that the leadership chose to turn this sensitive matter into a political issue. Unfortunately, it has become very clear that this leadership does not want to ban this procedure, they want a political issue.

I urge my colleagues to defeat this closed rule so that we can include a health exception to the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Texas [Mr. EDWARDS].

Mr. EDWARDS. Mr. Speaker, I strongly oppose late-term abortions, but I believe that when the mother's life or health are at risk, that choice should be made by a woman and her physician and not by the Federal Government.

Mr. Speaker, what the American people do not know about this bill is this: If we want to save babies, why does this bill just outlaw one abortion procedure? The fact is, this bill still makes it legal to have abortions at the end of the eighth or ninth month of pregnancy. What the American people

criminalized. We remember the days before Roe versus Wade. We know that thousands of women died undergoing unsafe, illegal abortions, and we will not allow this Congress to force American women into the back alley ever again. This is just the beginning. The Republicans will not stop with one procedure. They want to ban all abortions at any time by any method.

Mr. Speaker, as a mother of three beautiful grown children, as a recent grandmother, as one who respects life with every ounce of my soul, I urge my colleagues to vote against this ban.

□ 1315.

Mr. CANADY of Florida. Mr. Speaker, I yield 1 minute to the gentlewoman from Washington [Mrs. SMITH].

Mrs. SMITH of Washington. Mr. Speaker, I rise today in support of the Partial-Birth Abortion Ban Act. America is too good for infanticide. Babies have to stay protected by our Constitution. If babies go first, who is next?

I want to take this opportunity to share with you a memo from a pro-abortion group that I just got, assuming that all women will support this gruesome procedure. They gave us instructions on how to debate the procedure and they said, and I will quote, Do not talk about the fetus. No matter what we call it, this kills an infant. Do not argue about the procedure, the partial-birth procedure is gruesome. There is no way to make it pleasant to voters or even only distasteful.

Mr. Speaker, I urge my colleagues to see past the smoke screen that has been created by the abortion lobby. Again, America is too good to support infanticide.

NATIONAL RIGHT TO
LIFE COMMITTEE, INC.,

Washington, DC, March 20, 1997.

CONGRESSMAN HOYER SAYS THE GREENWOOD-HOYER "MOTION TO RECOMMIT WITH INSTRUCTIONS" ALLOWS EVEN THIRD-TRIMESTER ABORTIONS FOR "MENTAL HEALTH" AND "PSYCHOLOGICAL TRAUMA"

When the House takes up the Partial-Birth Abortion Ban Act (HR 1122) Thursday, March 20, Rep. Steny Hoyer (D-Md.) and Rep. Jim Greenwood (R-Pa.) are expected to offer a "motion to recommit with instructions" that will include the substance of the measure that they introduced on March 12 as HR 1032, which they call the "Late-Term Abortion Restriction Act."

The Hoyer-Greenwood measure would: Allow all methods of abortion, including partial-birth abortion, on demand until "viability"; and

Empower the abortionist himself ("the attending physician") to define what "viability" means; and

Even after this self-defined "viability," and even in the third-trimester, allow partial-birth abortions to be performed whenever "in the medical judgment of the attending physician, the abortion is necessary to avert serious adverse health consequences to the woman." [emphasis added] [see Hoyer's explanation below]

At a March 12 press conference in the House Radio-TV Gallery, which was tape-recorded, Congressman Hoyer was asked what that word "health" means in his statement. Mr. Hoyer responded as follows:

[We] included the language serious adverse health consequences. We're not talk-

ing about a hangnail, we're not talking about a headache. Does it include—and this is one of the things that the opponents of this particular legislation, the proponents of the pro-life position, would contend—does it include mental health? Yes, it does. [emphasis added]

I point out that the overwhelming majority of Americans, and Members who vote on this floor, are for an exception for rape and incest. The exception of rape and incest, of course, is not because a pregnancy resulting from rape or incest causes a physical danger to the woman. It is because it poses a psychological trauma to the woman to carry to term, either because she is very young, impregnated by her father or brother or some other family member, or because she is raped. In the debate some years ago, for example, I used Willy Horton as an example. [End of Hoyer quote. Italics indicate Mr. Hoyer's verbal emphasis]

Thus, by the explicit statement of its author, the Hoyer-Greenwood motion would allow partial-birth abortions (and other abortions) even in the final three months of pregnancy, whenever an abortionist simply affirms that this would prevent "serious" "mental health" "consequences." Further, Mr. Hoyer's own interpretation of "mental health" is not limited to women who are, say, severely psychotic. Rather, Mr. Hoyer explicitly acknowledged that "serious health" covers "psychological trauma." Legally, the language is all-encompassing.

Moreover, under the Hoyer-Greenwood measure, the abortionist himself decides what "viability" means. This is like Congress passing a bill to "ban" so-called "assault weapons," with a provision to allow each gundealer to define "assault weapon." The Hoyer-Greenwood bill does not "regulate" the abortionist; rather, it empowers the abortionist to regulate himself.

In real medical practice, "viability" begins at 23 weeks, when the baby's lung development is sufficient to allow survival in about one case in four. But late-term abortionists often have their own idiosyncratic notions of when "viability" occurs, which may have no relationship to neonatal medicine or to the babies' actual survival prospects.

In short, the Hoyer-Greenwood bill does not "restrict" abortions after viability, nor does it "restrict" third-trimester abortions. Indeed, the Hoyer measure would be an empowerment by Congress for abortionists to perform third-trimester abortions with complete impunity.

Under the Hoyer-Greenwood measure, Congress would confer on the abortionist himself explicit authority to judge, by his own standards and immune from review by any other authority: (1) what "viability" means, and (2) whether an abortion would prevent "serious" harm to "health," including "mental health" or "psychological trauma," in Mr. Hoyer's words.

Thus, under the Hoyer-Greenwood bill, it is impossible for an abortionist to perform an "illegal" third-trimester abortion, because he alone decides what is legal. Such a law would be a mere facade—it would not prevent a single partial-birth abortion, nor would it prevent a single third-trimester abortion.

For further documentation on partial-birth abortions, the Partial-Birth Abortion Ban Act, and the Clinton-Hoyer-Deschle "phony bans," contact the National Right to Life Committee's Federal Legislative Office at (202) 638-8821, fax (202) 347-5668, or see the NRLC Homepage at www.nrlc.org.

[From the Washington Post Health Section, Sept. 17, 1996]

VIABILITY AND THE LAW
(By David Brown, M.D.)

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

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

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

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

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

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

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

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

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

Mr. CONYERS. Mr. Speaker, I yield such time as he may consume to the gentleman from Massachusetts [Mr. FRANK] the ranking member of the Committee on the Judiciary.

Mr. FRANK of Massachusetts. Mr. Speaker, I thank our senior member for yielding me the time. I appreciate the skill with which he is managing our side of this very difficult issue.

I want to call attention to an amendment which the majority refused to allow. When Members have come forward, as the gentlewoman from New York just did, with an eloquence and passion that is a model of how issues ought to be discussed, and talk about threats to the health of women and talk about how this bill does not allow a doctor to take into account serious adverse health consequences, some of my friends on the other side said, well,

health is too vague. Health could mean severe mental health problems. We want to rule that out.

But what they do not say is that they do not only want to rule out mental health, which seems to be a valid consideration, they would deny the use of this procedure to a woman even if the doctor could show that it was necessary to avoid serious physical damage to her health. And I have offered an amendment that says only that, that we will not preclude this if a doctor finds it necessary to avoid long-term serious adverse physical health damage. They will not allow that amendment. They will not allow even a vote on that.

The chairman of the full committee, a man of great intellectual integrity who was against abortion in any form or shape, says the reason he voted against that amendment was that if it is a choice between the life of the fetus and severe physical health damage to the mother, then the mother must incur that damage and not only that, we in Congress will decide that the mother must incur that damage.

I think the failure to allow a vote on serious physical health adverse consequences in the first place deprives them the right to argue about mental health because they will not allow any health requirement.

We are not talking about whether or not you have an abortion at all but about the procedure. And what they are trying to do is to force a vote which would, and let us be very clear, the vote would make it impossible for a doctor to even try to show that it was necessary to use this procedure to avoid serious long-term physical damage.

Mr. COBURN. Mr. Speaker, will the gentleman yield?

Mr. FRANK of Massachusetts. I yield to the gentleman from Oklahoma.

Mr. COBURN. Mr. Speaker, I think the point is there is not ever a case, never a case where this procedure is needed to protect the life of a woman.

Mr. FRANK of Massachusetts. Mr. Speaker, the gentleman has made his point.

Let me say this, if in fact Members were confident of that, then the amendment would be harmless because this bill does not say, I do not like this bill, but I am dealing with the framework you put forward, the bill does not say, if in the opinion of the physician, it says you can have such an exception for life if it is necessary. My amendment tracks that language. My amendment says, the doctor would have to show that it was necessary to prevent long-term physical health.

The gentleman at the microphone, a doctor, is convinced that never, ever, ever in the whole history of the world would it be physically possible. That is a judgment he is qualified to make.

But I do not believe we as a Congress ought to legislate that it is never possible. The fact is that if it is never possible, the exception will not be a very

large one because it is not a subjective amendment.

I will go back to what the chairman of the full committee said, as I said, a man of great integrity, he said, if there is a choice between physical damage to the mother, serious adverse physical damage, and the life of the fetus, even if we are talking about a fetus with the brain on the outside, as the gentleman from New York pointed out, that tragic situation, this would not be allowed.

I want to make it clear, I do not believe you should restrict into physical health in general, but here we have an unusual bill. This bill concededly by its sponsors does not try to stop abortions. It would allow all manner of abortion except this procedure.

Now, your mental health would be relevant, and it still would be as to whether or not you could have an abortion. A severely depressive situation would be a justification for an abortion, as the exception. When we are talking only about this procedure versus that procedure, then it seems to me it is relevant to talk only about physical. But again the assertion that it is never, ever going to be physical, and we have had women and doctors who disagree, the doctors do disagree, the question is, Should the Congress adopt the view that it is never valid to try to avoid serious physical health damage to the mother if that means this particular abortion procedure?

That, I wanted to point out, is the amendment that they would not even let us vote on. That is the choice. I think it is unfortunately indicative of some Members who might rather have an issue to take to the country than a piece of legislation.

I believe the adoption of this legislation, of this amendment, even though I might not like it, could lead to a signed bill. The failure even to allow a vote on this and the insistence on defeating it, it seems to me, shows a preference for an issue over a piece of legislation.

I thank my ranking member for yielding me the time.

Mr. CANADY of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma [Mr. COBURN].

Mr. COBURN. Mr. Speaker, I think it is important, first of all, having delivered greater than 3,100 babies and cared for over 10,000 women in my medical experience, I want to again reemphasize, there is no medical indication ever for this procedure.

To answer the gentleman from Massachusetts' question, why would you, if in fact there is a reason to do this procedure, why would you do it to a live baby? Why would not the doctor kill the baby first, which in fact is what they do.

The very false arguments, false arguments that are put forward is that the baby, with the encephalocele or the externalized brain, the people that do this procedure actually kill the children first. There is no reason to use

that as an argument. That sets up my second point.

This argument is about whether or not we are going to talk about the truth of the procedure. You will not find in any medical textbook, you will not find in any residency training program where they teach doctors to care for women's health, you will never find where this procedure is taught or is shown as an indicated procedure. Why not? Very simple reason: It is not ever indicated. It is not indicated in the medical literature. It has been abhorred.

There was a statement earlier that said that the ACOG was worried about this because it had the potential of inhibiting. They said, they do not like this procedure either. What they said is the Congress dealing with these issues have the potential of inhibiting care. Potential is very much different than changing or affecting care.

We were told that this was done on a small number of infants and that it was always done or most always done on infants with severe deformities. That was an out-and-out lie. I stood on this floor last year and said that was untrue. I will tell Members today, it is untrue, absolutely, without question that this is ever needed to take care of a woman's health.

Second point, it was said that a woman's fertility can only be protected sometimes by using this. That is exactly the opposite of the truth. I can give you cases where women's fertility because of this procedure has been ruined forever. It goes against everything we are taught in the medical community to preserve fertility and to preserve a woman's health.

Mr. CONYERS. Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the gentleman for yielding time to me.

First, I would say, I think the gentleman from Oklahoma's comments help focus this. He said that as far as this legislation is concerned, if the fetus was killed earlier in the procedure, then this bill would not have any affect. I think that shows, we are not here talking about not having the abortion or not bringing an end to the potential life. I think that ought to be clear.

I think we have heard arguments on the other side that suggested that this is opposition to abortion. That underlines the point that has been made here. This is not a bill about stopping abortions in any circumstances, mental health, whatever the reason. It is saying, well, you did not perform the fatal act early enough.

I think that is a great distinction with very little difference. I think that it undercuts the arguments they have been making. I think people have been led to believe that this was going to prevent late term abortion. We have the acknowledgment that it does no such thing and does not even try to.

Mansullo
Mascara
McCollum
McCrery
McDade
McHugh
McInnis
McIntyre
McKeon
McNulty
Metcalf
Mica
Miller (FL)
Mollohan
Moran (KS)
Murtha
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oberstar
Ortiz
Packard
Pappas
Parker
Pascarelli
Paul
Paxon
Pease
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts

Porter
Portman
Poshard
Pryce (OH)
Quinn
Radanovich
Rahall
Regula
Riggs
Riley
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Schiff
Sensenbrenner
Sessions
Shadegg
Shaw
Shimkus
Shuster
Siskisky
Skeon
Skelton
Smith (MI)
Smith (NJ)

Smith (OR)
Smith (TX)
Snowbarger
Solomon
Souder
Spence
Stearns
Stenholm
Stump
Stupak
Sunnunu
Talent
Tausin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traffant
Turner
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)

NOT VOTING—10

Bono
Burton
Callahan
Hilleary

Kaptar
McIntosh
Oxley
Smith, Linda

Torres
Waxman

□ 1223

So the resolution was agreed to.
The result of the vote was announced as above recorded.
a motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. MCINTOSH. Mr. Speaker, on rollcall No. 62, I was unavoidably detained. Had I been present, I would have voted "aye."

GENERAL LEAVE

Mrs. MYRICK. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on House Resolution 100.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. MCINNIS). The Chair notes that there has been a disturbance in the visitor's gallery in contravention of the law and the rules of the House of Representatives. The doormen and the police will remove from the gallery those persons participating in the disturbance.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate has passed a concurrent resolution of the following title in which the concurrence of the House is requested:

S. Con. Res. 14. Concurrent resolution providing for a conditional adjournment or recess of the Senate and the House of Representatives.

The message also announced that pursuant to Public Law 104-284, the Chair, on behalf of the Democratic leader, appoints the following individuals to the National Civil Aviation Review Commission:

Linda Barker, of South Dakota; and William Bacon, of South Dakota.

PARTIAL-BIRTH ABORTION BAN ACT OF 1997

Mr. CANADY of Florida. Mr. Speaker, pursuant to House Resolution 100, I call up the bill (H.R. 1122) to amend title 18, United States Code, to ban partial-birth abortions, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The text of H.R. 1122 is as follows:

H.R. 1122

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

TITLE 18, SHORT TITLE.

This Act may be cited as the "Partial-Birth Abortion Ban Act of 1997".

SEC. 2. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.

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

"CHAPTER 74—PARTIAL-BIRTH ABORTIONS

"Sec.

"1531. Partial-birth abortions prohibited.

"§ 1531. Partial-birth abortions prohibited

"(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than two years, or both. This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury: *Provided*, That no other medical procedure would suffice for that purpose. This paragraph shall become effective one day after enactment.

"(b)(1) As used in this section, the term 'partial-birth abortion' means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

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

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

"(2) Such relief shall include—

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

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

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

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

"74. Partial-birth abortions 1531".

The SPEAKER pro tempore. Pursuant to House Resolution 100, the gentleman from Florida [Mr. CANADY] and the gentleman from Michigan [Mr. CONYERS] each will control 1 hour.

The Chair recognizes the gentleman from Florida [Mr. CANADY].

Mr. CANADY of Florida. Mr. Speaker, I yield myself such time as I may consume.

□ 1236

Mr. Speaker, today for the fourth time the House considers an issue

NOES—175

Abercrombie
Ackerman
Allen
Andrews
Baldacci
Barrett (WI)
Becher
Bentzen
Berman
Berry
Blahov
Blagojevich
Blumenauer
Boehert
Bonior
Boswell
Boucher
Boyd
Brown (CA)
Brown (FL)
Brown (OH)
Campbell
Capps
Cardin
Carson
Castle
Clay
Clayton
Clyburn
Condit
Conyers
Coyne
Cummings
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dellums
Deutsch
Dicks
Dixon
Doggett
Dooley
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frelinghuysen

Frost
Furse
Geddeson
Gephardt
Gillman
Gonzales
Green
Greenwood
Gutierrez
Harman
Hastings (FL)
Hilliard
Hinchey
Hinojosa
Hoolley
Horn
Hoyer
Jackson (IL)
Jackson-Lee
(TX)
Johnson (CT)
Johnson (WI)
Johnson, E. B.
Kennedy (MA)
Kennedy (RI)
Kennelly
Kilpatrick
Kind (WI)
Klug
Kolbe
LaFalce
Lampson
Lantos
Larso
Levin
Lewis (GA)
Loftgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Markey
Martinez
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McKinney
Meehan
Meek
Menendez
Millender
McDonald
Miller (CA)
Mingo
Mink

Moakley
Mollinari
Moran (VA)
Morella
Nadler
Neal
Obey
Oliver
Owens
Pallone
Pastor
Payne
Pelosi
Pickett
Pomeroy
Price (NC)
Ramstad
Rangel
Reyes
Rivers
Rothman
Roybal-Allard
Rush
Sabo
Sanches
Sanders
Santolin
Sawyer
Schumer
Scott
Serrano
Shays
Sherman
Skaggs
Slaughter
Smith, Adam
Snyder
Specter
Stabenow
Stark
Stokes
Strickland
Tanner
Tauscher
Thompson
Thurman
Tierney
Towns
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxler
Weyand
Wise
Wooley
Wynn
Yates

procedure is determined by a woman's physician to be medically warranted under the circumstances, then the Congress should respect that judgment not criminalize it. We should not substitute our political judgment for professional medical judgment grounded in the particular circumstances of real cases.

This bill should be defeated.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 100, the bill is considered as having been read for amendment and the previous question is ordered.

The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. HOYER

Mr. HOYER. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. HOYER. Yes, Mr. Speaker, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. HOYER moves to recommit the bill H.R. 1122 to the Committee on the Judiciary with instructions to report the same back to the House forthwith with the following amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE

This Act may be cited as the "Late Term Abortion Restriction Act".

2. PROHIBITION ON CERTAIN ABORTIONS

(a) IN GENERAL.—It shall be unlawful, in or attempting interstate or foreign commerce, knowingly to perform an abortion after the fetus has become viable.

(b) EXCEPTION.—This section does not prohibit any abortion if, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or to avert serious adverse health consequences to the woman.

(c) CIVIL PENALTY.—A physician who violates this section shall be subject to a civil penalty not to exceed \$10,000. The civil penalty provided by this subsection is the exclusive remedy for a violation of this section.

POINT OF ORDER

Mr. CANADY of Florida. Mr. Speaker, I rise to a point of order that the motion to recommit is not germane to the bill.

The SPEAKER pro tempore. The gentleman will state his point of order.

Mr. CANADY of Florida. Mr. Speaker, the fundamental purpose of the underlying bill, H.R. 1122, deals with a very limited class of abortions, specifically partial-birth abortions. This is a specific type of procedure as defined in the bill.

The fundamental purpose of the motion to recommit amendment deals with any abortion procedure done post-viability. It purports to cover a much broader class of procedures than the procedure specifically prohibited in this bill.

Therefore, since the fundamental purpose of the motion to recommit purports to deal with a class of procedures that is broader than the one pro-

cedure in the underlying bill, a proposition on a subject different from that under consideration, it is not germane to the bill and I insist on the point of order.

The SPEAKER pro tempore. Does the gentleman from Maryland [Mr. HOYER] wish to be heard on the point of order?

Mr. HOYER. I do, Mr. Speaker.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Maryland [Mr. HOYER].

Mr. HOYER. Mr. Speaker, I thank the Chair for recognizing me on the point of order.

Mr. Speaker, this amendment is offered for the purpose, as it says, of limiting all late-term abortions, of prohibiting all late-term abortions, including abortions to which the gentleman spoke. We believe it does in fact expand upon but is inclusive of the procedures to which the gentleman's bill speaks. We believe it is an effort and an opportunity for the Congress to say that not only the late-term partial birth to which the bill speaks but that all procedures to effect late-term abortions ought to be prohibited. They ought to be prohibited as the policy of the United States of America.

It does provide, as does the underlying bill, with certain exceptions: The life of the mother, as is consistent with the bill on the floor; it also expands upon that to say serious adverse health consequences as well.

We believe in that context and, frankly, got an initial judgment as it was offered in the Committee on the Judiciary that this amendment was believed initially to be in order.

We believed that initial judgment was in fact correct. We believed this gives an opportunity for Members not only to speak to the instant issue raised by the particular 1122 bill, but also importantly gives Members the opportunity to express their view that all late-term abortions, not just one procedure, but that procedure and all procedures to effect post-viability abortions be outlawed, be illegal, be against the policy of the United States of America, except in these limited circumstances.

Because of that, Mr. Speaker, Members will have the opportunity to express themselves as being against late-term abortions, which in the context I suggest to the Speaker, in which this debate has occurred and proceeded.

Because of that, this gives Members the opportunity to particularly but more broadly, as Mr. CANADY did in fact correctly observe, express themselves on limiting all procedures for late-term abortions.

For that reason, we think it expands upon, as is correct, expands upon and makes more broad the prohibition on late-term abortions. It is for that reason that we think it critically important that the Chair rule that this is in fact in order so that Members can appropriately—because we believe it to be in order—express themselves in opposition to late-term abortions.

□ 1500

The SPEAKER pro tempore (Mr. MCINNIS). The gentleman from Florida has made a point of order that the amendment proposed—

Mr. EDWARDS. Mr. Speaker, the gentleman from Florida stated his point of order very rapidly and I want to be clear on this.

Is the parliamentary point of order on the point that the bill before the House only prohibits one type of abortion procedure, but the motion of the gentleman from Maryland [Mr. HOYER] would actually prohibit more types, in fact all types of late-term abortion procedures?

Is that the point of order that the gentleman from Florida is trying to make and objecting to letting the measure of the gentleman from Maryland up on the floor?

Mr. CANADY of Florida. Mr. Speaker, will the gentleman yield?

Mr. EDWARDS. I yield to the gentleman from Florida.

The SPEAKER pro tempore. The gentlemen will suspend. The Chair will recognize Members to argue the point of order. Does the gentleman from Florida seek that recognition?

Mr. CANADY of Florida. Mr. Speaker, I seek the opportunity to respond to the question posed by the gentleman from Texas.

The SPEAKER pro tempore. The Chair will hear argument confined to the point of order. The gentleman may proceed, confined to the point of order.

Mr. CANADY of Florida. Mr. Speaker, the point of order is the fundamental purpose of the underlying bill, H.R. 1122, deals with a very limited class of abortion, specifically partial-birth abortions.

One specific type of procedure in the bill is what is dealt with in H.R. 1122. The fundamental purpose of the motion to recommit, in contrast to that, deals with any abortion procedure done post viability. It, therefore, purports to cover a much broader class of procedures.

I believe that the impact of the motion to recommit would essentially be nil, because although it purports to affect a broader class of procedures, due to the exceptions contained in the motion to recommit, it is essentially meaningless.

Mr. EDWARDS. Mr. Speaker, I guess going back to my original question to the Speaker, the point of order is being made on the basis that the bill before the House simply outlaws one type of abortion procedure, the motion made by the gentleman from Maryland would actually ban many other types of late-term-abortion procedures, and the gentleman from Florida objects to that being voted upon in the House; is that correct, Mr. Speaker?

The SPEAKER pro tempore. The Chair hopes to clarify this point in the Chair's ruling. The Chair is now prepared to rule.

The gentleman from Florida makes a point of order that the amendment proposed in the instructions with the motion to recommit offered by the gentleman from Maryland is not germane.

The pending bill prohibits a certain class of abortion procedures.

The amendment proposed in the motion to recommit prohibits any or all abortion procedures in certain stages of pregnancy. It differentiates between the stages of pregnancy on the basis of fetal viability. In so doing, the amendment arguably addresses a subset of the category of pregnancies addressed by the bill. Still, by addressing any or all abortion procedures, the prohibition in the amendment exceeds the scope of the prohibition in the bill.

The bill confines its sweep to a single, defined class of abortion procedures. Thus, even though the amendment differentiates between pregnancies on narrower bases than does the bill, the amendment also, by addressing any or all abortion procedures, broadens the prohibition in the bill.

One of the basic lines of precedent under clause 7 of rule 16, the germaneness rule, holds that a proposition addressing a specific subject may not be amended by a proposition more general in nature. As noted in section 798f of the House Rules and Manual, this principle applies even when both propositions address a common topic.

Thus, on March 23, 1960, the Chair held that an amendment to criminalize the obstruction of any court order was not germane to a bill to criminalize only the obstruction of court orders relating to the desegregation of public schools.

On the reasoning reflected in this line of precedent, the Chair holds that the amendment proposed in the motion to recommit is not germane to the bill. Accordingly, the point of order is sustained and the motion to recommit is not in order.

Mr. HOYER. Mr. Speaker, it is with great reluctance, because I believe very strongly that the Chair's rulings ought to be upheld, but in this instance, Mr. Speaker, I am compelled, because of the importance of the issue and the closed rule that prevented any amendments, and because I believe, Mr. Speaker, in your ruling you correctly indicated that the Hoyer and Greenwood bill broadens the scope of this bill and broadens the application to procedures beyond what the bill refers to, and for that reason held it not to be germane, I am compelled to appeal the ruling of the Chair.

Mr. CANADY of Florida. Mr. Speaker, I move to lay the appeal on the table.

The SPEAKER pro tempore. First of all, the question is, Shall the decision of the Chair stand as the judgment of the House?

Now, the Chair will recognize the gentleman from Florida [Mr. CANADY].

**MOTION TO TABLE OFFERED BY MR. CANADY OF
FLORIDA.**

Mr. CANADY of Florida. Mr. Speaker, I move to lay the appeal on the table.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida [Mr. CANADY] to lay on the table the appeal of the ruling of the Chair.

The question was taken, and the Chair announced that the ayes appeared to have it.

Mr. HOYER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. 654

The vote was taken by electronic device, and there were—yeas 265, nays 165, not voting 2, as follows:

[Roll No. 63]

YEAS—285

[illegible]

Schiff
Sensenbrenner
Seaton
Shadegg
Shaw
Shimons
Shuster
Siskiy
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowberger
Solomon

Souder
Spence
Stearns
Stenholm
Stump
Stupak
Sundin
Talent
Tamm
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traffant
Turner

Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Weygand
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)

NAYS—165

Abercrombie	Frost	Morella
Ackerman	Furze	Nadler
Allen	Geddeson	Oliver
Aldrews	Gephardt	Owens
Baldacci	Gonsales	Pallone
Barrett (WI)	Green	Pascroll
Becerra	Greenwood	Pastor
Bentzen	Gutierrez	Payne
Berman	Harman	Peicos
Berry	Hastings (FL)	Pickett
Bishop	Hefner	Pomeroy
Blagojevich	Hilliard	Price (NC)
Blumenauer	Hinchey	Rangel
Boehlert	Hinojosa	Reyes
Bonzel	Hoober	Rivers
Boydell	Hoyer	Rothman
Boucher	Jackson (IL)	Roybal-Alford
Boyd	Jackson-Lee	Rush
Brown (CA)	(TX)	Sabo
Brown (FL)	Jefferson	Sanchez
Brown (OH)	Johnson (CT)	Sanders
Capps	Johnson (WI)	Sandinlin
Cardin	Johnson, E. E.	Sawyer
Carson	Kennedy (MA)	Schumer
Clay	Kennedy (RI)	Scott
Olayton	Kennelly	Serrano
Cytarun	Kilpatrick	Shays
Cossett	Kind (WI)	Sherrman
Covatta	Klecko	Skaggs
Coryne	Lampson	Slaughter
Cummins	Latimer	Smith, Adam
Davis (FL)	Levin	Snyder
Davis (IL)	Lewis (GA)	Spratt
DeFazio	Loftis	Stabenow
Dingell	Lofgren	Stark
Delahunt	Lofgren	Stokes
DeLoach	Luther	Strickland
Delahou	Maloney (CT)	Tanner
Dingell	Maloney (NY)	Tauscher
Dingell	Merkley	Thompson
Dixon	Martinez	Thurman
Dixon	Mastani	Tierney
Dobson	McCarthy (MO)	Torres
Dowley	McCarthy (NY)	Towns
Edwards	McDermott	Velazquez
Eskola	McGovern	Vento
Evans	Mohr	Visclosky
Evans	Moynihan	Waters
Farr	Neuharth	Watt (NC)
Fitzah	Neuharth	Waxman
Fitzah	Neuharth	Wexler
Fisher	Neuharth	Wise
Fisher	McDonald	Woolsey
Fisher	Miller (CA)	Wyda
Fischel	Minge	Yates
Ford	Mink	
Frank (MA)	Moran (VA)	

NOT VOTING-2

K-12 On Day 19
 K-12 On Day 19

NEW PLAN 50 1525 E

Members BASS, KINGSTON, and RAMSTAD, and Mrs. KELLY change their vote from "nay" to "yes."

So the motion to table was agreed to.
The result of the vote was announced
as above recorded.

A motion to reconsider was laid on the table.

1530

REPORT OF RECENTLY CAPTURED REAR PAWS
OF MASSACHUSETTS

Mr. FRANK of Massachusetts. Mr. Speaker, I offer a motion to recommend

The SPEAKER pro tempore (Mr. McINNIS). Is the gentleman opposed to the bill?

Mr. FRANK of Massachusetts. I am in its form, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. FRANK of Massachusetts moves to recommit the bill H.R. 1122 to the Committee on the Judiciary with instructions to report the same back to the House forthwith with the following amendments:

Page 2, line 10, insert after the words "or injury" the following:

"...including a life endangering physical condition caused by or arising from the pregnancy itself, or to avert serious adverse longterm physical health consequences to the mother"

The SPEAKER pro tempore. The gentleman from Massachusetts [Mr. FRANK] is recognized for 5 minutes in support of his motion to recommit.

Mr. FRANK of Massachusetts. Mr. Speaker, after the Committee on Rules tried to keep this from being heard, I appreciate your helping make sure that it is.

This is an amendment that would in its most important form add one more exception. Remember we had the bill that does not prevent the abortions, as the gentleman from Florida acknowledged, but bans a particular procedure.

Mr. Speaker, the bill bans a specific procedure. The sponsors said in opposition to the amendment that we just voted on that was ruled nongermane when it came up before, well, we do not make health as an exception. I do. I wanted health as an exception. That was voted down, and I regret it. But now I am offering a narrower one that meets some of the arguments we heard.

Health broadly defined by the Supreme Court when there is no other reference, and it is just health when there is no modifier, the Supreme Court has said that includes mental health, et cetera, as I think it should. But in this case where we are talking about one procedure where we have already voted down health, I have a further amendment. This says, "You can have an exception if it is necessary to avert serious adverse long-term physical health consequences." This, Mr. Speaker, is what the House is about to vote on.

I ask my colleagues, "Are you prepared to say to a doctor if you believe in your best medical judgment that it is necessary to avert serious physical long-term adverse health consequences, and the only way to avert them is to use this procedure, this amendment says to a doctor, because it follows the language of the bill, if it is necessary, not if it's in your subjective opinion, but if it's necessary, and you can show in a judicial proceeding that it was necessary to avert serious long-term adverse physical health consequences you can perform the procedure." And the majority is going to say so apparently.

Well, some say it is never possible. If my colleagues really believe that, then

the amendment would do no harm. But is the House ready to tell every doctor in America that never under any circumstances can he or she use a medical judgment to say this procedure? Because again we are not talking about whether or not there can be an abortion. There can be an abortion. It may be on mental health grounds, it may be on physical health grounds. Then the question is what is the procedure. And we are asking for a vote that says if it is necessary so that a woman does not lose her fertility so that there is not permanent damage to her organs, if she is not in horrible pain for a prolonged period.

Is that not likely to happen? I do not know; along with almost everybody in the House, I do not know. And therefore I am not prepared to legislate it. I am prepared to say that the physicians can decide that.

How much time do I have remaining, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from Massachusetts has 2 minutes remaining.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield to the gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, in all my years in the House I have never been more disturbed by a vote, but yet what happened in the Committee on Rules last night and on the floor here today, my concerns have not been allayed. Mr. Speaker, let me talk about those concerns.

I do not think the State should interject itself before viability and that women should have the right to protect their life and their health as under Roe versus Wade. I am concerned about viability of pregnancies, and I know health has been broadly interpreted, but under Frank it will be interpreted as the serious, serious physical health of the mother.

I am concerned about this, and it is before us, this method. It is brutal, it is inhuman, and it should never be used. However, may I say that is not my decision. Under Roe versus Wade the law of the land aids the decision of the mother and the doctor.

Mr. Speaker, I am so concerned about this body today. We have let political considerations and efforts do away with Roe versus Wade take over this and not let us resolve this situation.

Forty States, Mr. Speaker, have resolved this situation. We can resolve it by putting the serious health of the mother into this mix.

Mr. Speaker, we can do better.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me anticipate. Members on the other side have said, "Well, when you say health, the Supreme Court reads a broader version." Yes, I have that opinion right here. When it only said health, the Supreme Court interpreted a statute referring to health more broadly. The Supreme Court has never said that health al-

ways—that physical health does not just mean physical health. There is no argument for that, and the Supreme Court has never interpreted a statute on physical health. That is the key issue here.

I also add a language point that others have brought up making it clear that, if life is endangered by a condition arising from the pregnancy itself, that is also an exception. And that is not in the bill explicitly, and it ought to be, but this key point is before us now: "Do you believe as the chairman of the committee said, and the chairman of the committee in his intellectual integrity said if the choice is serious long-term physical health damage to the mother or the life of the fetus, apparently even a severely damaged fetus that could not live long, the woman's health must suffer."

I hope the House will not vote that way.

The SPEAKER pro tempore. Is the gentleman from Florida opposed to the motion to recommit?

Mr. CANADY of Florida. I am, Mr. Speaker.

The SPEAKER pro tempore. The chair recognizes the gentleman from Florida [Mr. CANADY] for 5 minutes in opposition to the motion to recommit.

Mr. CANADY of Florida. Mr. Speaker, regarding the life exception language contained in the gentleman's proposal, it is already covered in H.R. 1122. The language in the amendment simply restates what is obvious in the language in the bill. The life exception in H.R. 1122 states, and I will read it; it is on page 2 beginning on line 7:

This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by physical disorder, illness, or injury.

That very statement is made on the floor today that this bill does not provide an exception for the life of the mother. It is clearly right here in the bill. I have asked the Members to read it, look at it with their own eyes.

Regarding the health exception, partial-birth abortion is never necessary for a mother's health or future fertility. Hundreds of obstetricians, gynecologists, and maternal fetal specialists, along with former Surgeon General C. Everett Koop, have come forward to unequivocally state that, quote, "Partial-birth abortion is never medically necessary to protect the mother's health or her future fertility. On the contrary, this procedure can pose a significant threat to both," close quote.

Furthermore, in an American Medical News article Dr. Warren Hern, a late-term abortionist, disputed the safety of the partial-birth abortion procedure. I want to quote directly from this article. Now, this is Dr. Hern, M.D., one of the leading experts on abortion procedures in this country. This is what he said:

I have very serious reservations about this procedure, said Dr. Hern, the

Mr. FOGLIETTA changed his vote from "aye" to "no."
So the motion to recommit re-
jected.

Mr. COBURN. Mr. Speaker, we once again deal with deception. There is no serious adverse long-term physical health consequence to the mother that can be best treated by this procedure. It does not exist, it has never existed, it will never exist. It is a falsehood. It is an untruth. Partial-birth abortion, D&E on the live baby is done for the

Abercrombie	Archer	Baessler
Aderholt	Armey	Baker
Allen	Bachus	Ballenger

3- 6-97 10:21AM :

F:\M5\HOYER\HOYER.001

Abortion - partial birth -
legislative materials.
2/4
H.L.C.

105TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. HOYER introduced the following bill; which was referred to the Committee
on _____

A BILL

To prohibit certain abortions.

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

4 This Act may be cited as the "Late Term Abortion
5 Restriction Act".

6 **SEC. 2. PROHIBITION ON CERTAIN ABORTIONS.**

7 (a) **IN GENERAL.**—It shall be unlawful, in or affect-
8 ing interstate or foreign commerce, knowingly to perform
9 an abortion after the fetus has become viable.

SENT BY:

3- 6-97 :10:22AM :

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H.L.O.

3/ 4

2

1 (b) EXCEPTION.—This section does not prohibit any
2 abortion if, in the medical judgment of the attending phy-
3 sician, the abortion is necessary to preserve the life of the
4 woman or to avert serious adverse health consequences to
5 the woman.

6 (c) CIVIL PENALTY.—A physician who violates this
7 section shall be subject to a civil penalty not to exceed
8 \$10,000. The civil penalty provided by this subsection is
9 the exclusive remedy for a violation of this section.

SEN BY:

3- 6-97 :10:22AM :

: # 4 / 4

Hoyer Overview of Late-Term Abortion Bill Issues

This memo attempts to clarify the three key issues raised during the members' meeting last Thursday. There are essentially three issues to be addressed: 1) post-viability vs. third trimester; 2) serious health vs. health; and 3) penalty options.

I. "Post-Viability" Language:

The post-viability language in the Hoyer bill is entirely consistent with Roe as modified by the Supreme Court's decision in Casey. Casey, taking notice of medical advancements which could render the trimester framework obsolete as an index of fetal viability, dropped the trimester framework in favor of a viability standard. Whereas Roe's trimester framework was fixed, Casey's viability standard is subject to movement as medicine's ability to save prematurely born babies improves. Casey (the current "law of the land") upholds a woman's constitutional right to have an abortion up to the point of fetal viability (subject to restraints which do not place an "undue burden" on that right), and after viability "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Senator Boxer's amendment to H.R. 1833 (the partial birth bill vetoed by the President last year) also uses Casey's "viability" rubric.

II. "Serious Adverse Health Consequences" Language:

The health exception in the Hoyer bill is practically identical to the life and health exception language contained in the Boxer amendment to H.R. 1833. This language narrows, theoretically, the health exception of Casey by providing that the threat to the health of the woman must be "serious" in nature ("in the medical judgment of the attending physician"). We believe that this will not have a substantial impact on the class of women who seek late-term abortions, because most women who seek post-viability abortions do so for health reasons a physician would consider "serious". We believe and intend that our "serious health" exception will encompass severe fetal anomalies, which pose a serious health risk to the health of the woman, but not minor birth defects such as cleft palate which do not pose such a risk. "Adverse" should have no narrowing effect because it is beyond question that the Court in Casey and Roe sought to avoid health endangerment (vs. improvement).

III. Penalty Options:

The Hoyer bill provides for a \$10,000 civil penalty for physicians who perform post-viability abortions which do not fall within the prescribed life or serious health exception. A civil penalty is preferable to no penalty because it provides the necessary "teeth" to counteract pro-life charges that the bill is illusory. The \$10,000 figure is sufficiently substantial to provide a plausible defense to the unavoidable pro-life criticism. If set much higher, the civil penalty could have a "chilling" deterrent effect on physicians, diminishing access to women who seek late-term abortions for permissible (i.e., "serious health") reasons under the bill. A criminal penalty would clearly have a "chilling effect" and would raise the disturbing specter of physicians being carted away in handcuffs -- an image most Americans would find offensive.

Tot Ben Freeland
Honorable Griffin

AMENDMENT NO. _____

Calendar No. _____

Purpose: To provide a procedure for determining whether a physician's conduct was necessary to save the life of the mother.

IN THE SENATE OF THE UNITED STATES—105th Cong., 1st Sess.

H.R. 1122

To amend title 18, United States Code, to ban partial birth abortions.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. SANTORUM

Viz:

1 On page 2, line 16, strike the semicolon and all that
2 follows through "purpose" on line 17.

3 On page 3, between lines 8 and 9, insert the follow-
4 ing:

5 "(3) As used in this section, the term 'vaginally deliv-
6 ers a living fetus before killing the fetus' means delib-
7 erately and intentionally delivers into the vagina a living
8 fetus, or a substantial portion thereof, for the purpose of

1 performing a procedure the physician knows will kill the
2 fetus, and kills the fetus.

3 On page 3, between lines 21 and 22, insert the follow-
4 ing:

5 "(d)(1) A defendant accused of an offense under this
6 section may seek a hearing before the State Medical Board
7 on whether the physician's conduct was necessary to save
8 the life of the mother whose life was endangered by a
9 physical disorder, illness or injury.

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

15 On page 3, line 22, strike "(d)" and insert "(e)".

TALKING POINTS ON FITZSIMMONS STORY

- Nothing that Mr. Fitzsimmons now says contradicts or undermines the President's position, which is that so-called partial-birth abortions should be banned except when they are necessary to save the life of a woman or prevent serious harm to her health.
- The President has never claimed that partial-birth abortions are used only to prevent death or serious harm.
- Indeed, the President has said, in several written statements on the subject: "Let me be clear. I do not contend that this procedure, today, is always used in circumstances that meet my standard -- namely, that the procedure must be necessary to prevent death or serious adverse health consequences. The procedure may well be used in situations where a woman's serious health interests are not at issue. But I do not support such uses, I do not defend them, and I would sign appropriate legislation banning them."
- The President's position today remains what it has always been: that he will sign a bill banning partial-birth abortions, but only if it has an exception that will protect those women -- even if few in number -- who need this procedure to save their lives or prevent serious harm to their health.

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- The President has never claimed that partial-birth abortions are used only, or even primarily, to prevent death or serious harm. What he has said is that when (but only when) the procedure is necessary for these reasons, a doctor must be allowed to perform it.
- The President has recognized that some doctors may use the procedure for elective reasons and has called for an end to this practice. He has stated on several occasions: "The procedure may well be used in situations where a woman's serious health interests are not at issue. But I do not support such uses, I do not defend them, and I would sign appropriate legislation banning them."
- The President's position today remains what it has always been: that he will sign a bill banning partial-birth abortions, but only if it has an exception that will protect those women -- even if few in number -- who need this procedure to save their lives or prevent serious harm to their health.

Background

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said this week that partial birth abortions are (1) performed more frequently than pro-choice groups have acknowledged and (2) often performed on healthy women with healthy fetuses.

There are no good statistics on these questions, and it would be a great mistake to challenge Fitzsimmons on the facts. The important point is that even if true, Fitzsimmons's claims do not undermine the President's position, as explained above.

Talking Points on Late-Term Abortion 5/21/97

- The President will veto the Santorum bill because it does not adequately protect women from grievous physical harm.
- The American College of Obstetricians and Gynecologists (ACOG), which is the organization of specialists who know the most about this issue, agrees with the President that the bill endangers women, because it prevents doctors from using a procedure that in a few cases best protects women from serious injury.
- The AMA's last-minute endorsement of the Act will not lead the President to change his position. The changes that the AMA bargained for in the bill protect doctors from criminal prosecution, but do not protect women from serious physical injury.
- The AMA insisted that a peer review process take place before any criminal prosecution so that doctors can obtain favorable testimony from others in the medical profession. The AMA also bargained for legislative language that defines more clearly the procedure that the bill prohibits.
- But these changes do not help the few women -- like the women who were with the President when he signed the bill -- who need the procedure that the bill prohibits in order to prevent grievous injury. The President vetoed the bill last year to protect these women, and he will veto the bill again to protect them.
- The AMA itself concedes that the procedure may be necessary to save a woman's life and that the bill must have a life exception to protect the few women faced with this danger. The President is saying only that this exception must extend to the few other cases in which the procedure is necessary to save a woman from serious physical harm, such as loss of the ability to have other children.

Q&A on Late-Term Abortion

Question: Does the AMA's endorsement of the Partial Birth Abortion Act -- and its statement that the partial-birth procedure is not good medicine -- change your view of this legislation?

Answer: No, because I am still not convinced that this bill adequately protects women from grievous injury. Let me remind you that the American College of Obstetricians and Gynecologists, which is the organization of doctors that knows the most about this issue, opposes this bill for the same reason I do -- because it prevents doctors from using a procedure that in a small group of cases best protects women from serious physical injury. The AMA endorsed this bill after bargaining for a change that protects doctors. I've implored Congress to make a narrow change in the bill to protect women -- to ensure that they don't suffer grievous injury because Congress has tied the hands of their doctors -- and I will not sign the bill until I get it.

Question: Senator Daschle has now said that he will vote for the Partial Birth Abortion Act. Does this mean that your veto will be overridden?

Answer: We'll have to see how the votes line up -- but that's not going to affect my decision. I will veto this bill because I think it doesn't adequately protect women from serious physical injury. I have said over and over that if Congress were to add a narrow exception covering these few cases, I would gladly sign the bill. But I will not sign the bill until it has that narrow exception for grievous injury, no matter how the votes stack up in Congress.

Q&A on Late Term Abortion

Question: Do you remain committed to vetoing the partial birth abortion bill? Didn't you base your prior veto of the bill on false information -- i.e., that this procedure is performed on only a few hundred women in desperate circumstances?

Answer: I will veto the bill, for the same reason as before -- because it doesn't adequately protect women from serious harm. I based my veto on the fact that there are a small group of women in desperate circumstances who need this procedure in order to save their lives or prevent serious injury to their health. Let's be clear: I've never said that these are the only circumstances in which the procedure is used; I've just said that these few women need to be protected. If Congress does so, I will gladly sign the bill, because I think this kind of procedure should be banned except when necessary to save the life of a woman or prevent serious harm to her health.

Question: If Congress were to add a health exception to the partial birth bill you vetoed last year, that bill would prohibit all partial birth abortions -- even if done before viability -- that aren't done for life or serious health reasons. Would you really sign a bill of that kind?

Answer: I have made very clear my condition for signing the partial birth bill. I told Congress that I would sign the bill if it protected women who need the procedure to save their lives or avert serious harm to their health. I continue to take that position. If Congress adds a provision to the bill that protects women who need the procedure for life or serious health reasons, I will sign that bill.

Question: Would you sign Senator Daschle's bill prohibiting all post-viability abortions except when done to save the life of a woman or avert serious harm to her health?

Answer: I have not seen Senator Daschle's language, but I believe that I could sign his bill. I have long opposed elective late-term abortions, regardless what procedure is used: when I was Governor of Arkansas, I signed into law a bill that barred all third-trimester abortions, with an appropriate exception for life or health. And last year, I said I would sign such a bill at the federal level. Assuming Senator Daschle's bill adequately protects women who need late abortion to prevent serious harm to their health, I will make it the nation's law.

TALKING POINTS ON FITZSIMMONS STORY

- Nothing that Mr. Fitzsimmons now says contradicts or undermines the President's position, which is that so-called partial-birth abortions should be banned except when they are necessary to save the life of a woman or prevent serious harm to her health.
- The President has never claimed that partial-birth abortions are used only, or even primarily, to prevent death or serious harm. What he has said is that when (but only when) the procedure is necessary for these reasons, a doctor must be allowed to perform it.
- The President has recognized that some doctors may use the procedure for elective reasons and has called for an end to this practice. He has stated on several occasions: "The procedure may well be used in situations where a woman's serious health interests are not at issue. But I do not support such uses, I do not defend them, and I would sign appropriate legislation banning them."
- The President's position today remains what it has always been: that he will sign a bill banning partial-birth abortions, but only if it has an exception that will protect those women -- even if few in number -- who need this procedure to save their lives or prevent serious harm to their health.

Background

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said this week that partial birth abortions are (1) performed more frequently than pro-choice groups have acknowledged and (2) often performed on healthy women with healthy fetuses.

There are no good statistics on these questions, and it would be a great mistake to challenge Fitzsimmons on the facts. The important point is that even if true, Fitzsimmons's claims do not undermine the President's position, as explained above.

Abortion--partial birth--
talking points

Question: Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said this week that he lied about partial birth abortions -- that they're performed more frequently than pro-choice groups have acknowledged and that they're often performed on healthy women with healthy fetuses. In light of his statements, are you going to change your position?

Answer: No. My position remains what it has always been -- that so-called partial-birth abortions should be banned except when they are necessary to save the life of a woman or prevent serious harm to her health.

Nothing Mr. Fitzsimmons has said conflicts with that position. I've never claimed that partial-birth abortions are used only to prevent death or serious harm. What I've said is that when the procedure is necessary for these reasons -- in those few cases when there are tragic circumstances involving serious harm to the woman -- a doctor must be allowed to perform it. But when the procedure isn't necessary for these reasons, a doctor should not be allowed to perform it.

So I will say again what I've said before: that I will sign a bill banning partial-birth abortions, but only if it has an exception that will protect those women -- even if few in number -- who need this procedure to save their lives or prevent serious harm to their health.

Question: Didn't you base your veto of the partial-birth abortion bill on false information -- i.e., that this procedure is performed only on a few hundred women in desperate circumstances?

Answer: No. I based my veto on the fact that there are a small group of women in desperate circumstances who need this procedure in order to save their lives or prevent serious injury to their health. I've never said that these are the only circumstances in which the procedure is used. Indeed, I've acknowledged that there are cases where the procedure is not necessary for life or serious health reasons -- and I've made very clear that I would sign legislation banning the procedure in those cases.

Question: If Congress were to add a health exception to the partial birth bill you vetoed last year, that bill would prohibit all partial birth abortions -- including pre-viability partial birth abortions -- that aren't done for life or serious health reasons. Are you really saying that you would sign a bill of that kind -- a bill that prohibited a particular procedure (except if done for life or serious health reasons) in the pre-viability period?

Answer: I have made very clear my condition for signing the partial birth bill. I told Congress that I would sign the bill if it protected women who needed the procedure to save their lives or avert serious harm to their health. I implored Congress to send me such a bill. I continue to take that position. If Congress adds a provision to the bill that protects women who need the procedure for life or serious health reasons, I will sign that bill.

THE WHITE HOUSE
WASHINGTON

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*Abortion -
partial birth -
talking points*

NOTE FOR ERSKINE BOWLES
SYLVIA MATTHEWS
MELANNE VERVEER
DON BAER
MIKE MCCURRY
CHUCK RUFF
BETSY MYERS
ANN LEWIS

FROM: ELENA KAGAN

Attached talking points on
Fitzsimmons story for your
information.