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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Gracious God, for tomorrow and its needs we do not pray, but keep us, guide us, strengthen us, just for today. Help us to live in day-tight compartments by being faithful and obedient to You in this new day You have given us. Yesterday is a memory and tomorrow is uncertain. But today, if we live it to the fullest, will become a memorable yesterday and tomorrow will be a vision of hope. A great life is an accumulation of days lived, one at a time, for Your glory and by Your grace. Anything is possible if we take it in day-sized bites. Help us make today a day to be that different person we've wanted to be, to start doing what we've procrastinated, and to enjoy the work we have to do. We want this to be a special day to love You, serve You, and be an encourager of others around us. One day to live, it will go so fast; Lord, make it a good memory, before it's past. In our Lord's name. Amen.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

PARTIAL-BIRTH ABORTION BAN ACT

The PRESIDENT pro tempore. Under the previous order, 9:30 a.m. having arrived, the Senate will now resume consideration of H.R. 1833, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 1833) to amend title 18, United States Code, to ban partial-birth abortion.

The Senate resumed the consideration of the bill.

MOTION TO COMMIT WITH INSTRUCTIONS

The PRESIDENT pro tempore. Under the previous order, the Senator from Pennsylvania [Mr. SPECTER] is recognized to make a motion to commit with the time until 12:30 p.m. equally divided and controlled between the Senator from New Hampshire [Mr. SMITH] and the Senator from Pennsylvania [Mr. SPECTER].

Mr. SPECTER. I thank the Chair. I thank the distinguished President pro tempore.

Mr. President, on behalf of Senators JEFFORDS, SNOWE, CAMPBELL, KASSEBAUM, SIMPSON, and COHEN, I move to commit H.R. 1833 to the Committee on the Judiciary with instructions to hold not less than one hearing on this bill and report the bill with amendments, if any, back to the Senate within 19 days.

The motion to commit with instructions is as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. SPECTER (for himself, Mr. JEFFORDS, Ms. SNOWE, Mr. CAMPBELL, Ms. KASSEBAUM, Mr. SIMPSON, and Mr. COHEN) moves to commit the bill H.R. 1833 to the Committee on the Judiciary with instructions to hold not less than one hearing on such bill and report the bill, with amendments (if any), back to the Senate within 19 days.

Mr. SPECTER. Mr. President, I have selected a bare minimum amount of time, which is really only a 9-day commitment from today, November 8, until November 17 when the Senate will go out of session under a previously announced recess period by the majority leader. And then there would be an additional 10 days while the Senate is in recess, from November 17 to November 27, for a total of 19 days. But the effective period of this referral, as I say, will only be for 9 days.

After considerable thought, I have abbreviated the referral period to this very short time to emphasize to everyone the importance of the issue and the need to have very prompt consideration and to allay any concern or reject any argument that this referral is being made to, in effect, defeat the bill.

Mr. President, I submit that this kind of consideration and this kind of a hearing is really indispensable because of the very complex matters which are involved in this issue. I would enumerate them as humanitarian considerations, medical considerations, statutory interpretation considerations, and constitutional considerations.

The humanitarian considerations have been broached to a significant extent in terms of the circumstances of the mother and the circumstances of the fetus with considerable doubt as to what actually occurs during these so-called late-term abortions. It is a very complicated picture as to what pain and suffering is sustained by the fetus, a subject which requires our very thorough consideration because of the very serious humanitarian implications on pain and suffering to the fetus during the course of this medical procedure.

The matter has had a very, very brief hearing in the House of Representatives—as I understand it, for less than a full day.

Mr. President, I ask unanimous consent that at the conclusion of my statement the full transcript of the hearing before the House of Representatives may be printed in the RECORD so that everyone in the Senate who will be considering this matter in the course of the next day or two, or however long it takes, will have an opportunity to see the brevity of those hearings and the impossibility of consideration of the many complicated issues which are involved in this matter.

The PRESIDING OFFICER (Mr. INHOFE.) Without objection, it is so ordered.

(See exhibit 1.)

Mr. SPECTER. Mr. President, there is no question about the chilling effect

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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of this medical procedure. It is something that, I submit, has to be understood thoroughly on all sides.

I say candidly that I am not sure what my ultimate judgment would be on this kind of a medical procedure if, as some claim, it is really infanticide. I have spent a large portion of my career as a district attorney being very much concerned about the issue of homicide, which takes many, many forms. And, if we genuinely have an issue of infanticide—the killing of an infant—that is something which existing law does not tolerate, and that is something which has to be considered very, very carefully on the basic question of whether there is an infant where the medical procedures would take the life of the infant, or whether we do not have an infant in the contemplation of the law. And that is something which has to be considered carefully.

There has been considerable controversy as to just what the medical circumstances are with the children who are involved. One case, which I have had referred to me through the media, involved a fetus where the brain had grown outside the skull so that on the medical procedure involved it was not a question of whether the baby would die, not a question of whether the fetus would die, but only a question of when and how.

Other matters that I have heard about involve situations where the mothers and the fathers were desperately interested in saving the pregnancy but the medical facts were such that there was such severe brain damage and heart damage that there really was not a live human being.

There will doubtless be considerable discussion on the floor of the Senate today about the status of the fetus on these medical procedures.

I suggest that while argument and debate is obviously a very important part of our process, a more important part of our process involves the hard medical facts as to what is involved. That really requires medical testimony as opposed to the kinds of arguments which are traditionally made on the Senate floor. Those arguments have real value, but they have to be evaluated and judged in the context of what the hard medical evidence is. On this date of the record, at least from the House hearings, there is not much to go on. So that I think this is a matter which cries out for that kind of a hearing and the establishment of the evidence to enable the Senate to make a judgment.

I find it, candidly, a little hard to understand the procedures which brought this legislation to the floor without a hearing by the Judiciary Committee. But facing the procedural posture of this matter, the remedy is to move from the decision of the majority leader to put this matter in the Chamber to having consideration by the full Senate as to what is the appropriate course. It is rumored that this is going to be a close vote. I do not know whether that is true or not. But if we send this matter to committee for hearings, we may be saving considerable time because if the vote is close on a motion to commit as to having a simple majority, I think it is fair to say it is unlikely there would be the 60 votes present to cut off debate. So that prompt action by the Senate in sending the matter to committee may well save us time, not only in the long run but in the short run as well.

Beyond the considerations of humane treatment for the fetus and the mother, we then come to very, very complex questions of statutory interpretation which I submit have not been thought through by the proponents of this bill in the House or by the hasty action that it went through in the House and the heavily emotionally charged context.

According to the information provided to me, there is a real question as to the applicability of this statute in the broader terms of how a fetus is delivered. Subsection (b) provides that a partial-birth abortion is defined as ''an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

On a note, a statutory interpretation—and again, candidly, I think this needs further verification and further analysis, but according to this definition the prohibition established in H.R. 1833 would not apply to (1) abortions performed by C section or hysterectomy, that is, where the fetus is not extracted vaginally, and it would not apply either to abortions in which the fetus is acted upon prior to being moved into the birth canal.

So what we may realistically be doing here is to be legislating in a halfway manner in the area of vaginal births without other ways of dealing with the issue which ought to be dealt with in terms of effective legislation, if this is, indeed, an issue with which we feel we ought to deal.

Subsection (c) then establishes an affirmative defense to the prosecution of a physician performing a partial-birth abortion if it is established by a preponderance of the evidence that the physician reasonably believed that ''the partial-birth abortion was necessary to save the life of the mother; and no other procedure would suffice for that purpose.''

As a matter of statutory interpretation, there are very complex issues involved where you provide for an affirmative defense as opposed to making those elements of proof a part of the prosecutor's case. In a criminal case, the Government has the burden of proving beyond a reasonable doubt all of the elements in a prosecution, and it may well be that this language is ineffective as a matter of law to shift the burden of proof to the defendant.

There are many items which have been affirmative defenses such as alibi, not being present at the time the offense was committed, which have been incorporated into the prosecutor's affirmative duty to show beyond a reasonable doubt all elements of the offense. There is no indication that any consideration has been given on that complex subject by the House of Representatives.

The constitutional issues are present here because the Supreme Court of the United States has held that the States may prohibit an abortion in late term—''may proscribe an abortion except where it is necessary in an appropriate medical judgment for the preservation of the life or health of the mother,'' language from Roe versus Wade.

That involves making the life of the mother an affirmative defense, and it also opens a broader context as to whether the health of the mother would be an exception to the prohibition against the State's eliminating late-term abortions.

This is a very shorthanded description, in the course of having a relatively limited amount of time available for this issue in this Chamber because of our crowded calendar, but these are matters which could be taken up in some detail in the course of the 9 days between now and the 17th, when the Senate is in session or when the Judiciary Committee may see fit to interrupt the recess process. And I can speak for myself. I would be glad to be here to take whatever time is necessary on a hearing or hearings so that these matters may be inquired into and we may legislate, if at all, in a rational way.

There is another consideration involved here that I do not intend to dwell on, but that is the consideration which is articulated so frequently in this Chamber. That is the appropriate area of legislation for the Federal Government in terms of federalism generally and in terms of the 10th amendment where Members of this body are proud to pull from their vest pocket the 10th amendment which specifies that all matters not expressly given to the Congress are reserved to the States.

Subsection (a) provides:

> Whoever, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years or both.

It raises a real question basically as to whether this is a matter appropriately for the Congress. Provisions of the criminal law are traditionally left to the States. Recently, the Supreme Court of the United States in the Lopez case sharply limited the authority of the Congress of the United States to legislate in areas which have long been viewed as areas where the Congress had authority. So that we do have State legislatures ready, willing, and able to act affirmatively on the subject.

On this date of the record, I do not know what States, if any, have moved to legislate on late-term abortions. But

I think it ought to be at least mentioned with whatever degree of emphasis we choose to make on it as to the Federal considerations which are involved here.

Customarily, when you have issues involving jurisdiction, our pattern has been to move a little fast over any such considerations, as we have been known to move a little fast over constitutional considerations, leaving those matters ultimately for the courts.

But where you have a matter of overwhelming importance on the constitutional issue of life of the mother, or health of the mother, and especially where even the most restrictive interpretations on abortion have always carved out an exception for life of the mother, this statute does not do that.

This statute purports to have it raised only as an affirmative defense, which is very different from even under the restrictive interpretations of when an abortion may be performed excepting life of the mother.

Then the issue of jurisdiction, again, not often focused on the floor of either the Senate or the House of Representatives, is worthy of consideration.

But I would say, Mr. President, that the fundamental considerations really here involve the humanitarian considerations: What is actually happening to the fetus? Is the fetus subjected to pain and suffering? If so, is there a way that the legislation could encompass a procedure which would eliminate that pain and suffering? What are the humanitarian considerations involved for the life of the mother?

If it is determined medically that it is preferable to have the fetus acted upon vaginally, as opposed to alternatives which are apparently not covered by the statute, a C section, hysterotomy, or where action is taken on the fetus prior to removal from the birth canal, why should the Congress of the United States rush to judgment to criminalize a medical procedure which is in the vaginal channel as opposed to a hysterotomy or C section or action prior to the entry of the fetus into the vaginal channel, where those matters are really matters for the medical profession as opposed to the Congress? At least should not the Congress be informed as to the intricacies of these matters before we pass judgment on a matter of this great importance?

EXHIBIT 1

HEARING ON PARTIAL-BIRTH ABORTION BEFORE THE HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON THE CONSTITUTION, COMMITTEE ON THE JUDICIARY, June 15, 1995

The subcommittee met, pursuant to notice, at 10:23 a.m., in room 2237, Rayburn House Office Building, Hon. Charles Canady (chairman of the subcommittee) presiding.

Present: Representatives Canady, Hyde, Inglis, Sensenbrenner, Hoke, Goodlatte, Frank, Conyers, and Schroeder.

Also Present: Representative Jackson Lee.

Staff Present: Kathyrn Hazeem, chief counsel; Keri Harrison, counsel; Jennifer Welch, secretary; Jacquelene McKee, secretary; and Robert Raben, minority counsel.

Mr. CANADY [presiding]. The subcommittee will come to order. I am pleased to have the opportunity to hold this hearing to examine the partial-birth abortion procedure. We will hear primarily from medical experts today. They will describe the partial-birth abortion procedure in which a live baby's entire body, except for the head, is delivered before the baby is killed, after which the practitioner completes the delivery. They will testify regarding whether the baby undergoing this procedure feels pain.

We invited two of the abortionists who specialize in and advocate the use of this type of abortion. They agreed to testify. But apparently after further consideration, they found that their position was a position they did not wish to speak to the subcommittee about today. I am very disappointed to report that both practitioners canceled at the last minute.

This hearing focuses on partial birth abortion because while every abortion sadly takes a human life, this method takes that life as the baby emerges from the mother's womb while the baby is in the birth canal. The difference between the partial-birth abortion procedure and homicide is a mere three inches.

A fundamental principle on which our country was founded is that we are endowed by our creator with the unalienable right to life. Roe v. Wade alienated that right from a powerless group by taking away their legal personhood. Richard John Neuhouse correctly stated that, ''We need never fear the charge of crimes against humanity so long as we hold the power to define who does and who does not belong to humanity.'' The Supreme Court instituted abortion on demand by deciding that unborn human beings do not belong to humanity.

Partial-birth abortion procedures go a step beyond abortion on demand. The baby involved is not unborn. His or her life is taken during a breech delivery. A procedure which obstetricians use in some circumstances to bring a healthy child into the world is perverted to result in a dead child. The physician, traditionally trained to do everything in his power to assist and protect both mother and child during the birth process deliberately kills the child in the birth canal.

Because we believe it is an inhuman act, Barbara Vucanovich, Tony Hall, Henry Hyde, and I introduced a bill yesterday with 28 of our colleagues to ban the performance of partial-birth abortion. Partial-birth abortion is defined in the bill as, and I quote, ''An abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

On June 12, the National Abortion Federation sent a letter to Members of Congress in response to a letter Barbara Vucanovich and I sent to inform our colleagues of our intention to introduce the partial-birth abortion ban. The National Abortion Federation letter made a number of claims about the partial-birth abortion procedure that are inconsistent with the statements of Drs. McMahon and Haskell, two abortionists who use and advocate the use of the procedure.

The letter claims that the drawings of the partial-birth abortion procedure that we included with our Dear Colleague are highly imaginative and misleading. But Dr. Haskell himself told the American Medical News that the drawings were accurate from a technical point of view.

Professor Watson Bowes of the University of North Carolina at Chapel Hill, a distinguished physician and prominent authority on fetal and maternal medicine, and coeditor of the Obstetrical and Gynological Survey, reviewed an article by Dr. Haskell describing a partial-birth abortion procedure and confirmed that the drawings are an accurate representation of the procedure described in the article by Dr. Haskell.

The National Abortion Federation letter also claims that the fetal demise is virtually always induced by the combination of steps taken to prepare for the abortion procedure. Both Dr. Haskell and Dr. McMahon, however, told American Medical News that the majority of fetuses aborted this way are alive until the end of the procedure. In a Dayton News interview, Dr. Haskell referred to the scissors thrust that occurs after the baby's entire body is delivered and only the head of the baby is still lodged in the birth canal as the act that kills the baby. He said, and I quote, ''When I do the instrumentation on the skull, it destroys the brain sufficiently so that even if it,'' that is, the baby's head, ''falls out at that point, it definitely is not alive.''

After his review of Dr. Haskell's article, Professor Bowes concluded that the fetuses are alive at the time the partial-birth procedure is performed. Indeed, Dr. Bowes notes that Dr. Haskell explicitly contrasts his procedure with other procedures that do induce fetal death within the uterus.

The National Abortion Federation letter implies that partial-birth abortions are performed only in unusual circumstances. Neither Dr. Haskell nor Dr. McMahon claims that this technique is used only in limited circumstances. In fact, their writings advocate this method as the preferred method for most late-term abortions. Dr. Haskell prefers the method from 20 to 26 weeks into the pregnancy. Dr. McMahon uses the method throughout the entire 40 weeks of pregnancy. In fact, a previous National Abortion Federation memo to its members counsels them not to apologize for this legal procedure, and states, ''There are many reasons why women have late abortions, life endangerment, fetal indications, lack of money or health insurance, social, psychological crises, lack of knowledge about human reproduction,'' et cetera.

It is my hope that we can have a candid debate on the realities of this procedure without disinformation or euphemisms. I believe that when they are informed about the truth about the procedure, my colleagues who value the dignity of human life and believe in common decency, will agree with me that partial-birth abortion is inhuman and should be banned.

Mr. Frank.

Mr. FRANK. Mr. Chairman, I have very strong views on this. But given the importance of this particularly to women, I am going to yield my time to the senior woman in the U.S. Congress, the gentlewoman from Colorado.

Mrs. SCHROEDER. I want to thank the ranking member for yielding. I mean that very sincerely, because as the senior woman in this House, this is a day I had dreaded. I see us really rolling back on women's rights.

I think what we are doing here today is bad medicine, it's bad law, it's bad public policy, and it's intrusive Government at its very, very worst.

What this bill is doing is saying that doctors should put aside their best medical judgment in favor of some political judgments made my Washington politicians. I do not know of any other area where we go in and legislatively mandate medical practices. In other words, some of the written testimony I have seen on this has said that what we are really doing is legislatively mandating malpractice.

First of all, the partial-birth procedure is not a medical term. It is a political term. We all know that what people are really trying to get at here is the fundamental right of women to receive medical treatment that they and their doctors determined to be safest and best for them. That is the essence. That is a constitutional right. That right has

been around for more than 20 years. Today we are moving to try and tamper with that.

Today we are going to try and make a procedure sound so terrible and so awful that only women who are demons would consider doing this. Only doctors who are demons would consider doing this. It is almost reinciting witchcraft of a sort, trying to see women as witches. Well, let's talk about this.

There are very, very, very few of these procedures. These procedures are heartbreak procedures. These are procedures that nobody wants to engage in. But sometimes everything goes wrong. Everything goes wrong and it is left to a woman, her spouse, her doctor, to sit down and make hard choices. I do not think we want the Government in Washington taking those choices away.

When you hear from some of the women who had to make these hard choices, they came to them by medical science. Things that we thought were progressive. Things such as amniocentesis and many of the procedures now that tell us more about what is happening along the different markers of birth. I must ask, are we going to do away with those things too? Are we going to do away with all medical procedures and go back to the Dark Ages?

I remind you that in World War I, more women died in childbirth in this country than American solders died in World War I. We have gone a long way to making all of this safer for women. I hate to see us rolling back.

We are going to see a gruesome parade of photos today. That is going to be part of why they are going to say this should all be banned. But I must say that you could do that with almost any medical procedure. All of us are a little squeamish about medical procedures of almost any kind. Do you want to see liver transplants? Do you want to see heart transplants? Do you want to make people squirm? You can start doing all of that.

The issue is, is this a valid life-saving medical procedure that a doctor could reach under reasonably difficult situations. I think that we have all agreed, yes.

I want to say there are some very brave women that are sitting here in this hearing. I don't know how they are doing it. First there is Vicky Wilson, who is a nurse married to an emergency room physician. She had to end a wanted pregnancy because of devastating fetal malformations. She is standing. I want to say I salute you and your husband for being here and listening to this.

There is also Tammy Watts, a California woman, who terminated a wanted pregnancy because the fetus was so horribly deformed and could not live outside the womb. I think you are a very brave woman to be here and stand up to this too.

Vicky Smith, who is an Illinois mother of two children ages 7 and 11, had to end a wanted pregnancy because again, the fetus was microcephalic, had multiple fetal deformations. Vicky Smith is now pregnant again. Vicky, thank you for having the courage to come here.

I also want to say that none of these people engaged in this process lightly. I think that is why they have the courage to come here and say do not demonize them. These were very difficult decisions for them to make and their doctors to make. Who are we, as politicians, to say we know better?

Also, I would like to offer for the record a letter from Rabbi Shira Stern and her husband Rabbi Donald Weber. They wrote to count their experience with abortion. They said, you don't have to show us pictures of fetuses in jars. We held our own shortly after the abortion. Don't talk to us of pain. We worked for 5 years as volunteer chaplains on the pediatric floor of the Memorial Sloan Kettering Cancer Center in New York, and we watched countless children die in agony. Our baby would have died at birth with pain sensors that were much more sophisticated at its full gestational age than they did at the time of the abortion. We have all sorts of problems. This is very painful.

I think because this bill begins the imposition of restrictions on abortion, and that will also increase the medical risks to the life and health of women, it should be considered unconstitutional. I know and I hope that the American women will say this is unacceptable. This is a beginning of chopping away at a right we have spent much too long in trying to ascertain. One of the fundamental rights under the constitution is one, to health care, and to be treated fully as an adult.

I must say again, as the only woman, what a sad day this is. I hope that the women in America will wake up, realize what is happening. Your rights are at stake today. My rights are at stake today. Physicians' rights are at stake today. If we want the physicians to treat us to deal with their best medical judgment and not have political judgments slapped all over their training, this is the day to draw the line in the sand and say, ''No more.'' It's our choice. It is not politicians' choice. I thank the gentleman from Massachusetts again for yielding.

Mr. CANADY. Mr. Hyde.

Mr. HYDE. Well, I thank the chairman. It's always instructive to hear the gentlelady from Colorado. I radically disagree with her. She cited some tragic examples of children born with deformities who were aborted because of that. When I hear cases like that I think of Terry Wiles, who was born from a woman who had taken phalitimide. He was born without arms, legs, with one eye, a little lump of flesh left in an ally in London, found by a bobby, and taken to a home run by an eccentric, wealthy woman called The Guild of the Brave Poor Things.

Little Terry was there until he was aged 10, when he was adopted by a couple in Britain who had lost their own three children, had been taken away from the mother by the court. She was adjudicated an unfit mother, but she was fit enough to adopt Terry, and her husband, and unemployed war veteran. They became quite a family. Terry wrote a book called, ''On the Shoulders of Giants.'' Prince Phillip comes to visit occasionally to get his spirits bolstered, because this little grotesque lump of flesh was so grateful that his mother permitted him to live, at least didn't exterminate him, which is what abortion is, even though he was a little lump of flesh.

I think of Gregory Wattin, whom I watched get an Eagle Scout badge, although he was confined to a wheelchair, profoundly affected by cerebral palsy, could not speak, pointed to letters on an alphabet card. I saw him with a chest full of merit badges I couldn't have earned in the best day of my life, the best year of my life. Hike 10 miles. He crawled on his knees 1 mile, pushed himself 9 miles in a wheelchair.

Do we need people like that? People that have gotten the short end of the stick. When we get depressed, when we think the world is piling up on us, people who have been given so little and have done so much. I think so.

So for all of these cases, there are other cases that inspire us. Beethoven conducting his premier of the Ninth Symphony in the Vienna Opera House and can't hear a note. He said, ''I am wretched. I cannot hear.'' Yet he wrote and conducted this divine music and had to be turned around to face the audience so he could see what he couldn't hear.

So there are cases and there are cases and there are cases, that abortion is the intentional and direct killing of a human life once it has begun. To do that, some people may say is a right. I say for every right there is a responsibility. We have a responsibility to protect human life where and when we can.

So this is an endless discussion. It never ends. It goes on and on and on. Perhaps that's a good thing in a democracy. I thank the gentleman.

Mrs. SCHROEDER. Would the gentleman yield?

Mr. HYDE. Sure. With pleasure.

Mrs. SCHROEDER. I just want to say that I think all of us would attribute great inspiration to the cases that you talk about. But I hope that we also listen with open ears, and I think we'll find that the women did exercise these rights with great responsibility. Their lives were in jeopardy, or maybe other things. I think there's two, you know, we really need to listen to the whole thing, because there is the woman's life that we are also looking at. I know the gentleman from Illinois——

Mr. HYDE. I would say to my dear friend, that a life for a life is certainly an even trade. And that when a mother's life is threatened, that the tradeoff is equal. But when something less than a life is at risk, then I don't think the trade is equal. I stand in awe of the gentlelady of Colorado, who presumes to speak for all women. I certainly wouldn't pretend to speak for——

Mrs. SCHROEDER. Well, if the gentleman will yield further. I don't believe I ever said I spoke for all women. I must say that I do think that when we start talking about how we start measuring rights and responsibilities, those are very serious issues. But one of the great things about this country is that we have tried to keep the Federal Government out of coming down very hard on one side or the other. I think that's what I am——

Mr. HYDE. I couldn't agree more with the gentlelady. When they force taxpayers to pay for abortions, they are involving us coercively in something that we abhor. Again, it seems to me the purpose of Government is to protect the weak from the strong. Otherwise, there's no reason for Government.

While I am a Republican, I am no libertarian. I believe there is a use for the Government, sometimes a unique use. When a pregnant woman, who should be the natural protector of her child in her womb, becomes her child's deadly adversary, the Government ought to intercede to protect the weak, there's nothing weaker than the defenseless pre-born child, from the strong. But you and I can go on indefinitely. Let's do that some time. We'll hire a——

Mrs. SCHROEDER. Well, Mr. Chairman, I'd be more than happy. Again, let's not demonize.

Mr. CANADY. Mr. Frank.

Mr. FRANK. I should note first that everything that gentleman from Illinois has said applies not to partial-birth abortions or however you want to describe them. It applies to all abortions. The gentleman from Illinois has given, with his usual eloquence, his objection to any form of abortion whatsoever.

That is relevant because this is the first step in a sincere effort by some people who believe that all abortion should be outlawed, and if they can not be outlawed because the Supreme Court will not be made to change its position, they should be made as unavailable as possible. As I said, this is the first step.

People should understand that nothing in what the gentleman from Illinois said differentiates this particular type of abortion from any other. He is consistently and conscientiously against all abortions. This is the first step in that effort.

But I have some problems even with it as done. The gentleman from Illinois said when

the pregnant woman who should be protector turns on the child. Well, why then would you pass a law if you believe that the woman who volunteers to have such an abortion, if you believe that the woman who seeks out a doctor, and by the way, as far as speaking for all women, I believe myself that on this issue, the gentlewoman from Colorado speaks for most women, but the key point is, that none of us are proposing to——

Mr. CANADY. Let me tell the members of the audience that we appreciate your being here, but no matter which side you are on, we would ask that you not express your approval or disapproval of the statements by the members or of the statements of any of the witnesses. Thank you.

Mr. FRANK. I think making faces is OK. The key point is this. The gentlewoman from Colorado and I are not proposing a law for all women. We are not presuming to tell all women what to do. We recognize that this choice, the choice that was described of some of the brave people who were here, is a very difficult one. We don't think the Federal Government ought to make it for them. We are not saying all women must do one thing or must do another. We are saying this is the most intimate and difficult choice, and people should make it within their own families and within their own views.

But what does this bill say? If you commit an act that people here are describing as a terrible act, if you the woman do that, not only are you subject to no penalty whatsoever, but you can sue the doctor who you asked to perform it. That is in this bill.

What about your notions of personal responsibility? We are told on the conservative side that people should be held to a standard of personal responsibility. We are presented with a bill which says you can seek out a doctor, ask that doctor to perform this procedure which you think is a terrible procedure, voluntarily participate in the procedure. Indeed, you are obviously indispensable at procedure. And then turn around and sue the doctor and get money from the doctor who did what you asked him to do, and which you participated in.

That goes so contrary to your notions of personal responsibility that it is puzzling. It can only be a recognition that for all the rhetoric, this is obviously not something that you want to really treat as criminal. Why else would you take the woman whose participation is the essential element in all this? The woman who makes the decision, the woman who seeks out the doctor, the woman who goes to the doctor and submits to the procedure. She comes out in this as someone who has a right to sue the doctor who simply did what she wanted.

That shows to me a fundamental ambivalence in the minds of the people who say this. Because if it were everything that you said it was, you would be at least punishing, you would be punishing the woman in a logical sense if she has participated in a murder. You certainly would not be empowering her to sue. Now would you be empowering others to sue, and for psychological damages.

That is just the other great inconsistency we have here. We have been told on the conservative side that we should return things to the States. This is a matter the States have full jurisdiction over right now. This is not anything preempted by the Federal Government. I am not talking constitutionally now. I am talking about the matter of public policy.

How can people who talk about how they want to return things to the States now come and say we're going to have this Federal statute regulating abortion. The States are fully free to do it. If the overwhelming majority in a State think this is a bad thing and they have a way to do it constitutionally, then they can do it. In some States, provisions like this do exist.

The argument for doing it on the Federal level is, that there are some States that have chosen not to ban it. My conservative colleagues believe that the States have no business exercising their judgment in this regard. I understand that. I have never claimed to be Thomas Jefferson without the wig. But don't come to me on the one hand and say, ''We're for State's rights. We are going to undo this Federal monolith.'' And then for the first time in my memory, inject intimate decision.

So I think that this is flawed in several regards. I would just reaffirm what the gentlewoman from Colorado has said. We are not trying to make any decision for anybody. We are respecting the individual integrity of this very difficult decision, and therefore, I hope that this legislation does not go anywhere.

Mr. CONYERS. Mr. Chairman.

Mr. CANADY. Yes.

Mr. CONYERS. I would like to make a comment or two.

Mr. CANADY. Well, you will be recognized in turn. Mr. Inglis has been here. I will recognize him now. We'll come back to you.

Mr. CONYERS. Thank you.

Mr. INGLIS. Thank you, Mr. Chairman. I start any comments I make by saying this. That we're now on the probably one of the most volatile issues that we can possibly face. I always try to start that discussion by indicating compassion for the victims of abortion that are walking around today. The fact is, there are a lot of victims of abortion that are alive. They are the women that were deceived, and now realize that they wish they had not had an abortion.

If we look in our families, somewhere in the family somebody has had an abortion, a sister, a mother, a cousin, an aunt. Somebody in almost every family has had an abortion. That is why this is such a huge tragedy.

So I start anything I say by way of compassion for the victims of abortion who are walking around today, that are still dealing with the guilt of what they now realize they did. With that opening, I would also say that I am really quite disappointed. I thought we might have found some common ground here. I thought that there wouldn't be anybody who would rise in defense of this type of abortion. I guess I'm too Pollyanna. I thought the gentlelady from Colorado, for example, would say well surely this is a case where we can agree, that this is a horrible procedure and one that we should not make legal.

But I guess I am finding out just how radical the other side is on this issue. It's a really interesting thing to see the radical nature of someone who would defend a procedure in which a live child is halfway delivered and then killed on the way out. I just can not imagine anything more radical than that position.

So I thought really we would find some common ground here and agree that yet this is something that people of good faith can agree on. That surely this is a type of abortion that we can't abide in a civilized society, where a child if it were just literally inches in a different realm, inches away from life, inches away from the protection of the Constitution, is murdered, and a civilized society defends it as some sort of a right.

I think what it rises to is it indicates that this is really some sort of sacrament in a very perverted religious system almost. Some sort of a statement that we've got to have abortion and you can't stop us from having it. Some sort of an assertion of—I'm really not sure what it is, but a rather strange assertion that literally inches from life and protection of the Constitution, we murder a child. I am really surprised that we wouldn't have found some common ground, particularly, I look forward to the panelists making it clear that the real world here is that this is not going on that often in the cases that the gentlelady from Colorado cited about people in hard decisions. It is rather going on in people's minds who choose conscientiously to go to a place that is going to, in the gentleman's word from Illinois, exterminate a living human being. They are not involved in a normal healthy delivery. They are going to a place that specializes in the extermination of human life.

So in the real world, contrary to what the gentlelady has indicated, the real world, this is happening in abortion chambers. This is happening where people pay another person to exterminate a human being that is literally inches from life and protection of the Constitution.

Mrs. SCHROEDER. Would the gentleman yield?

Mr. INGLIS. I'd be happy to. Maybe you could explain to me why this isn't radical.

Mrs. SCHROEDER. This is happening by some of our best educated medical minds making a decision that this is the safest procedure for the woman's health. Now I think it's——

Mr. INGLIS. Let me reclaim my time. Let me reclaim my time because—let me reclaim my time because the gentlelady persists in not living in the real world. The gentlelady is not living in the real world. We are talking places where one consciously decides to go to pay another person——

Mrs. SCHROEDER. A doctor's office.

Mr. INGLIS. To exterminate.

Mrs. SCHROEDER. A doctor.

Mr. INGLIS. Another human being.

Mr. FRANK. Would the gentleman yield?

Mr. INGLIS. I will not because I'm not finding any common ground. I'm not finding any rationality in what the woman has to say.

Mr. FRANK. Will the gentleman yield to me?

Mrs. SCHROEDER. You are trying to——

Mr. INGLIS. Reclaiming my time, I want to make clear that this is a very—I mean, I listened as the gentlelady talked about how hard decisions and medical professionals—you are not in the real world.

The real world is that people are going to a place, consciously deciding to engage the services of a specialist who is good at pulling a baby within inches of life and then sucking the brains out of the child. That is not a medical specialist who is involved in a hard decision.

Mr. CONYERS. Would the gentleman yield?

Mr. INGLIS. That is a radical procedure.

Mr. CANADY. The gentleman's time is expired. Mr. Conyers.

Mr. FRANK. Would the gentleman yield to me for 15 seconds at the outset?

Mr. CONYERS. Thank you, Mr. Chairman, I would yield to Mr. Frank.

Mr. FRANK. I would just then say to my friend from South Carolina, he talks about someone who makes this conscious choice to go and do this, and then apparently he votes for a bill which would allow her to then to sue and get damages for it.

So if this is such a terrible decision this woman is making, why are you then going to vote for a bill if you are going to vote for this, which lets her then sue the person? I am just baffled by that evaluation of human life. The person who submits to what you consider murder, who is indispensable to the murder, then makes a profit off it.

Mr. CONYERS. Ladies and gentleman, it is obvious that this is one of these subjects that are very personally and tenaciously held by people that oppose abortion. It is the law that allows abortion. It is the law that we are examining.

But what we are doing here today is continuing a strategy, an obvious one, of limiting abortion rights since we can't—we don't have the support or the legal justification for changing the law, is that we're going to begin in this new conservative Congress to cut back in every place we can. What more convenient strategy than to start off here in one of the most painful, difficult, unhappy decisions in the abortion arena than this politically claimed decision or title that we have on this subject matter here today.

I submit to you that there is no medical term called partial-birth abortion. I am getting drawn further and further into this dispute because I sense the difference between those who fight to curb abortion and their difficulty in helping to deal with the children who are born, who come out of the birth circumstance, and what do we do after they get a life? What do we do in terms of training them and educating them and trying to build up their families? Well, we cut back. That's what we do.

We say well, this is an incredible right, that we know when life occurs in the fetus. But after it does, let's abolish the Department of Education. Let's cut back on Aid to Families With Dependent Children. Let's reduce the budgets for the children of the poor. All these wonderful statements that are being made about this period from the beginning of life to the existence as a fetus. Yet we are faced with a society with more and more dysfunctional families, more children that are leading lives of despair, more joblessness. But those are different subjects, these are people alive. But when we get to this, we're going to impose our views on you.

So I see this as a strategy. I am prepared to withstand it. I always like to hear people talking about Government funded abortions. Why should taxpayers pay for abortions. Why should taxpayers that don't like war pay for wars? Why should taxpayers that don't like anything else have to pay for it? Because we have determined that is the appropriate way that we have to run a system to raise money for the government.

So I don't see any real value in Beethoven not being raised as a case on one side or the other on this issue. I think the fact that he was deaf is totally irrelevant to these proceedings.

But it is a sad moment when we are in the biggest frenzy of cutting the funds necessary for children and families and health to flourish in this country, that we are now here meeting in a committee of this importance over a subject which I think is probably very low on the list, Partial-birth Abortion Ban Act of 1995. I deplore it.

Mr. CANADY. The gentleman's time is expired. Mr. Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman. I very much appreciate you holding these hearings. I appreciate your courage in addressing this issue, because I think it's an issue that every American should be aware of and consider and think about. Quite frankly, I am appalled that there would be objection to not being willing to ban a procedure like this, that if the doctor would bring that baby a few inches further into full delivery, would clearly have the full protection of the law.

Mr. Frank and Ms. Schroeder have spoken eloquently about a woman's right to choose. You know, if there were only one right involved, if there were only one life involved, I think there would be nobody in this room who would disagree with that. But therein lies the responsibility of Government, and responsibility of every one of us to have Government intercede when there is more than one right involved. We do have to act responsibly in protecting those who can not protect themselves.

One of the individuals on the other side mentioned bringing this up about what could be the most unhappy decision that not only a woman, but hopefully a man too, might be involved in making a decision about this. Well here we have the opportunity to take away what is clearly not only an unhappy decision, but a wrong decision, to be allowed to do something like this. I think that we are clearly on the right track in addressing this issue today. Thank you, Mr. Chairman.

Mr. CANADY. Thank you, Mr. Goodlatte. Mr. Hoke.

Mr. HOKE. Thank you, Mr. Chairman. I will be brief because I want to hear the testimony of the witnesses, as do you. I want to thank you as well and commend you for bringing this hearing today. I think it takes a tremendous amount of courage and is the sort of thing that this committee should be doing. I am very grateful that you decided to do it.

I also want to make a quick observation regarding the State that I come from, Ohio, where we recently outlawed or made this specific procedure illegal. It was the right thing to do there. It will be the right thing to do here as well.

I am particularly looking forward to the testimony of Dr. White, who is one of this Nation's most preeminent neurosurgeons. He is from Cleveland. I mentioned him particularly, because I am interested in not only what he has to say about the ability of a fetus to experience pain, but also because I make the observation that he trained my own father who is also a neurosurgeon, I won't say how many years ago, to protect all of those that are involved.

Finally, the other observation I would like to make is that I am particularly appalled at this procedure for the reasons that have been described already, but also because this is a procedure that can only take place, that only takes place after the 20th week, and usually takes place much later than that. I have been consistently opposed to any abortions that would take place in the second or third trimesters, except under the most extraordinary circumstances to save the life of the mother. So I look forward to this hearing, Mr. Chairman. Thank you.

Mr. CANADY. Thank you, Mr. Hoke. I'd like to now ask that the other witnesses on our first panel please come forward and take their seats. I'll introduce all the members of our panel, and then we'll recognize them in turn.

First we will hear from Dr. Pamela Smith, who comes to us today from the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago, where she is the Director of Medical Education. In addition to serving as president-elect of the American Association of Pro-Life Obstetricians and Gynecologists, Dr. Smith has written several articles for medical journals on the subject of pregnancy and issues relating to complications during pregnancy.

Second, Dr. J. Courtland Robinson will testify. Dr. Robinson is from the school of hygiene and public health at Johns Hopkins University.

Third, we will hear from Dr. Robert J. White. Dr. White is Professor of Neurosurgery at the Case Western Reserve University School of Medicine, and is director of the Division of Neurosurgery and the Brain Research Laboratory at the Metro Health Medical Center. He is internationally known for his expertise in clinical brain surgery. He has been the recipient of several honorary doctorate degrees and visiting professorships.

Fourth, we will hear from Ms. Tammy Watts, with us today from California. Ms. Watts has had personal experience with abortion.

Finally, Mary Ellen Morton, a nurse specializing in neonatal care will testify. Mrs. Morton has developed a program on neonatal and pediatric pain control that she presents to health care professionals. For the past 5 years she has practiced as a flight nurse with Med Flight, an air medical program in Columbus, OH, where she helps to stabilize and transport premature or ill infants to Columbus Children's Hospital.

I would like to ask each of our witnesses to please summarize your testimony in no more than 10 minutes. If you can summarize it in less than 10 minutes, that would also be appreciated. Without objection, the entirety of your prepared statements will be placed in the record.

Our first witness, Dr. Smith.

STATEMENT OF PAMELA SMITH, DIRECTOR OF MEDICAL EDUCATION, MOUNT SINAI HOSPITAL; ACCOMPANIED BY J. COURTLAND ROBINSON, JOHNS HOPKINS UNIVERSITY, SCHOOL OF HYGIENE AND PUBLIC HEALTH, ROBERT J. WHITE, PROFESSOR OF SURGERY, CASE WESTERN RESERVE UNIVERSITY, TAMMY WATTS, AND MARY ELLEN MORTON, NEONATAL SPECIALIST

Statement of Pamela Smith

Dr. SMITH. Thank you, Mr. Chairman, and honorable members of the subcommittee. Abortion provides claim that participation in intrauterine dismemberment or a D&E, dilation and evacuation techniques, often cause severe psychological ill effects in counseling staff and surgical providers. Partial-birth abortion techniques, which are distinctly different surgical procedures, compound this problem even further.

The partial-birth abortion method is strikingly similar to the technique of internal podalic version, or fetal breech extraction. Breech extraction is a procedure that is utilized by many obstetricians with the intent of delivering a live infant in the management of twin pregnancies, or single infant pregnancies complicated by abnormal positions of the pre-born infant.

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

The development and growing use of the partial-birth abortion method is particularly alarming when one considers the recent actions of the Accreditation Council for Graduate Medical Education. This council, whose members include a nonvoting Federal official, has tremendous power. It is responsible for accrediting medical education programs. Nonaccredited programs are not eligible for Federal funding, and students who graduate from nonaccredited programs may not be able to obtain State licenses, hospital privileges, or board certification.

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

What I would like to do at this time is to demonstrate for you, using this model, which is a replica of how small the average baby would be that is subjected to this procedure. This is the length and a model of a 19 to 20 week old infant. I would like to just go through this very quickly, the procedure, to

show you the similarities between this procedure and the procedures that are used by obstetricians not to destroy the baby's life, but to save the baby's life.

Breech presentation is when the buttocks or the feet are coming first. This area here is the bottom of the womb of the cervix. Normally, when you are trying to deliver a premature baby that may be breech, what you would like to do is to have the bag of waters intact around the baby, because that serves two things. It can buffer the baby as you are pulling the baby out. It also serves to keep the cervix open, so that the head does not get trapped.

When you do partial-birth abortion, however, because you want the head to be trapped, you don't want the bag of waters there, particularly when the baby is premature. So the bag of waters is ruptured.

You then grab the feet. If the infant is very small, you would use the forceps that are there. If the infant is larger, you would probably put your hand in, the same way we would do if we did an internal podalic version, grab the feet and start to pull the baby down the cervix and into the vagina.

Normally when I do this with the intention of delivering the baby alive, I like to have the back toward the mother's bladder, which would be here, because it will be easier for me once the head gets to the level of a cervix to flex the head and deliver the baby safely.

When you do partial-birth abortions, you want the head here in this position, so that you can have access to the neck. Again, when you are delivering a breech baby, cervical entrapment is a complication. It's a complication that we basically handle by either cutting the cervix with a certain kind of incision to release the head, or by doing a cesarian section sometimes. Especially if it's a large baby and that doesn't work.

With the abortion technique that we are describing today, however, you want the head to get trapped, because if the baby gets passed there and slips out, then his status changes from an abortus to a living person. So what you do to make sure that the baby does not move the few inches that is required is you hold your hands here. Basically, when you want to deliver the baby live, you use your hands in this position to buttress the baby. Again, you usually have an assistant up here pressing and flexing the mother's abdomen to deliver the head.

But when you are doing an abortion technique, you are steadying the baby so that the baby won't slip out. Then you take the Metzenbaum scissors, which are these scissors here. Put them in the back of the baby's head. Push them in to try to sever the cord, the spinal cord, open the scissors up to create a hole big enough to put a catheter in. You then put the catheter in and suck out the baby's brains. That way, the baby is dead. When the baby comes out that ends the abortion technique.

Of course when you are doing this to deliver a live baby, the differences are primarily at the level of the cervix. If by change the cervix is floppy or loose and the head slips through, the surgeon will encounter the dreadful complication of delivering a live baby. The surgeon must therefore act quickly to ensure that the baby does not manage to move the inches that are legally required to transform its status from one of an abortus to that of a living human child.

Although the defenders of this technique proclaim that it is safe, they have not substantiated these claims. Only two individuals have provided any kind of data to evaluate. Included in this scanty amount of data, there is a report of a hemorrhagic complication that required 100 units of blood to stabilize the patient, along with an infectious cardiac complication that required 6 weeks of antibiotic therapy.

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

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

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

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

The National Abortion Federation letter also claims that the drawings of the partial-birth procedure distributed by Congressman Canady and others are highly imaginative and misleading. But Dr. Haskell himself validated the accuracy of these drawings, as reported in the American Medical News. Again I quote. ''Dr. Haskell said the drawings were accurate from a technical point of view, but he took issue with the implication that the fetuses were aware and resisting.''

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

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

The National Abortion Federation letter also suggests that these partial-birth abortions are commonly done in a variety of unusual circumstances, such as when the life of the mother is at grave risk. I have practiced obstetrics and gynecology for 15 years and I work with indigent women. I have never encountered a case in which it would be necessary to deliberately kill the fetus in this manner in order to save the life of the mother.

There are cases in which some acute emergency occurs during the second half of pregnancy that makes it necessary to get the baby out fast, even if the baby is too premature to survive. This would include for example, HELLP syndrome, a severe form of preeclampsia that can develop quite suddenly. But no doctor would employ the partial-birth method of abortion, which as Dr. Haskell carefully describes, takes 3 days.

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

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

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

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

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

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

Mr. CANADY. Thank you, Dr. Smith. Dr. Robinson. I will point out before Dr. Robinson's testimony that the two doctors, McMahon and Haskell that Dr. Smith referred to in her testimony, were the doctors we had invited and who had agreed to appear for this hearing, but who canceled at the last minute. We wanted to give them the opportunity to be here to testify and explain the procedure. But they were——

Mrs. SCHROEDER. If the Chairman will yield. I think one of the reasons that we have to be very honest about this, is doctors have been harassed and sometimes don't feel very secure in this environment that we live in. I think it is only fair to put that on the record.

Mr. CANADY. Thank you. Dr. Robinson.

Statement of J. Courtland Robinson

Dr. ROBINSON. I would like to thank the Chairman and the members of the subcommittee for inviting me to be here today. My name is J. Courtland Robinson, associate professor on the full-time faculty in the Department of Gynecology and Obstetrics at the Johns Hopkins University School of Medicine, and a joint appointment with the

Johns Hopkins School of Hygiene and Public Health.

I have been involved in all aspects of reproductive health care for women for over 40 years, including complete obstetrical care, abortion, special oncologic and gynecological care, with an extra interest in family and sterilization. I am here on behalf of the National Abortion Federation, the national professional association of abortion providers.

My experience with abortion began in the 1950's, when as a house officer at the Columbia Presbyterian Medical Center in New York City, I watched women die from abortions that were poorly done. Over a 5-year period when in training at the medical center, many women died before our eyes. Many survived only with aggressive pelvic surgery. On occasion, we did save the very sick.

These are not events learned from books, but reality that I painfully experienced and witnessed. This experience with poorly performed abortions was further extended during my 11 years as a medical missionary with the Presbyterian Church while I worked and taught in Korea.

In 1971 at Baltimore City Hospital, we were already doing legal first and second trimester abortions before the Roe versus Wade decision came down. We did about 1,000 a year. Thirty percent were second trimester. At that time, the method of management of second-trimester abortions was saline induction. When the saline did not work, it was often my task to carry out an evacuation in order to meet the patient's needs in a safe and timely manner. I have performed abortions in different settings, and have performed second-trimester abortions using different techniques, depending upon the clinical situation.

When a woman is faced with a need to terminate a pregnancy, the physician can manage the surgical procedure using a number of techniques, hypotonic glucose, saline, urea, prostoglandins, potossin, suction, D&C, D&E. We have used different techniques over the years as our skill and understanding of basic physiology has become clearer. As in all of medicine we develop techniques which are more appropriate, study the long-term impacts, and determine which is safer.

The physician needs to be able to decide, in consultation with the patient, and based on her specific physical and emotional needs, what is the appropriate methodology. The practice of medicine by committee is neither good for patients or for medicine in general.

This legislation appears to be about something you are referring to as partial-birth abortion. I now am beginning to learn a little about what you think it means, but I did not know it until a few days ago. Never in my career have I heard a physician who provides abortions refer to any techniques as a partial-birth abortion. That, I suspect, is because the name did not exist until someone who wanted to ban abortions made it up. Medically, we do not do partial-birth abortion. There is no such thing.

When an intact fetus is removed in the process of abortion, as is sometimes done, fetal demise is induced either by an artificial medical means or through the combination of steps taken as the procedure is begun. Thus, in no case is pain induced to the fetus. If neurologic development at the stage of the abortion being performed even made this possible, which in the vast majority of cases it does not, analgesia and anesthesia given to the women neutralizes any pain that may be perceived by the fetus.

So when I read in your legislation that you seek to, ''Ban an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery,'' my reaction is that you are banning something that does not happen. To say partially vaginally delivers is vague, not medically oriented, just not correct. In any normal second-trimester abortion procedure done by any method, you may have a point at which a part, an inch of cord, for example, of the fetus passes out of the cervical os, before fetal demise has occurred. This does not mean you are performing a partial birth.

I have seen the sketches that have been passed around. I have read your description of a particular physician's method of performing this procedure, a method by the way which is not at all common. It represents a particular surgical decision by that physician, one which works in his practice. The sketches in any case are not particularly correct. They may in a very technical sense represent an approximation of what occurs in some cases, but they do not represent medical or scientific accuracy. Rather, they are designed to be upsetting and inflammatory for the lay person. They do not advance medical practice.

The words of the legislation are equally inflammatory. No one doing this procedure is partially delivering a fetus. So then, I have to wonder what you are trying to ban with this legislation. It sounds to me as if you are trying to leave any late abortion open to question, to create a right of action, and in fact, a criminal violation. To force doctors to affirmatively prove that they have not somehow violated such a law.

I know that a number of physicians who have performed abortions for years who are experts in the field, look at this legislation and do not understand what you mean or what you are trying to accomplish. It seems as if this vagueness is intentional. I, as a physician, can not countenance a vague law that may or may not cut off an appropriate surgical option for my patient.

Women present to us for later abortions for a number of reasons, including congenital anomalies, of which I have a few pictures if necessary. I can tell you from my long experience that women do not appear and ask for any abortion, particularly those that I saw die in the 1950's, particularly a later abortion, cavalierly or lightly. They want an answer. It is a serious and difficult decision and has been for centuries for women to make. It is not my place to judge my patient's reason for ending a pregnancy, or to punish her because circumstances prevented her from obtaining an abortion earlier.

It is my place to treat my patient, a woman with a pregnancy she feels certain she cannot continue, to the best of my ability. That includes selecting the most appropriate surgical technique using my skill and knowledge developed from experience, to determine what method is safest for this woman at all times and in all circumstances.

Sometimes, as any doctor will tell you, you begin a surgical procedure expecting that it will go one way, only to discover that a unique demand, the case requires you to do something different. Telling a physician that it's illegal for him or her to adapt a certain surgical method for the safety of the patient is absolutely criminal and flies in the face of the standards for the quality of medical care.

For many physicians, this law would amount to a ban on D&E entirely, because they would not undertake a surgery if they were legally prohibited from completing it in the best way they saw fit at the time the procedure was being done. Because the law itself is so vague and bizarre, leaving them to wonder whether they are open to prosecution or not.

This means that by banning this very rare technique, you end up banning D&E, essentially recognized as the safest method of performing secondary-trimester abortions. That means that women will probably die. I know. I have seen it happen.

With all due respect, the Congress of the United States is not qualified to stand over my shoulder in the operating room and tell me how to treat my patient. If we are to allow women of this country the right to decide when and whether to bear children, we, as their doctors, must be allowed to be doctors and treat them to the best of our abilities and according to their sense of personal control. Thank you.

Mr. CANADY. Thank you Doctor. Dr. White.

Statement of Robert J. White

Dr. WHITE. Mr. Chairman, members of this distinguished panel. I am delighted to have the opportunity to testify before you. I appreciate Mr. Hoke's remarks, whether true or otherwise.

I come before you as not an obstetrician or an gynecologist. I come before you as a brain surgeon and as a neuro scientist. When I was undergoing my training at Harvard Medical School and was working at Children's Hospital in Boston, when I saw the efforts that the pediatricians and the neonatalogists were putting forward to save children, infants, it had a mark on my consciousness and on my practice. I have been trained through all of my years, including many years at the Mayo Clinic, to save lives. Not to take lives.

I go back to a time in American medicine when abortion was abhorred by the medical profession. The things that we have to consider here is we are dealing with a human being, a fetus. By the 20th week of gestation and beyond, has in place the neurocircuitry to appreciate pain. Now I'm not going to bore this distinguished panel by going through the neuroanatomy and the neurochemistry and the studies that are on board that reflect that these fetuses can perceive and appreciate pain. As a matter of fact, there are studies that demonstrate at 8 weeks through 13 weeks, there's enough neurocircuitry present so that pain noxious stimuli could be perceived.

It is well to remember at this particular time, beyond the 20th week of gestation, that not only are the fiber tracks in place from the surface of the skin in through the spinal cord and to special areas of the brain where pain can be appreciated. But the system which is equally important in the modulation and suppression of pain is not yet as mature as the one conducting pain. Some authorities feel that fetuses at this age can perceive pain to a greater degree than the adult. So I would like to come before you emphasizing that within the framework of the fetus, his nervous system, pain can be perceived and appreciated.

Now, I am not an obstetrician. But as I view and understand this particular procedure, the compression, the pulling, the distortion must be a painful experience for the fetus as it is advanced into the birth canal. But for me, what is most disturbing is the procedure itself. You are talking about a brain operation on a fetus who could have reached an age where I would be called upon as someone trained and experienced in pediatric neurosurgery to operate.

We operate on preemies within this range, conducting brain surgery to save their lives. We would never consider any procedure giving us access to that preemie's central nervous system without sophisticated anesthesia.

As I read as you do that the procedure to terminate the fetus' life requires the opening of the scalp, the entering of the spinal canal. Now interestingly, I am really wondering if these people who conduct this procedure really know what they are doing in a technical way. We operate on infants beyond the 24th week of gestation using magnification.

Some of the most sophisticated instrumentation allows us to enter these areas.

I can conceive that these people eventually sucking out the brain have not even divided the upper cervical cord, which incidentally, and we should think about that, is the area where Mr. Reeves has been injured. We're bringing to bear the greatest technology, and he's being treated by some of the finest neurosurgeons in this country, to save his life.

The obstetrician who conducts this type of partial abortion, is attempting to undertake brain surgery. There is no description in any of the doctors' articles or responses who do these procedures, to give me any indication whether they are operating on the upper cervical spine or cord, or on the brain stem.

Now it is true, once you sever that area, then of course the capability of respiration and so forth has been separated, as has happened to Mr. Reeves. But I can believe that these are not trained neurosurgeons. In the process of terminating this child by removing its brain, could be even conducted in a poor infant whose pain situation, capabilities, the tracks, the neurocircuitry, could be in place because they are not trained to carry out even this dastardly procedure.

Members of the panel, we are talking about a procedure, and I have no idea how often it is conducted, by individuals who are not trained neurosurgeons. We are trained to save lives.

Since I became involved in this, as I sit at the operating table, spending hours utilizing intensive medication, special instrumentation, to remove blood from the brain, to direct specially developed hydraulic tubing into the fluid passages of the brain, in infants of this age or perhaps a little older, to save their lives it frankly disgusts me to think that other medical professionals are undertaking these procedures that we have spent years of study and training to undertake to save lives, are being conducted to terminate lives.

I would also remind you that the animal rights groups in this country have displayed great concern over animal rights, particularly as it relates to pain and to medical experimentation. It seems to me that we have reached a point where far greater care would have to be exercised by the veterinarian or the medical scientist experimenting on animals in terms of pain reduction or elimination, than is a part of this particular procedure. It is almost as if, from an ethical standpoint, it would be more disturbing, even morally incorrect and inappropriate, to cause pain in a rat than a human fetus.

I doubt very much, ladies and gentlemen, if this type of procedure, and as I said before I am not an expert as to how often it would be undertaken, were conducted within the framework of the lower animal, I am sure that the animal rights groups would be able to bring sufficient pressure on Congress and within the media to have it totally eliminated.

In conclusion, the fetus is at an age of gestation where he or she can perceive pain and possibly more exquisitely, than he or she would if they were allowed to go on to be born. The procedure itself is a brain operation. But the details of it are so limited and so ghastly, that it seems to me that it is impossible to believe that medical colleagues at another specialty would carry it out. Thank you, ladies and gentlemen.

Mr. CANADY. Thank you, Dr. Ms. Watts.

Statement of Tammy Watts

Ms. WATTS. Good morning. My name is Tammy Watts. I would like to thank the subcommittee for inviting me here today. My story is one of heartbreak, one of tragedy, but also one of compassion.

When I found out I was pregnant on October 10, 1994, it was a great day, because on the same day, my nephew, Tanner James Gilbert was born. We were doubly blessed. My husband and I ran through the whole variety of emotions, scared, happy, excited, the whole thing. We immediately started making our plans. We talked about names, what kind of baby's room we wanted, would it be a boy or girl. We told everyone we knew, and I was only 3 weeks pregnant at the time.

It was not an easy pregnancy. Almost as soon as my pregnancy was confirmed, I started getting really sick. I had severe morning sickness, and so I took some time off of work to get through that stage. As the pregnancy progressed, I had some spotting, which is common, but my doctor said to take disability leave from work and take things 1 month at a time.

During that leave, I had a chance to spend a lot of time with new newborn nephew, Tanner, and his mom, Melanie, my sister-in-law. I watched him grow day by day, sharing all the news with my husband. We made our plans, excited by watching Tanner grow, thinking, ''This is what our baby is going to be like.''

Then I had more trouble in January. My husband and I had gone out to dinner, came back and were watching TV when I started having contractions. They lasted for about a half an hour and then they stopped. But then the doctor told me that I should stay out of work for the rest of my pregnancy. I was very disappointed that I couldn't share my pregnancy with the people at work, let me watch me grow. But our excitement just kept growing, and we made our normal plans, everything that prospective parents do.

I had had a couple of earlier unltrasounds which turned out fine. I took the alphafetoprotein test, which is supposed to show fetal anomalies, anything like what we later found out we had. Mine came back clean.

In March, I went in for a routine seven month untrasound. They were saying this looks good, this looks good. Then suddenly, they got really quiet. The doctor said, ''This is something I did not expect to see.'' My heart dropped. He said he was not sure what it was, and after about an hour of solid ultrasound, he and another doctor decided to send me to a perinatologist. That was also when they told us we were going to have a girl. They said, ''Don't worry. It's probably nothing. It can even be the machine.''

So we went home. We were a little bit frightened so we called some family members. My husband's parents were away and wanted to come home, but we told them to wait. The next day the perinatologist did ultrasound for about 2 hours, and said he thought the ultrasound showed a condition in which the intestines grow on the outside of the body, something that is easily corrected with surgery after birth. But just to make sure, he made an appointment for me in San Francisco with a specialist.

After another intense ultrasound with the specialist, the doctors met with us along with a genetic counselor. They absolutely did not beat around the bush. They told me, ''Your daughter has no eyes. Six fingers and six toes, and enlarged kidneys which were already failing. The mass on the outside of her stomach involves her bowel and bladder, and her heart and other major organs are also affected.'' This is part of a syndrome called trisomy-13, where on the 13th gene there's an extra chromosome. They told me, ''Almost everything in life, if you've got more of it, it's great, except for this. This is one of the most devastating syndromes, and your child will not live.''

My mother-in-law collapsed to her knees. What do you do? What do you say? I remember just looking out the window. I couldn't look at anybody. So my mother-in-law asked, ''Do we go on? Does she have to go on?'' The doctor said, ''no,'' that there was a place in Los Angeles that could help if we could not cope with carrying the pregnancy to term. The genetic counselor explained exactly how the procedure would be done if we chose to end the pregnancy, and we made an appointed for the next day.

I had a choice. I could have carried this pregnancy to term, knowing that everything was wrong. I could have gone on for 2 more months doing everything that an expectant mother does, but knowing my baby was going to die, and would probably suffer a great deal before dying. My husband and I would have to endure that knowledge and watch that suffering. We could never have survived that, and so we made the choice together, my husband, and I, to terminate this pregnancy.

We came home, packed, and called the rest of our families. At this point, there wasn't a person in the world who didn't know how excited we were about this baby. My sister-in-law and best friend divided up our phone book and called everyone. I didn't want to have to tell anyone. I just wanted it to be over with.

On Thursday morning, we started the procedure. It was over about 6 p.m. Friday night. The doctor, nurses, and counselors were absolutely wonderful. While I was going through the most horrible experience of my life, they had more compassion than I have ever felt from anybody. We had wanted this baby so much. We named her Mackenzie. Just because we had to end the pregnancy didn't mean we didn't want to say goodbye. Thanks to the type of procedure that Dr. McMahon uses in terminating these pregnancies, we got to hold her and be with her and love her and have pictures for a couple of hours, which was wonderful and heartbreaking all at once. They had her wrapped in a blanket. We spent some time with her, said our goodbyes, and went back to the hotel.

Before we went home, I had a checkup with Dr. McMahon and everything was fine. He said, ''I'm going to tell you two things. First, I never want to see you again. I mean that in a good way. Second, my job isn't done with you yet until I get the news that you have had a healthy baby.'' He gave me hope that this tragedy was not the end, that we could have children just as we had planned.

I remember getting on the plane, and as soon as it took off, we began crying because we were leaving our child behind. The really hard part started when I got home. I had to go through my milk coming in and everything you go through if you have a child.

I don't know how to explain the heartache. There are no words. There's nothing I can tell you, express or show you, that would allow you to feel what I feel. If you think about the worst thing that has happened to you in your life and multiply it by a million, maybe then you might be close. You do what you can. I couldn't deal with anybody, couldn't see anybody, especially my nephews. It was too heartbreaking. People came to see me, and I don't remember them being there.

Eventually, I came around to being able to see and talk to people. I am a whole new person, a whole different person. Things that used to be important now seem silly. My family and my friends are everything to me. My belief in God has strengthened. I never blamed God for this. I am a good Christian woman. However, I did question.

Through a lot of prayer and talk with my pastor, I have come to realize that everything happens for a reason, and Mackenzie's life had meaning. I know it would come to

pass some day that I would find out why it happened, and I think it is for this reason. I am supposed to be here to talk to you and say, you can't take this away from women and families. You can't. It is so important that we be able to make these decisions, because we are the only ones who can.

We made another painful decision shortly after the procedure. Dr. McMahon said, ''This will be very difficult, but I have to ask you. Given the anomalies Mackenzie had so vast and different, there is a program at Cedars-Sinai which is trying to find out the cause for why this happens. They would like to accept her into this program.'' I said, ''I know what that means, autopsies and the whole realm of testing.'' But we decided how can we not do this? If I can keep one family from going through what we went through, it would make her life have more meaning. So they are doing the testing now. Because Dr. McMahon does the procedure the way he does, it made the testing possible.

I can tell you one thing after our experience, I know more than ever that there is no way to judge what someone else is going through. Until you have walked a mile in my shoes, don't pretend to know what this was like for me. I don't pretend to know what someone else is going through. Everybody has got a reason for doing what they have to do. Nobody should be forced into having to make the wrong decision. That's what you'll be doing if you pass this legislation. Let doctors be free to treat their patients in the way they think is best, like my doctor did for me.

I understand this legislation would make my doctor a criminal. My doctor is the furthest thing from a criminal in the world. Many times I have called him my angel. They say there are angels working around the world protecting us, and I know he is one. If I was not led to Mr. McMahon, I don't know how I would have lived through this. I can't imagine where we would be without him. He saved my family, my mental stability, and my life. I could not have made it through this without him and I know there are a great many women out there who feel the same.

I have still got my baby's room and her memory cards from her memorial service. Her foot and hand prints. Those are good things and good memories, but she's gone. The best thing I can do for her is continue this fight. I know she would want me to. So for her, for Mackenzie, I respectfully ask you reject this legislation. Thank you.

Mr. CANADY. Thank you. Mrs. Morton.

Statement of Mary Ellen Morton

Ms. MORTON. Mr. Chairman, members of the committee, thank you for the opportunity to testify. With your permission, could I use slides to illustrate my testimony?

Mr. CANADY. Certainly.

Ms. MORTON. Could we lower the lights? Thank you. My name is Mary Ellen Morton. I am here today to challenge and to dispel the notion that unborn babies would not feel agonizing pain before they are reduced to human rubble during the partial-birth abortion procedure.

Now I have practiced as a nurse for 12 years. Nine of those have been in the neonatal intensive care units. Taking care of babies like this little neonate.

[Slide.]

Now a neonate is defined as a baby that is born, whether premature or full term, until the time they about 4 weeks of age. As you see, this little baby is about 1½ pounds. He falls right into the time line of when this partial-birth abortion procedure is routinely done. He is not even on life support systems. As you see, that's an adult 02 mask there for size. This little boy, named Al, is just about 26 weeks along at this point along in the picture.

As the Chairman stated, I am a flight nurse in Columbus, OH. A portion of my flights is dedicated to picking up the smallest of premature babies and transporting them via air back to Columbus Children's Hospital in an isolet. Viability is an arbitrary term to medical people like myself. The reason for that is, is because it's a measure of the sophistication of the external life supports that is available to us. We know that that is ever changing.

[Slide.]

In fact, this little boy, Donnie, is in the midst of all that technology. He was born at 24 weeks. He is now at about three pounds. That is him laying on his tummy under an oxygen hood.

Now the reason viability is arbitrary, because it varies from institution to institution in my experience. It also varies from baby to baby, because neonatologists, when they call a gram weight or a gestational age as when a baby is viable, you will always have a baby that will prove the definition wrong. It also increases, of course, with our sophisticated technology.

[Slide.]

Now this little baby, it's kind of hard to see, but she was born at 23 weeks gestation in Columbus, OH. She had multiple operations done. One of them was to restore intestines that were born outside of her tummy. It is the standard of care that a baby like this would receive narcotic analgesics for pain control after surgery. It is also the standard of care that these babies would receive skeletal muscle relaxant drugs, such as valium. Also, that has kind of an amnesic effect, so the baby will not remember the painful experience. Also, an antianxiety effect.

It is also the standard of care that these babies receive anesthetic for any kind of surgical procedure. That could be from a central line insertion, chest tube insertion, even to a circumcision. Now the reason we have standards of care, nurses know that it promotes the physical well-being of that baby. More importantly, it is the compassionate thing to do for these little ones, and it holds the medical community accountable for what we do.

I fought long and hard for 12 years to get adequate pain control for these little babies. As Dr. White can probably testify, it has been a long time coming. It has been a struggle. But finally, we are using more and more pain technology and we realize that hospitals should not be a place of torture and torment, but use the adequate pain technology available to us.

[Slide.]

Now I have ample experience as a nurse to assess the pain experience in the smallest of babies. Just to give you an idea from this drawing, there are breathing tubes, there are oral gastric tubes that need to be inserted. We do vena punctures, arterial punctures. We draw blood from the heels of these babies. Their skin, especially the 21 to 23 week babies, they have very sensitive skin. So it requires that we take much caution when we remove electrodes from their skin. We use electrodes for heart monitoring, for oxygen monitoring through the skin, for temperature monitoring. So how is it that nurses know that this little babies are in pain? What it is that I have discovered over the 12 years of taking care of them?

[Slide.]

Well, this just kind of sums it up for you. But basically, we see differences in their vocalizations. There's different kinds of cries. Even your small babies can actually moan, just like an adult would. The facial expressions. We see chin quivering, eye squeezing, we see eye rolling, all kinds of brow bulge, a square chin when they are experiencing pain activity. We see differences in their sleep wake cycles. We see a lack of consolability. Their sucking ability changes when they are in pain. There general appearance, their color actually deteriorates because they deoxygenate their blood when they are in severe pain. We also see posture motor responses, such as jitteriness and arching, when they are exhibiting a pain stimulus.

[Slide.]

Now this little girl, Sarah, she's under a pound. She is only 420 grams with 454 grams being 1 pound. When she was born at 23 weeks gestation, it required that she have a medication called Adavan, which is like valium, administered to her, and also she was on a fentanyl drip at different points. That is actually a pain killer for the discomfort of all the technology.

[Slide.]

This is her a little bit older. As you see, it was very important to even swaddle her while she's on a breathing machine there. It was important for her parents to put a tape into her isolet, where she could be nurtured by the parents verbally. We even gave a pacifier that she can suck on around that breathing tube. We also play internal womb sounds to these babies to kind of console them.

[Slide.]

Now here she is several years ago with the same little doll. As you can see, she has grown quite a bit. But nurses have known this for years, that babies that have adequate pain control and they have people, whether it just be the nurses or adoptive parents, whoever is caring for the child, to give them emotional care. Those babies fare better. They gain weight better. They have less incidence of inner-cranial bleeds. We see a lot of good outcomes.

[Slide.]

Now unquestionably as Dr. White has said, the research has shown that these premature babies, they possess full sensation. This is a summary of the research that has been done. I just want to show you that this validates what nurses have always known for years. I have already told you a few of these, eye rolling, breath holding, jitteriness, eye squeezing, chin lip quivering, limb withdrawal. We also see physiological changes. Their heart rates will race when they are in pain. Or small babies, it will go down. Their oxygen levels, they also have stress hormones that go off the wall. Cortisol, adrenalin levels, will increase during pain.

[Slide.]

Now this is Kelly Thorman of Toledo, OH, born in 1971. As you see, she doesn't require much sophistication of external life supports. In the 1970's, there probably wasn't very much.

[Slide.]

This is her at 368 grams. That is three-quarters of a pound. That is her nurse's wedding ring on her wrist.

[Slide.]

Now as depicted on the front of Life Magazine. This is a baby that is the same age and weight as Kelly Thorman, the baby I just showed you. I have to ask, what is the difference? Both of those babies, whether inside or outside the womb, can perceive pain and experience it. But the difference is, the baby outside the womb is required to have humane care inside of the hospital. But this baby inside of the womb can be pulled violently down into a breech position, partially delivered, only to experience an agonizing death.

[Slide.]

Now this little girl from Columbus, OH, is shown here in two different stages of her life. At 23 weeks gestation and just over a pound, she is full of technology there you can see at

the bottom. But you know, as a premature neonate at the bottom and also as a preschooler, do you know that she can experience the same things. She can breath, digest, swallow, taste, hear. This baby can feel pain at both stages in her life. In fact, at both of these stages in her life, she had a learned response to pain. I will show you one of the reasons we know this.

[Slide.]

This baby on his 3-month birthday, when he reached about 3½ pounds.

Mr. CANADY. Ms. Morton. There's a vote taking place on the floor. If you could conclude your remarks in about a minute or two. We are going to have to go to the floor to vote.

Ms. MORTON. I am closing right now. This is the last statement. This baby, before he has blood drawn, it requires that we warm his heel as you see on his right heel. After doing this several times to these babies, they actually know when that pain response is coming, because they will start to become agitated. Their heart rates will race when we put the warm pack on.

In closing, as a nurse and also as a mother, I am really disturbed that this abortion procedure could be permitted on these babies. I believe that I have shown that there is unmistakable humanity. I hope with proposed legislation before you, that it will stop that. Thank you.

Mr. CANADY. Thank you, Mrs. Morton. I want to thank all the members of this panel. As you know, there is a vote taking place on the floor of the House. The members of the subcommittee must go to the floor to vote. We will return and reconvene as soon as the vote is concluded. The committee will now stand in recess.

[Recess.]

Mr. CANADY. The subcommittee will come to order. I apologize to our panel for the interruption. I will also tell you that the subcommittee will have to conclude its proceedings somewhat in advance of 1 o'clock due to the fact that the full Judiciary Committee has a meeting scheduled at that time. I regret that. I wish we could have an extended session here of questions, but that is not going to be possible

In light of that, I would like to at this point recognize Mr. Hyde. We're going to switch places, and I'll let Mr. Hyde proceed with questions at this point. Then when it would have been Mr. Hyde's turn, it will be my turn. Mr. Hyde.

Mr. HYDE. Well, I thank you for that gesture. Dr. White, I have yet to find a doctor who performs abortions that calls himself an abortionist. They all say they specialize in reproductive health. I have racked my brain and I try to find something reproductive about abortion. It is contrary, reproductive. Of course health is irrelevant for the fetus that has been exterminated. It just seems ironic that this is the surgery that dares not speak its name.

Dr. Robinson, over the years, about how many abortions have you performed?

Dr. ROBINSON. I really have great difficulty going back to 1953 when in New York City, we didn't do them except under rather limited and special conditions when a committee of four or five physicians would get together and have vote concerning was this a reasonable reason for this young woman to interrupt this pregnancy, just as we had committees to decide whether a woman could have her tubes tied or not. This was all done by committee.

In Korea, since I was working with the Presbyterian Church, I was active in teaching, therefore others in the community were doing the abortions.

When I came back in 1981 or 1971, then at City Hospital I began getting involved in it. I can't give you any sense. It has not been a major job. On the other hand, I have on many occasions introduced myself at church meetings as an abortionist.

Mr. HYDE. You have?

Dr. ROBINSON. Oh, yes.

Mr. HYDE. You are the first then.

Dr. ROBINSON. I'm a Christian abortionist.

Mr. HYDE. That is an interesting juxtaposition.

Dr. ROBINSON. Well, we have Christian crusaders. We have the Christian inquisition in Spain. We have a lot of Christian militants. We have lots of Christians——

Mr. HYDE. Some more nominal than others, I daresay.

Dr. ROBINSON. I daresay.

Mr. HYDE. I have read a statement by Dr. Bernard Nathanson, who was one of the founders of the modern abortion movement and who ran the biggest abortion clinic in New York for years. He said that he can't escape the notion, he said, I can't escape the notion that I have presided over 50,000 deaths. Do you think your record could equal that?

Dr. ROBINSON. I doubt it.

Mr. HYDE. Or is Dr. Nathanson ahead of you?

Dr. ROBINSON. I doubt if that number—on the other hand, the thing that he left out of his statement is that he found 50,000 women who were incredibly pleased.

Mr. HYDE. Who were what?

Dr. ROBINSON. Incredibly pleased with the outcome.

Mr. HYDE. No doubt.

Dr. ROBINSON. One of the pleasures of doing abortions is that no longer do I have to go to a committee. When women leave on the occasions that I have been involved or where the units do, these are very happy women.

Mr. HYDE. Do you ever find that remorse sets in? Do you ever find women who have had an abortion are troubled by it in later years?

Dr. ROBINSON. I find remorse occurs in many women. I do a hysterectomy in women and they grieve later on, because they have lost their ability. Grieving over illness and problems is very common. I think careful studies have indicated that grieving over this issue, as Koop said many years ago as Surgeon General, that this isn't any more common than anybody else. It is an event of life.

Mr. HYDE. You have said that you have spent in your medical experience, you have witnessed women who have died from botched abortions. We are aware that that happens. The statistics are there. The mortality rate for the unborn in abortions is 100 percent though. Isn't it?

Dr. ROBINSON. It better be.

Mr. HYDE. It had better be?

Dr. ROBINSON. Yes.

Mr. HYDE. Thank you Doctor. I have no more questions.

Mr. CANADY. Thank you, Mr. Chairman. I would like to continue, Dr. Robinson, with a couple questions for you.

Dr. Martin Haskell prefers an abortion technique which he calls dilation and extraction. Dr. James McMahon prefers a similar technique and calls it intact dilation and evacuation. The same basic technique has also been called interuterine cranial decompression. Are you familiar with the abortion techniques that are used by Dr. Haskell and Dr. McMahon that are referred to by these particular terms?

Dr. ROBINSON. I must confess, Mr. Chairman, that up to about a week ago, I had never heard anything about this at all. I am in an academic center in which varying issues are discussed. I was totally unaware that even people were talking about it.

Mr. CANADY. Well that was a week ago. So you didn't know anything about the subject you came to testify on today until starting a week ago?

Dr. ROBINSON. I know a lot about abortion. I know a lot about the attempts to describe what is being done. But as a medical piece of information, this is not widely known. It is not generally known. It has not been published in literature. It has not been published in scientific journals. It hasn't even been mentioned in throw-away journals.

Mr. CANADY. Let me ask you this. Would you consider yourself to be familiar, have some familiarity with the subject now? You have been expressing opinions on it.

Dr. ROBINSON. I am very familiar with the subject right now.

Mr. CANADY. OK. Very good. Glad to hear that. Now are you familiar with the paper by Dr. Haskell entitled, Second Trimester DNX 20 Weeks and Beyond, which was presented as part of the National Abortion Federation's Second Trimester Abortion From Every Angle Risk Management Seminar held in September of 1992?

Dr. ROBINSON. As I have testified before, I did not attend that particular meeting of NAF. I was not present. I have not seen that publication.

Mr. CANADY. Oh. You have not seen Dr. Haskell's publication on that subject at all?

Dr. ROBINSON. I have not seen what he has published.

Mr. CANADY. Have you consulted any other literature on this subject?

Dr. ROBINSON. There is no published literature in what we consider the normal medical literature. If I did a Med-Line search, I would not find this term anywhere in the Med-Line search covering about 6,000 medical journals.

Mr. CANADY. What term is that?

Dr. ROBINSON. Med-Line search, it's a way——

Mr. CANADY. No, no, no, no. You said you would not if you did a Med-Line search find this term.

Dr. ROBINSON. The term being used in the legislation.

Mr. CANADY. I refer to some other terms. Dilation and extraction, intact dilation and evacuation, interuterine cranial decompression. What about those terms?

Dr. ROBINSON. If I was to look up the word dilation and extraction, a standard D&E, this is an accepted and considered by many one of the safer methods of accomplishing a second trimester abortion. With that I am familiar with and have done it.

Mr. CANADY. Dilation and extraction?

Dr. ROBINSON. D&E.

Mr. CANADY. OK. Let me ask you this. Now a letter has been sent out by the National Abortion Federation in which you were quoted as saying that the drawings in some materials that I distributed, which are identical to these drawings on the posters, had little relationship to the truth or to medicine.

Now in your prepared testimony, which you submitted to the subcommittee, you said I have seen the sketches that have been passed around. They are medically inaccurate and not designed to advance proper understanding of a surgical procedure. Rather, they are designed to be upsetting and inflammatory to the lay person. Now there you said they were medically inaccurate. When you were giving your testimony a few minutes go, I thought you said something a little different than what is in your written statement. Could you tell me what your current view is of these?

Dr. ROBINSON. I apologize to the committee. Coming down here I took advantage to read what I had prepared and did a little maintaining.

Mr. CANADY. I have no problem with people changing their minds if they get additional

information that convinces them that an earlier view is not correct.

Dr. ROBINSON. My view is essentially that those drawings would not appear in a textbook. These drawings would not appear in a journal.

Mr. CANADY. Do you think they are technically correct?

Dr. ROBINSON. They describe, the first one where he is reaching up there. I think they have taken some artistic license to sort of move things around.

Mr. CANADY. But you do think they are technically correct?

Dr. ROBINSON. That is exactly probably what is occurring in the hands of the two physicians.

Mr. CANADY. OK, well, I appreciate that. I think that's a very different thing than what was referred to in the letter sent out by the National Abortion Federation, in which you were quoted as saying they had little relationship to the truth or to medicine. I am glad to clarify that point.

Now, there's some controversy here about whether a baby is, in fact, being delivered or whether it is correct to call this partial-birth abortion. I just want to quote this paper you have not seen. I will be happy to provide a copy of it to you, you might find it of interest, that was prepared by Dr. Haskell, in which in describing this procedure he says, ''With the lower extremity in the vagina, the surgeon uses his finger to deliver the opposite lower extremity, then the torso, the shoulders, and the upper extremities.'' The term deliver is specifically used by I think one of the leading practitioners of this particular procedure. I just wanted to note that.

I will now turn to Mr. Frank and recognize him.

Mr. FRANK. Thank you, Mr. Chairman. I'd like to ask I guess Ms. Smith, Dr. White, Ms. Morton, your opposition to abortion on the various grounds, does that extend beyond this particular procedure, Ms. Smith?

Dr. SMITH. Dr. Smith, please.

Mr. FRANK. Sorry. Dr. Smith.

Dr. SMITH. Excuse me. You want to know whether or not I have a problem with abortion in general?

Mr. FRANK. Do your objections extend beyond this particular procedure?

Dr. SMITH. OK. I was asked today to come and speak about this procedure.

Mr. FRANK. I understand, but I'm asking you to talk about other things.

Dr. SMITH. As the president of the American Association of Pro-Life OB/GYN's, I think that should be quite obvious that I have a problem with abortion.

Mr. FRANK. I will be honest with you. I don't always read people's biographies. I like to ask them questions and get answers.

Dr. SMITH. I'm sorry. I thought you knew. I'm sorry.

Mr. FRANK. I'm sorry you find that an imposition, but I'm asking you your position. I won't do that again, if that's bothersome. Dr. White.

Dr. WHITE. The answer is yes.

Mr. FRANK. Now do you feel that one of the points you made and I heard Ms. Morton make too, was that the fetus, the baby, feels pain. That is true with regard to other procedures besides this one, I assume? That the fetus would feel pain?

Dr. WHITE. I so testified.

Mr. FRANK. Yes. Again, I apologize. I can't always be everywhere at the same place. So the pain point then applies to others as well. Ms. Morton.

Ms. MORTON. You are saying the babies, that it would undergo any other surgical procedure?

Mr. FRANK. Would also feel pain?

Ms. MORTON. Yes. They certainly do.

Mr. FRANK. OK. Well, my point then is that if there is consensus that pain is felt in every situation, to my mind that does not become a basis for differentiating between abortion and this situation and abortion elsewhere. I understand there are people who think abortion is wrong. But the question is, why we would single this out.

Let me then ask also the three witnesses whom I just addressed. This particular legislation says that not only would the pregnant woman be subject to no penalties whatsoever, but she could, in fact, sue the doctor who performed the procedure.

Dr. White, do you think that is appropriate, that a woman who decided to have this done, sought out the doctor, went to the doctor's office voluntarily, submitted to the procedure, and then with no malpractice or anything, we're not talking here about malpractice, because I don't want to get doctors really upset. We are talking only about the doctor who performs the procedure exactly as described and it has exactly the results projected, and the woman then can sue him. Do you agree with that part of the law?

Mr. CANADY. Could I just——

Mr. FRANK. If I get extra time.

Mr. CANADY. Absolutely. You'll get extra time. It is my understanding that under tort law, it is generally the case that it is considered malpractice to perform a procedure which is illegal. I just would point that out.

Mr. FRANK. Yes. I understand. But this statute, if it was simply general tort law you wouldn't have to do it in the statute. I assume this is not going on my time, because I am responding to the gentleman, but what the gentleman is saying is, please don't pay attention to the law I broke. I mean if that was general tort law, what did you put it in the statute for? You clearly meant to do more than general tort law. That's the principle that is explicitly written in here.

So Dr. White, do you think that a woman in that situation should be allowed to recover damages from the doctor who performed the procedure exactly as she asked him to?

Dr. WHITE. I'm no legal expert, Mr. Frank.

Mr. FRANK. This is a matter of policy. It is not a question of what the law is.

Dr. WHITE. But I find the procedure so inhumane and so nonscientific, that if this particular part of the bill became law, I could accept it.

Mr. FRANK. You think the woman should be allowed to sue. Dr. Smith?

Dr. SMITH. I would like to answer your question. First of all, I don't know how the people who do abortions do their practice. I do know that most of the times when women ask about abortion, and people do come to me and talk to me about it, they don't usually go in saying I want a particular procedure. They usually go in saying I don't want to be pregnant any more, or in a particular case if they find out that they have a baby that has an abnormality that is incompatible with life, they generally don't ask you, do you do D&Es.

Mr. FRANK. What if they do? Ms. Watts said she did, and she had it explained to her.

Dr. SMITH. I'm telling you——

Mr. FRANK. I understand, but I am asking the question.

Dr. SMITH. I am answering your question.

Mr. FRANK. No, you are not, Dr. Smith.

Dr. SMITH. Well, let me try to. OK?

Mr. FRANK. You are not answering it. Let me explain to you why. Maybe I better rephrase the question better. The bill covers every situation. You are talking about there may be situation where the woman was mislead. The bill would allow the woman to sue in situations where it was explained to her exactly, as it apparently was to Ms. Watts.

My question to you is, where it was explained to a woman exactly what was going to happen, and that's what happened, should she be allowed, as this bill would allow her, to sue the doctor?

Dr. SMITH. If the doctor is doing something illegal and he hurts the woman, then first of all, if it's a law, he is breaking the law.

Secondly, if he is doing an experimental procedure.

Mr. FRANK. No——

Dr. SMITH. I am trying to answer your question. If he is doing an experimental procedure——

Mr. FRANK. You are not answering my question.

Dr. SMITH. We must tell the woman that this is what I am doing, and therefore, do you agree to it. Most patients do not ask their doctors for a specific abortion technique.

Mr. FRANK. You are evading the question.

Dr. SMITH. They ask, I don't want to be pregnant.

Mr. FRANK. Yes, Dr. Smith. You are deliberately evading the question.

Dr. SMITH. I am not evading the question.

Mr. FRANK. Excuse me, Dr. Smith. I am going to finish. You are deliberating evading the question. I said to you where we have circumstances where the woman explicitly is told by the doctor what is going to happen, it's not experimental, et cetera.

Mr. CANADY. The gentleman's time is expired.

Mr. FRANK. With my extra time?

Mr. CANADY. Yes. I think you got more than the time I took.

Dr. SMITH. Can I just ask question? Can I ask him a question, please?

Mr. CANADY. No. I'm sorry. We're going to have to recognize Mr. Inglis at this point. Then we'll have another round of questions. Hopefully, Mr. Frank will have another opportunity on the second round. Mr. Inglis.

Mr. INGLIS. I would love for you to ask your question.

Dr. SMITH. I would like to know, you are setting up a situation where you are telling me that my patient is coming in and asking me to do something that I know is against the law? And then you are supposing that the doctor knows this is against the law and then is going to ask, cahoots with the patient to do something that is against the law when they have another alternative to help that person if they don't want to be pregnant not to be pregnant?

I guess the reason I didn't understand your question is that I don't assume that doctors break laws that they know they are not supposed to be breaking. So if you are asking me if two people want to conspire together to do something that is criminal, I don't know how to respond to that. You'd have to ask a doctor who does that. I don't do that.

Mr. FRANK. Would the gentleman yield for me to answer the question?

Mr. INGLIS. Sure. Just briefly though. I've got another question.

Mr. FRANK. Well, you yielded to her to ask me a question. It would seem to be only fair.

The answer to you is that you seem to think it was a stupid question. But what you really mean is that it is a stupid bill, because I asked you the question that came from the bill. It is the bill that sets up those circumstances. You say you are presuming these circumstances. I am reading from the bill. The bill is the one that assumes that there will be a doctor who will do that and the woman will sue. So your discussion——

Mr. INGLIS. Let me reclaim my time.

Mr. FRANK. Is about the bill itself. I was asking you a circumstance from the legislation.

Mr. INGLIS. I'm going to reclaim my time and yield to the Chairman for a response to that attack on the bill.

Mr. CANADY. I hope and presume that there will never be any prosecutions under this law

once it is enacted. I believe that respectable practitioners will not violate this law. So I think what we have in the bill is a mechanism to ensure that there is a consequence if they do. That will encourage their compliance with the law. I will yield back to the gentleman——

Mr. FRANK. Will the gentleman yield?

Mr. INGLIS. No, no. I am going with the question. I have got another question. I am very interested in, and understand I am running back and forth between two subcommittee hearings, but I understand that Dr. Robinson, you testified that partial birth is a misnomer, that this is not really what it is. I would ask you, sir, distinguish for me the difference between the child let's say on these charts that is—I'm not a medical expert, but I assume it's about 5 inches, maybe less than that. Maybe 2 inches difference.

In other words, when the child is once delivered, which is a matter of inches I take it, can you explain to me the difference in your opinion, between the child that has been delivered and the difference between the child whose head is still in utero?

Dr. ROBINSON. Actually, I am not clear what the question is.

Mr. INGLIS. You said that there was not a——

Dr. ROBINSON. We have in our tradition we have other terms. I am surprised the word partial extraction was not used. This is a standard term in obstetrics that we use for delivering. That could have been used. The use of the word living, these types of——

Mr. INGLIS. Let me refine the question a little bit. Do you understand that if you did this procedure it would be legal, but if the child were delivered out of the canal, and you took your same instruments and whacked off its head, do you understand a legal difference between the way you might be treated there?

Dr. ROBINSON. Well, as a younger resident before we had a lot of sophisticated techniques, I was often faced with the delivery of a breech, in which I found the baby at that point still alive, with an enormous head. Yes. I have upon occasion——

Mr. INGLIS. No, no, no, no, no. You are missing the question. Let me explain the question. I want you to explain to me the difference between the child that you may legally kill inside, with its head inside the canal, and the situation that would occur if you were once it was delivered those last few inches, to whack off its head. What is the difference between what would happen to you?

Dr. ROBINSON. If the law was passed, I have no idea what would happen. The law has not passed. I know that I am under law right now, permitted to meet my patient's needs in providing her an abortion.

Mr. INGLIS. OK. Let me ask you this. Now we are talking about the legal. Tell me how you justify in your own soul, if you will, the difference in treatment between the last few inches. I mean describe for me the status difference of that human being. What is the difference in status? One, it's almost all out. In fact, I think the shoulders are out, are they not, and the head is simply in. In the other, the head is out.

I have witnessed four beautiful births of my four children. I recall that that's a rather triumphant moment. Can you tell me the difference in the status in your own mind, between those children? The one that's head is inside, and the one that's head is outside?

Mr. CANADY. If you could do so briefly, please, because the gentleman's time is expired.

Dr. ROBINSON. In my situation, I am dealing with a woman who has come to me for reasons that she wants to interrupt her unplanned, unwanted pregnancy. There are congenital anomalies. In some cases, the babies may be partially dead or won't live when it is on the outside. The conditions under which I, my staff, the nurses in which we are delivering this, as was described, the support and the concern.

The other than you are describing when I am dealing with a patient who is desperately trying to have a live child, and through the mistake of nature, delivers early, prematurely. In most cases, I would probably not have delivered that baby this way. I would have done a caesarian section.

Mr. CANADY. The gentleman's time is expired. Mr. Hoke.

Mr. HOKE. Dr. Robinson, you had stated that in no case is pain induced to the fetus. The fetus feels no pain at all. We have heard a lot of conflicting testimony regarding that, from a nurse and a neuro scientist.

If the baby is alive right up until the very end of the procedure, do you still stand by that testimony?

Dr. ROBINSON. I am not a neuroscientist. I have read some of the literature, although it's not an area that I spend a great deal of time at. I have listened to the nurse testify as to what instinctively she has learned. Instincts, of course, are not the way we learn.

Mr. HOKE. What do you base your statement that there is no pain?

Dr. ROBINSON. Because I'm not sure I know what pain is. Spinosa called it a chronic condition. I am an expert in chronic pain. I deal with a lot of people with chronic pelvic pain. What is it, where does it start.

Mr. HOKE. How about when like if you took a knife and you were cutting a tomato and you sliced into your finger, would you experience something that you might describe as pain?

Dr. ROBINSON. That would be an acute pain reaction. Yes.

Mr. HOKE. Al right. Well then if we can use that definition, which I think is probably one that many people share. Using that kind of definition, are you saying that in no case is that kind of pain induced to the fetus? Is that what you meant by your testimony?

Dr. ROBINSON. I am sure that if you had the fetus outside and had it sophisticated, you would see EKG changes, you would see certain reactions. But this simply the passage of information from a no-susceptive sensor up to the brain. Whether that is pain or not pain, I do not know the answer to that.

Mr. HOKE. Well, Dr. White, the testimony that we had heard from Dr. Robinson was that if there was pain, and apparently there is some question in Dr. Robinson's mind about that, whether or not there is pain, that it wouldn't be felt because under the circumstances there's an anesthetic that has been given to the patient, to the woman. Would an anesthesia, would local anesthesia affect the fetus or would the fetus be inside the uterine sack, would it be different, a different set of circumstances?

Dr. WHITE. Well, there are certain pharmacological agents that are administered as anesthetics, mainly in the use of general anesthetics, which do transfer through the placenta, and at a significantly reduced amount do reach the child.

There isn't the number of studies that we need on that. I think the difficulty is that under these circumstances and the evidence we have in terms of cardiovascular responses, certain chemistries that have been drawn from the fetus under these circumstances, demonstrate the fact that there is considerable stress and indeed, overwhelming pain.

There are enough studies in children of this age. Much in the age range that the nurse has demonstrated to us. I think there is really very little argument any longer that the fetuses that we are talking about in the gestational age, the idea is, they do receive pain and appreciate it. I don't want to bore you certainly in the question period, evidence and so forth. I personally think it is incontroversial.

But going back to what is said here, that when you actually attempt to divide, and it's not clear whether it's the spinal cord or the brain stem, and then suck out the brain, in a sense, modern medicine feels that the brain is the very essence of human existence. That is what the concept of brain death is based on, equals human death. You might as well cut the head off under those circumstances, because you are destroying the very organ that is the essence of humanhood.

But it is the procedure itself. The idea as Dr. Smith has shown, of a scissors being introduced into this area. I doubt these people even know where they are operating. I need a microscope to see this area. So it is very possible they could be removing this brain in this tragic way of extraction, sucking, whatever you want to call it, when the child is still alive under those circumstances.

Mr. HOKE. I guess what I don't understand about this when I hear the testimony is why those who are proponents of the procedure are trying to jump through such extraordinary hoops to say that it is not painful or that it is not inhumane, or that somehow there is—I mean, let's call it exactly what it is, and then if in fact under those circumstances it's something that a nation can tolerate, then that's fine. But let's not pretend that somehow this is not grotesquely painful to the fetus that it's been subjected upon.

I wanted to, there's one other—yes, Doctor.

Dr. WHITE. Sorry to interrupt. You are absolutely correct. Because the two papers that have been cited over and over again, and unfortunately Dr. Robinson hasn't read it, are the two experts in this field that do this sort of abortion. You will note that in their papers they do not stress the fact that because of the anesthesia administered to the mother, if indeed any, that the child, the infant, the fetus, is not suffering pain. That is not a part of their written remarks.

Mr. CANADY. The gentleman's time has expired. The time for this meeting has about expired. We're going to have to adjourn this hearing.

Mrs. SCHROEDER. Mr. Chairman.

Mr. CANADY. I'm sorry. There's a——

Mr. FRANK. Excuse me, Mr. Chairman. I thought we had a 1 o'clock meeting of the full committee. But Mrs. Schroeder not to be able to ask questions, we do have until 1 o'clock.

Mr. CANADY. The Republicans on the committee have a caucus which we are late for at this point, preliminary to the meeting.

Mrs. SCHROEDER. Mr. Chairman.

Mr. FRANK. Mr. Chairman, I do have to object. You guys scheduled these two meetings. To deprive our members of a chance to ask questions. Then be a few more minutes late or leave one person behind. But to deprive Ms. Schroeder and Ms. Jackson-Lee of a chance to answer questions while the panel is here, over 10 minutes.

Mr. CANADY. Mrs. Schroeder, you will be recognized for 5 minutes. I'm sorry, Ms. Jackson-Lee, you are not a member of this subcommittee. We will have to conclude at the end of your 5 minutes. Please proceed.

Mrs. SCHROEDER. Well, Mr. Chairman. I appreciate that. I was a little startled. I am sorry. I had an amendment on the floor so I was a little late getting back.

But let me just say my understanding is while I was gone, that the witnesses that testified for the bill said they really were against abortion at any stage. I take it that all of you would agree with the premise that this bill should go forward even if a doctor were to ascertain this medical procedure was

much better for a woman who was seeking abortion. Is that correct?

Dr. SMITH. No. First of all, there has been no proof that this procedure is safe for anybody.

Mrs. SCHROEDER. Wait a minute. Let me take back my time. That was not my question. I said if it is proven, and if a doctor says this is safer for the woman, would you still want this to pass? You still want to outlaw this procedure?

Dr. WHITE. I don't think that is possible. It is not scientific. I mean, you are going to violate science.

Mrs. SCHROEDER. I mean we have two big views of what science really is. We are hearing about pain. My understanding, birth is also painful for babies.

But one of the things I think we should do as we—Dr. Robinson, I understand you had some slides. Is that correct?

Dr. ROBINSON. Just pictures of congenital anomalies such as has already been adequately discussed here. I don't think it would necessarily enhance the proceedings. It would prolong it. They are simply standard pictures of babies in very poor shape.

Mrs. SCHROEDER. Because of the interest. I think it is very important that we have some balance there.

Dr. White, when you were talking about humanity comes from a brain. Does that mean if a baby does not have a brain then this procedure would be OK? Is that then not human?

Dr. WHITE. Well, even the anacephalic child has a brain stem. While we have a great deal of difficulty defining brain death, as we can do in adults, in children and certainly in infants, it is not true that under ordinary circumstances, a child would be born or would be at these gestational ages, totally without even a brain stem. I mean it's not impossible, but I mean the thing is, in general, the anacephalic child has a brain stem. Therefore, they have a part of a brain.

Going to your question, would I consider this appropriate under those circumstances, that is, with the brain stem retained. My answer would be no.

Mrs. SCHROEDER. And then what if it were a mole? Well, never mind.

Dr. WHITE. I don't know what you mean.

Dr. SMITH. He doesn't know what a mole is.

Mrs. SCHROEDER. I guess I feel a lot of pressure because the Chairman doesn't want me to ask questions. I have got many questions that I want to ask here.

One of the things I am so troubled by is I think as Congress moves in and starts micromanaging what OB/GYN's can teach, what the medical profession is saying, what kind of procedures are legal and illegal, where is the line, are you going to have Federal people in these operating rooms watching this?

You know what I think is going to happen is it is going to be very difficult to get high quality docs ever wanting to deal with women's issues, women's health issues, because who needs this, who needs this. It is the only area of medicine where I know that there is this kind of micromanaging.

I see two distinguished members of the medical profession sitting side by side. I think traditionally you would say that they have had very high ethics. You have had your own oath, you have had your own policing.

Mr. CANADY. There are three physicians here and another medical practitioner.

Mrs. SCHROEDER. Three physicians, I'm sorry. Three sitting side by side and a nurse. So we have four, OK. But let me say, you have had high standards. I don't think we probably need to get Congress into micromanaging down to the details of what is going on. That is why I am very troubled by this beginning, because I see this as a tremendous erosion. I see it as a backsliding.

I have talked to many deans of medical schools who are very troubled by this, who say, you know, we're not sure we really want to continue even dealing with obstetrics and gynecology. Long term, I think that hurts all women, because you don't have the safe standards. We know women's health has not been dealt with very well in this country any way. To begin this, I think is very troubling.

So, Mr. Chairman, I have a lot of questions that I would like to ask for the record, if that's OK, since you would like me to be quiet. I would like to yield the remaining time to Ms.——

Mr. CANADY. I have not wanted you to be quiet. As a matter of fact, we recognized you at the beginning of the hearing, and you will have the last word in the hearing as well, because your time is now expired. The full committee is commencing a meeting in about two minutes. In light of that, we're not going to be able to continue with this subcommittee meeting. I wish we could. There's an additional witness. Prof. David Smolin of the Cumberland Law School, who has come for the hearing today. I apologize to you, Professor, that due to this meeting of the full committee, that it was only scheduled yesterday, because of our inability to finish the work we had to conclude yesterday. We will not be able to continue.

I want to again thank all of the members of this panel for being here. We appreciate your valuable testimony. The subcommittee is adjourned.

Mr. SPECTER. Mr. President, how much time remains on my side?

The PRESIDING OFFICER. The Senator has 68½ minutes.

Mr. SPECTER. I thank the Chair and yield the floor to my distinguished colleague from New Hampshire.

Mrs. FEINSTEIN addressed the Chair.

The PRESIDING OFFICER. The Senator from California.

Who yields time to the Senator from California?

Mr. SPECTER. How much time would the Senator—5 minutes.

Mrs. FEINSTEIN. I will do my best.

Mr. SPECTER. We have a number of Senators who have already requested time. I yield the Senator 5 minutes.

I say to my distinguished colleague from California that I wish we had more time, but we have many requests. I think it is important to hear the intentions of those in opposition who wish to respond. But I do yield 5 minutes to the Senator from California.

Mrs. FEINSTEIN. I thank the Senator.

Mr. President, I rise to support the motion to commit to the Judiciary Committee, and I do that as the only woman in the U.S. Senate on the Judiciary Committee. This is a matter which basically affects women, and I think it really is appropriate to have the hearings that have been requested and to come to grips with some of the problems that are inherent in this legislation.

I would like to give you my major reasons for suggesting that hearings in the Judiciary Committee are appropriate.

I believe that the language in this bill is unduly vague. It is not based on medical terminology. The bill holds a doctor criminally liable for a procedure that is defined not in medical terms but in a description devised by legislators. I think we need to come to grips with that and find out exactly which procedures would be impacted by this legislation.

Second, Roe versus Wade already provides for States to legislate in the third trimester. And, in fact, 41 States do already have statutes on the books which govern abortions in the third trimester. There are also very strong writings and beliefs that this bill would violate the Constitution. I think that is worthy of a hearing.

Finally, there is a very real human dilemma in this. Unfortunately, the genetic code which carries out God's creation is sometime's tragically faulty. And this produces heartbreaking circumstances in which children have developed in the fetus without brains, children have developed with the brain outside of the skull, children develop without eyes or ears, whose stomachs are hollow, and the materials having to do with intestines and bladder are created outside of the physical structure of the individual.

When we consider the nature of these heartbreaking pregnancies, these very dire circumstances, we must also consider the life and health of the mother. So I believe very strongly that this is the correct action to take, to have these hearings and to report this bill back to this body within a specified period of time.

Let me just very quickly speak to certain issues. In 1973, in Roe versus Wade, the Supreme Court established a trimester system to govern abortions. In that system, in the first 12 to 15 weeks of a pregnancy, when 95.5 percent of all abortions occur, and the procedure is medically the safest, the Government may not, under Roe, place an undue burden on a woman's right to an abortion.

In the second trimester, when the procedure in some situations poses a greater health risk, States may regulate abortion, but only to protect the health of the mother. This might mean, for example, requiring that an abortion be performed in a hospital or performed by a licensed physician.

In the later stages of pregnancy, at the point the fetus becomes viable and is able to live independently from the mother, Roe recognizes the State's strong interest in protecting potential human life. On that basis, States are allowed to prohibit abortions, except in cases where the abortion is necessary to protect the life or the health of the woman. I repeat, the life or the health of the woman.

Contrary to the many myths put forward by opponents, abortion in the latest stages of pregnancy is extremely rare and performed almost exclusively under the most tragic of circumstances—to protect the life or health of a woman who very much

wanted that pregnancy, or in the case of a severe and fatally deformed fetus.

As I said, 41 States have enacted laws restricting abortions in the later stages of pregnancy. Even when such abortions have been restricted, States have, in nearly every case, made exceptions to protect the life and the health of the mother.

States such as Alabama, Arkansas, Florida, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Missouri, Nebraska, Nevada, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, and Utah—all these States, and many more, have recognized the crucial need to consider risks to a woman's health, in addition to risks to a woman's life, in balancing the important considerations of both the fetus and the mother. To do otherwise would be to fail to accord consideration to the safety and well-being of our Nation's women. To do otherwise would be callous, and cruel.

Certain States have chosen to remain silent on the issue—most likely because these abortions are so rare and considered so tragic, that new laws are not necessary to interfere with what many believe is a medical decision between a woman and her doctor.

THE FEDERAL GOVERNMENT SHOULD NOT BE STEPPING IN HERE

There are several compelling reasons why the Federal Government should not step in and interfere in this medical decision between a doctor and a patient.

First, there is no need to. Except in the rarest of cases, abortions late in the pregnancy simply do not occur, and when they do, as I have said, it is due to the most tragic of circumstances. Only one-half of 1 percent of all abortions are performed after the 20th week of pregnancy. Fewer than four one-hundredths of 1 percent (.04) occur in the third trimester, and nearly all of these are performed due to severe fetal abnormalities or grave risks to the health or life of the pregnant woman.

Many of the people pushing this legislation profess to believe in States' rights, and keeping government off our backs. Why, then, do they suddenly think Big Brother should step in when the issue is abortion? Roe versus Wade gave States the authority to regulate and even ban abortion after viability. Why, then, is there a compelling need for the Federal Government to interfere?

Lets be candid. Although this Congress has seen a host of back-door efforts to restrict women's access to abortions, this legislation represents a direct, and blatant, challenge to Roe versus Wade. Proponents of this measure openly admit that this is a strategic milestone in the road toward making abortion illegal in this country. If this measure passes and is enacted into law it will be a significant victory for the antichoice forces.

THIS IS A MEDICAL DECISION

Finally and most importantly, the reason politicians should stay out of this is because this is a medical decision, not a political one. It is important to remember that in the heartbreaking cases where medical intervention in pregnancy is warranted—these were wanted pregnancies. The decision to have an abortion for these women and their families was one that they desperately tried to avoid. And the Federal Government has no business making that decision any harder on these families. Take the case of Viki Wilson:

Viki Wilson is a nurse who lives in Fresno, CA, with her husband, Bill, an emergency room physician, and their two children, Jon and Kaitlyn. Viki and Bill very much wanted more children and she became pregnant in August 1993 with a baby girl.

After what seemed to be a normal, healthy pregnancy filled with baby showers, a freshly painted nursery, and family members touching Viki's stomach to feel the baby kick, Viki received the worst imaginable news: her beautiful baby girl had a fatal deformity, known as encephalocoeles—a condition where the brain forms outside the skull and is always, unconditionally, fatal.

Viki and Bill would have done anything on Earth to save their baby girl, whom they named Abigail. But she had no chance of survival.

Viki was warned that, if she continued the pregnancy, she risked rupturing her uterus, or causing a massive infection that would leave her unable to have more children. After consulting with their physicians, Viki and Bill decided that the safest thing to do was to abort the pregnancy.

An abortion at this late stage of pregnancy is not easy, and Viki's doctor recommended a procedure known as intact dilation and evacuation. In layperson's terms, it means attempting to induce cervical dilation artificially and removing the fetus intact. In cases such as Viki's, the deformed head of the fetus could not fit through the cervix, and fluid had to be extracted in order to complete the delivery safely.

This abortion procedure saved Viki Wilson's health and perhaps her life. It is the same procedure that opponents of abortion have called a ''partial birth abortion,'' in order to mislead people into believing that a live and healthy fetus is being disposed of. Nothing could be further from the truth.

After Viki Wilson's story was published, I received a letter from a constituent of mine who had been through a similar tragedy. She wrote:

My husband and I lost our baby on March 10, 1995. Our baby was diagnosed with a herniated diaphragm . . . preventing its heart and lungs from growing normally. My husband and I had to make the most devastating decision of our lives during my 19th week of pregnancy. This baby was our first child, and we had so much love and excitement for its birth. The doctors gave us two choices: terminate the pregnancy, or continue the pregnancy with surgery in utero, understanding that [the baby] would only live for a few weeks under life support after birth . . . My health was at risk if I carried to term and my baby would not live for even one month on this earth.

This woman needed the same procedure that Viki Wilson had, the same procedure that this bill would outlaw.

And a woman named Karen Ham became critically ill with diabetes during her second trimester and had to be flown 450 miles to a clinic in Colorado for an abortion necessary to save her life. When she arrived, she was in shock and about to go into cardiac failure.

THE NEED FOR HEARINGS

This body is attempting to legislate a complicated medical decision without even so much as an adequate public hearing on the matter. I listened to Senator SMITH on the floor some months ago. It was the first time I had seen photos depicted on C-SPAN full screen. With all due respects, I believe that his presentation was one-sided and fully misleading. If this legislation is to go forward, it is essential that the Judiciary Committee hold hearings on the bill, as this bill would create criminal liability for doctors who perform this late-term procedure.

We need to hear from the experts—the doctors and other health professionals, and from the parents who have been through this procedure.

There are many health risks that women can face during pregnancy, risks that could worsen during pregnancy, requiring a late-term abortion: heart disease, cancer, diabetes, just to name a few. These risks cannot be dismissed as we consider legislation that would ban what may be the only medically safe option to terminate a pregnancy.

S. 939 REPRESENTS A DIRECT CHALLENGE TO ROE VERSUS WADE

Every Senator in this Chamber should make no mistake about what this bill is: This bill is a direct challenge to Roe versus Wade.

Roe versus Wade firmly established that, after viability, abortion may be banned as long as an exemption is provided in cases where the woman's life or health is at risk. This provision was explicitly reaffirmed by the Court in Planned Parenthood versus Casey.

This bill is unconstitutional on its face because it allows for no exception in the case where the banned procedure may be necessary to protect a woman's health. Even further, the bill holds the doctor criminally liable unless he or she can prove that the banned procedure was the only one that would have saved a woman's life. The doctor must go to court to prove this. This places an undue burden on access to late-term abortions to save a woman's life under Roe versus Wade.

The Smith bill also ignores the viability line established in Roe and reaffirmed in Casey. The bill would criminalize use of a particular abortion procedure, virtually without exception, even before fetal viability. This again constitutes an undue burden—prohibiting a procedure that for some women would be the safest in light of their medical condition.

The proponents of this bill know quite well the challenges to Roe this legislation presents. That is their intent. The magnitude of this bill is enormous for the long-term preservation of safe and legal abortion in this country. It will have an immediate and direct effect on the lives of women facing tragic and health-threatening circumstances. This bill needs to be considered thoroughly before it is brought to the floor for a vote.

I urge my colleagues to vote for the motion to commit S. 939 to the Senate Judiciary Committee for hearings.

I would like to enter into the RECORD a letter written to the American Medical Association by a San Francisco physician, David Grimes.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. FEINSTEIN. May I have 1 minute?

Mr. SPECTER. The Senator may. Let me say we are going to have to proceed on a limited basis. I already have requests from about 10 Senators to speak. The Senator may have 1 additional minute.

Mrs. FEINSTEIN. I thank the Senator very much.

I would like to enter a letter into the RECORD from a physician, an obstetrician, a surgeon, who served as chief of the Abortion Surveillance Branch at the Centers for Disease Control in Atlanta, where he did some preliminary work in evaluating third-trimester abortions, and finds this issue to be largely a smokescreen for those opposed to abortion. He points out the rarity of these abortions. He points out that in a study in Atlanta, the rate of third-trimester abortions was 4 per 100,000 abortions. I think this letter provides some accurate and vital testimony.

Mr. President, I ask unanimous consent that the letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

UNIVERSITY OF CALIFORNIA,
SAN FRANCISCO,
San Francisco, CA, October 11, 1995.

Re H.R. 1833/S. 939.

ROSS RUBIN, J.D.,
Legislative Council, American Medical Association, Chicago, IL.

DEAR MR. RUBIN: As a member of the AMA and a long-time provider of abortions, I write to express my concern about the reported intention of the AMA to endorse a ban of certain abortion techniques. As background, I have conducted research on the safety of abortion for two decades. Some of that research has appeared in JAMA. I am Board certified in both obstetrics and gynecology (for which I am an Examiner) and in preventive medicine. In the 1980's, I served as Chief of the Abortion Surveillance Branch at the Centers for Disease Control in Atlanta, where I was the principal federal agent responsible for determining the safety of abortion in the U.S. I have served as a consultant to the Planned Parenthood Federation of America and the American College of Obstetricians and Gynecologists concerning abortion issues. I currently chair the Steering Committee for the World Health Organization Task Force on Post-Ovulatory Fertility Control, which studies abortion internationally. I have testified before Congressional subcommittees several times concerning abortion issues.

First, the term being used by abortion opponents, ''partial birth abortion,'' is not a medical term. It is not found in any medical dictionary or gynecology text. It was coined to inflame, rather than to illuminate. It lacks a definition.

As I understand the term, opponents of abortion are using this phrase to describe one variant of the dilation and evacuation procedure (D&E), which is the dominant method of second-trimester abortion in the U.S. If one does not use D&E, the alternative methods of abortion after 12 weeks' gestation are ''total birth abortion:'' labor induction, which is more costly and painful, or hysterotomy, which is still most costly, painful, and hazardous. Given the enviable record of safety of all D&E methods, as documented by the Centers for Disease Control and Prevention (Lawson et al. Abortion mortality, United States, 1972 through 1987. Am J Obstet Gynecol 1994;171:1365–1372), there is no public health justification for any regulation or intervention in a physician's decision-making with the patient.

Second, the issue of alleged ''third-trimester abortion'' is largely a smoke screen of those opposed to abortion. Abortions after 24 weeks are exceedingly rare in the U.S. Indeed, my colleagues and I at the Centers for Disease Control investigated two years' worth of reports of such abortions in Georgia. Nearly all were coding errors concerning gestational age or fetal death in utero. We found two uterine evacuations for anencephaly, and one case with inadequate documentation. The rate of third-trimester abortion was 4 per 100,000 abortions. (Spitz et al. Third-trimester induced abortion in Georgia, 1979 and 1980. Am J Public Health 1983;73:594–595)

According to Congress Daily, the legislative council felt that some unspecified D&E variation is not a recognized medical procedure. If so, this may reflect only the composition and medical background of the legislative council. Several variations of the D&E technique have been widely used in the U.S. over the past twenty years (Grimes et al. Midtrimester abortion by dilation and evacuation: a safe and practical alternative. N Engl J. Med 1977;296:1141–1145) and are well known to gynecologists and others who provide abortions.

In summary, abortions after 24 week's gestation are exceedingly uncommon and are done for compelling fetal or maternal indications only. Variations of D&E are by far the most common means of abortion in the U.S. after 12 weeks' gestation. Outpatient D&E dramatically reduces medical costs and patient suffering, while having morbidity and mortality comparable to labor induction. From a public health perspective, any intrusion of Congress into this medical issue is both unwarranted and unjustified. I hope that the AMA will strongly oppose any such regulation of the practice of medicine by anti-abortion activists.

If I can be of help to the legislative council by providing references or by meeting with your group in Chicago, I would be glad to do so. Thanks very much for your consideration.

Sincerely yours,
DAVID A. GRIMES, M.D.,
Professor and Vice Chair.

Mrs. FEINSTEIN. I thank the Chair, and I yield the floor.

Mr. SMITH addressed the Chair.

The PRESIDING OFFICER (Mr. CAMPBELL). The Senator from New Hampshire.

Mr. SMITH. Mr. President, I yield whatever time I may consume to myself.

The PRESIDING OFFICER. The Senator from New Hampshire [Mr. SMITH] is recognized.

Mr. SMITH. Mr. President, I rise in opposition to Senator SPECTER's motion to refer H.R. 1833 to the Committee on Judiciary.

Make no mistake about what this motion is. Let us not kid ourselves. It is a motion made by the opponents of the bill that is intended to get the bill off the Senate floor, to get it out of the public spotlight, to spare the full membership of this body from having to face up to the grisly reality of partial-birth abortions. That is what this motion is all about. Nothing else.

They do not want to see what happens in this grisly, disgusting procedure. They do not want the American people to see it. That is why they want to move this bill off the floor and send it back to Judiciary.

But frankly, Mr. President, the American people are sick and tired of politicians doing just this: Ducking and weaving and dodging. The Ali shuffle, that is what it is here in the Senate: Let us not face up to reality, do not make the tough choice, do not give us a recorded vote, do not come out here and vote your conscience; shuffle it off to committee.

Originally, the Senator from Pennsylvania was going to make it a 45-day motion, which would have taken us to December 23, which means it would have taken us into the next year. Then he surprised us, I suppose, in this element of surprise which is so common here, and he now brought it back to December 7, 19 days, where he says we will report the bill with amendments, if any. Of course, what he does not say is they could report the bill with a recommendation to defeat it. He does not point that out.

This is dilatory. It is an act of cowardice. It is a refusal to face reality, to face the issue. That is what this is about.

I want to make it very clear to my colleagues, I may lose on this motion today. I hope not. I think when we get finished with the debate you will know why I hope not. But if I do, and this motion carries, I want my colleagues to understand that we are going to vote on this. We will vote on it on the next bill that comes in here if it is an hour after this, a day after this, a week after this, a month after this. The next time I can get this amendment attached, it is going on and we are going to vote on it because I am not going to let the U.S. Senate back off from going on record on this issue.

Not tomorrow, not after some hearings. We have already had hearings. The House has had hearings. The House has had a subcommittee markup, a committee markup, a report. We have had all of that. We have had a debate. Senator BOXER and I debated last night on two national programs.

Everybody knows what happens here, especially the opponents. They know what happens here in this process. I am going to show you what happens here in this process in a few moments. Everybody knows what happens, and you will notice the opponents do not talk about that. ''What we are talking about here is broad legal concepts, legalese,'' I hear from the Senator from Pennsylvania. This is not legalese.

Three inches from the head coming into the world with the rest of the baby's body, 3 inches and maybe 3 or 4 seconds, the difference between when that needle or if that needle, Mr. President, is injected into the head of that child. That is what we are talking about here, I say to my colleagues. That is what the issue is. That is why nobody wants to talk about it on the other side. Of course, they do not want to talk about it because it is a horrible, grisly, grotesque, gruesome killing of a child that is 3 inches from completion through the birth canal.

So 3 inches and 3 seconds before that happens, you insert the scissors in the neck, you open up a wound, you insert the catheter and you suck the brains out. But for 3 more seconds and 3 more inches, that child is under the full protection of the Constitution of the United States and, as the Senator from Pennsylvania pointed out, under the protection of the law. Three seconds and 3 inches; 3 seconds and 3 inches.

The opponents voted down an effort to send the matter back to the Rules Committee and did the job the American people sent them here to do in the House of Representatives 288 to 139—288 to 139. The House of Representatives had the courage to face this issue. It was debated, they had hearings, they had markups, subcommittee and full committee hearings, votes, full floor debate, committee report.

As if the American people would not know, as if the Senators here do not know what is going on. Does anybody really believe some Senator is going to change their vote as a result of 19 more days? Give me a break.

I have been called an extremist for pointing this out, I say to my colleagues—an extremist. It was said on the floor yesterday, not directly attributed to me, but it was said on the floor that those of us who support this bill are extremists. Senator KENNEDY said it. Senator BOXER said it. Others have said it.

Well, here is a list of some of those extremists: The Democratic leader in the House, RICHARD GEPHARDT; Democratic Whip DAVID BONIOR; Representative JOHN DINGELL, ranking Democrat on the Commerce Committee; Representative LEE HAMILTON, ranking Democrat on International Relations; Representative DAVID OBEY, ranking Democrat on Appropriations; Representative JOE MOAKLEY, ranking Democrat on the Rules Committee; Representative JOHN LAFALCE, ranking Democrat on the Small Business Committee; Representative PATRICK KENNEDY, Democrat of Rhode Island; Representative BLANCHE LAMBERT LINCOLN, Democrat of Arkansas, and on and on and on. MARCY KAPTUR, Democrat of Ohio, all extremists. Welcome aboard.

This is not an extremist issue. If we are extremist for wanting to stop this, what are the people who do it, who commit this act? It is really fascinating to hear the defense of this procedure on the floor of this Senate.

Let me tell you how they defend it. Listen carefully, I say to my colleagues, as you listen to the debate. Find one individual, just one, who will point to these charts that I am going to show you in a minute and talk about what happens to this baby when it comes out of the birth canal. Find me one.

No, no, we are not going to hear about that. We are going to hear about legal procedure, legalities, hearings. That is what we hear about, because nobody wants to accept reality here, and not only that, they do not even want to vote on it. The Senator from Pennsylvania does not even want to vote on it.

I want my colleagues to know what it is. I want them to know what this procedure is and, as I said yesterday on the floor of the Senate, I hope this time the press will get it right because last time, in case you missed it—I said this yesterday, I will repeat it—the press accused me of showing photographs of aborted fetuses, showing photographs of women giving birth, showing photographs of dead babies. None of it was true but, of course, that does not matter, just put it out there.

Here is what I am showing you: A medical drawing approved by the American Medical Association. A medical drawing.

Here is what happens. This is supposed to be an emergency, I hear the Senator from California say, and others, to save the life of a mother. If it is an emergency to save the life of the mother, why does the process take 3 days? Can anybody tell me that? Why is it that when the head is ready to come through the birth canal, the abortionist stops the child from being born by holding it, not letting the child come out of the birth canal, and stops it to kill it?

Tell me how that helps preserve the life of the mother. My God, this is the United States of America. Do we not have more important things to do than this? This is not a simple debate about pro-choice and pro-life. There are people who differ on this issue, and I respect that. That is not what this debate is about. This is about a specific, brutal, cruel way to kill a child. But for 3 inches, or 3 seconds, it is a child—after 3 inches more and 3 seconds. Here is a fetus that we can destroy.

I ask you—anyone, any of my colleagues, any American citizen listening to me now, if tomorrow morning you picked up your newspaper and the announcement in your community was on the headline of your paper that the local humane society, with a surplus of pets, reluctantly had to come to the conclusion to destroy surplus pets because nobody would adopt them, and they said they would use this method to destroy them, no anesthetic, open up the back of the skull with a pair of scissors, insert a catheter, suck the brains out of the dog or cat or horse, whatever it is; how would you feel about that? You would be outraged. There would be people screaming.

But do you know what? Not here on the floor of the U.S. Senate. We cannot even get a vote on it. We want to refer it back to committee, let alone stop it.

Let us look at what happens. They hate to hear this. I have to say it again, as I said it yesterday, because you are not going to hear this from the other side, but you need to know. This baby is inside this womb, anywhere from 20 weeks on, snug and warm inside womb. You know that baby has feelings, moves its fingers, its feet, kicks, it hears its mother. It is in that womb, snug and warm. Then come the forceps. Those forceps go up there and they take the feet of that child and turn the child so that the feet come out first.

As you can see in the next picture, why do we do that? Why do we do that? You know why? Because if the child is born head-first, it is breathing, it is alive. Now we have a problem, do we not? We cannot have a live birth. Oh, no, we cannot have that. So the baby, tiny little legs, moving toes—moving—clamp it on and pull the child from the birth canal.

The third illustration. This is the part that is the worst, the most sickening. If you think I enjoy standing on the floor of the U.S. Senate having to talk about this, you are wrong. If you think I enjoy standing on the floor of the U.S. Senate having to defend against this, to stop this, you are wrong. We should not have to be doing this. This is a basic right for this little baby to come into this world. It is a basic right.

I do not care what Senator SPECTER says about all his legal jargon. This is a baby. This is not some vague concept about choice. This is a baby. And that doctor, or abortionist—call him what you may—takes that child in his hands and those of you that have had children—and I have witnessed the birth of all three of mine and know what a beautiful thing that is—he takes that baby, moving feet, moving legs, moving fingers, holds it in his hands, feels the legs, feels the feet, feels that little bottom, soft as they are with these little babies, takes the torso, brings the arms and shoulders out and then stops it—stops it firmly, holds it. Do not let the baby be delivered.

The next picture. Then what? No anesthetic, no painkiller at all. Scissors are inserted into the back of the skull, open up the scissors, insert the catheter, and that little moving child is now hanging limp, dead—in the United

States of America. People here on the Senate floor—it is bad enough they would vote not to stop it; they do not want to vote. The Senator from Pennsylvania and seven of his colleagues do not want to vote on it. They want to have more hearings on it. One baby a day dies like this that we know of. So 19 will die by the time we get the bill back here, if we do not stop it.

As I said yesterday, 19 babies—who knows who might be in that 19, the first black President, the first woman President, another Senator, somebody who cures cancer or AIDS? Who knows? We will never know, will we? Snuffed out. But that is choice, is it not? That is the nebulous concept of choice. That is what that is.

Ladies and gentlemen, this is a brutal procedure that is not necessary. We have statements everywhere that it is not necessary to do this. If it is truly an emergency, why do we stop the baby from being born? Why do we stop it from being born? Why do we hold the head, refuse to allow the head to be delivered? It has nothing to do with the life of the mother—nothing. It has to do with the life of the child because when this child is born, that is the problem for the abortionists.

I am absolutely amazed—amazed—at the number of people who have taken the floor and spoken on this issue and have talked about deformities, as if we had the right to play God on deformities. What do you tell a young man or woman today with Down's syndrome, or some other deformity—perhaps a missing limb, perhaps they had some disease and they are in a wheelchair, but they are human beings and they are contributing to their country, making a life for themselves? What do they tell them? ''Gee, if we only thought of this procedure when you were in the uterus, we could have gotten rid of you and would not have had to deal with you.''

I am absolutely flabbergasted that we would make those kinds of decisions—that anybody would want to make those kinds of decisions. Down's syndrome—what do you use? What is the excuse? Let me be honest with you. Even though the deformity case is a horrible reason, the truth of the matter is that 80 percent of these types of cruel abortions—80 percent, and this is testimony from the doctors who perform them, not my numbers—80 percent of these types of abortion, they say, are elective. They are elective. It has nothing to do with deformities or anything else. It is just elective. We do not want the child and we are going to do it this way.

Now, that is Dr. Haskell himself. He stated, ''I will be quite frank. Most of my abortions are elective in that 20-to-24-week range. In my particular case, probably 20 percent are for genetic reasons, and the other 80 percent are purely elective.''

Pamela Smith said, ''In the situation where a mother's life was in danger, no doctor would employ the partial-birth method of abortion, which, as Dr. Haskell carefully describes, takes 3 days.''

It is all a phony argument. It is a phony argument to keep from getting to the facts of what is happening.

I say to my friends who claim to be pro-choice, let me repeat and go back to the basic issue here: 3 inches, 3 seconds. That is what we are talking about, the difference between living and dying.

What is the difference, Senator SPECTER, what is the difference between a child whose head is in the womb 3 inches from birth, 3 seconds from birth, and a child whose head is removed from the womb, 3 inches and 3 seconds later? Who are we to say that one should live and one should die? What is the difference?

Mr. SPECTER. Does the Senator yield for a response to a question?

Mr. SMITH. I yield for a response to that particular question.

Mr. SPECTER. The difference is the standards established by the laws of the United States as determined by State assemblies, by Congress, and permitted by the courts.

How does that differ upon a C section? Or how does that differ before the child has gone into the vaginal cavity or the vaginal canal?

Does the Senator from New Hampshire say that those late-term abortions are satisfactory? There you have a situation where you do not have the 3 inches which you talk about but you have reaching the fetus the same substantive contents, through a C section.

I ask the Senator to address that question. If you reach the fetus through a C section or you reach the fetus some other way before the fetus comes into the vaginal cavity, does that make it satisfactory in terms of the Senator from New Hampshire?

Mr. SMITH. No.

The Senator from New Hampshire believes wherever that fetus is, that is a life. That is not what we are talking about here.

I assume from the Senator's response that he assumes that this process is acceptable, that this process is acceptable because the head still remains in the vaginal canal; therefore, this is an acceptable procedure.

Mr. SPECTER. If I may respond.

Mr. SMITH. Is it acceptable?

Mr. SPECTER. I have not said it is acceptable. I do not know, and I do not know because I do not know the facts. I describe it as a chilling matter.

When the Senator from New Hampshire cites two doctors, neither of those doctors has testified, I want to know a little more than the short statement which appears on the chart. That is not enough for this Senator to legislate on a matter of great importance. That is just not enough.

If the Senator from New Hampshire says that it is not acceptable to have a C section on a late-term abortion or not acceptable to have an abortion which occurs before going into the vaginal canal, then let us make this legislation effective, if you really want to deal with this problem.

Does the Senator from New Hampshire disagree with the conclusions I stated in my opening statement, that this legislation would not reach a C section on a late-term abortion?

Mr. SMITH. This is a very specific, I say to the Senator from Pennsylvania, this is a very specific procedure that is so cruel in the way that it is performed that it ought to be outlawed.

The Senator knows, and I think I know his position—he knows mine—on the issue of abortion. That is not what we are talking about here.

We are talking about a specific process, procedure, which is cruel, which is used to abort a child. And indeed, some would say, to kill a child. I say to kill a child. That is the issue.

I do agree, I say to the Senator, I believe it is the taking of a life, yes, when it is a C section. That is my personal opinion. I am not engaging in that personal opinion in this debate. I am engaging in the particular procedure that we are talking about.

This procedure, when a child is that close to being born, whether or not this is not a cruel procedure to use against an unborn child that is 90 percent born, with feeling. That is the issue here.

Mr. SPECTER. If the Senator would yield for one final question on this subject, would the Senator not prefer a statute which dealt with a late-term fetus, in the same medical condition which also precluded a C section?

Mr. SMITH. The answer to that question is yes, but that is not what we are talking about here.

Mr. SPECTER. You may have that if it is referred back to the Judiciary Committee.

Mr. SMITH. I am smarter than that. I know what will happen when it goes back to the Judiciary Committee. I know full well what the Senator's position is.

The issue here is whether or not this type of abortion, and indeed whether it is an abortion—is that what we define as an abortion—a child that is brought purposely into the birth canal, 90 percent of which comes into the world with only 10 to 15 percent of the child still remaining in the birth canal, whether or not that is a birth or not. So we talk about partial birth.

Mr. INHOFE. Would the Senator yield for a couple of minutes, and before yielding, would the Senator read a statement from the registered nurse I discussed yesterday? I want to have that read before I make a comment.

Mr. SMITH. We have that and are happy to provide that to the Senator from Oklahoma.

Mr. INHOFE. If the Senator would not mind reading the statement of Brenda Shafer.

Mr. SMITH. This is a nurse named Brenda Pratt Shafer, an RN who assisted Dr. Haskell, I believe, in the clinic, or at least assisted a doctor who performed this. She was so overcome by what she saw that she basically

quit—she quit the clinic where this was performed and then became an advocate against this procedure.

What she says is very heartrending, frankly. I will read what she says, and it is up here on the chart.

The doctor kept the baby's head just inside the uterus. The baby's little fingers were clasping and unclasping, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when he thinks that he might fall.

Then she goes on to say, ''I'm Brenda Pratt Shafer, a registered nurse with 13 years of experience.'' And she goes on to talk about being there. She said she thought this assignment would be no problem for her to work in this clinic because ''I am pro-choice, but I was wrong. I stood at the doctor's side as he performed the partial-birth abortion procedure and what I saw is branded in my mind forever.''

The mother is 6 months pregnant, the baby's heart beat was clearly visible on the ultrasound. The doctor went in with forceps and grabbed the baby's legs and pulled them into the birth canal. Then he delivered the baby's body and the arms—everything but the head. The doctor kept the baby's head inside the uterus. ''The baby's little fingers were clasping and unclasping and his feet were kicking.'' Then the doctor put the scissors through the back of the head, the baby's arms jerked out and the doctor opened up the scissors, stuck a high-powered suction tube into opening and sucked the baby's brains out. Now the baby was completely limp.

The last line, and I yield to the Senator, that the nurse said is particularly compelling: ''I never went back to that clinic. But I am still haunted by the face of that little boy—it was the most perfect angelic face I have ever seen.''

I yield to the Senator from Oklahoma whatever time he may consume.

Mr. INHOFE. First of all, Mr. President, I was not planning to make any remark, but as I was presiding a few minutes ago and listening to some of the arguments, I remember that yesterday I had an occasion to meet the registered nurse, Brenda Shafer.

What was impressed upon me was that she went into that position as an acknowledged pro-choice nurse. That was the way she felt. When she went through the experience that was just expressed by the Senator from New Hampshire in such an emotional way—I have a hard time listening to that and maintaining composure—she changed her whole philosophy because she saw a child, a living child, dying in their hands and she was in some way a part of that.

I wish there were a way of getting her on the Senate floor to tell the story she had to tell. I say to the Senator from Pennsylvania, I do not mean this in a personal way, but as I was presiding a few minutes ago, I have never been so thankful that I am not a lawyer, because to have to try to find provisions in the law where you can almost rejoice in saying we found a loophole so we can take this baby's life and expand this whole idea of abortion to someone who is just about to take that first breath. And, when you say perhaps we need—that is the subject of this discussion right now, submitting it to a committee, if we did that.

Let us just say the committee reported it out and it passed. Let us say it took 3 weeks, that is an average time for something like this. We are talking about 400 more of these little babies who would have this procedure done to them.

Then the Senator talked about, under the 10th amendment, this is, perhaps, something that should be addressed by the States. I have been a defender of the 10th amendment. I think it has been abused too much, and I agree this is something that should be approached on a State level. But during that period of time, you are not talking about 4 weeks, now. You are talking about months and years. To quantify that in lives—I have not done the math yet so I cannot do that. But if you see one of these procedures, then you do not have to quantify it because one is enough.

Then we talk about how much pain there is. This is something that is difficult to quantify, too. But when you have this procedure taking place, as was described in such an articulate way by the Senator from New Hampshire, you know there is pain. You know the pain would be unbearable. But there is a loophole in the law that allows us to inflict that pain.

My wife and I have four children and we have three grandchildren. Actually, our third grandchild is not yet born, but it is still a grandchild. I am looking forward to Christmas Day when he will be born.

I do not think there has ever been any woman who has gone through a pregnancy and has reached, say, the 9th month or 8th month and has not gone through some degree of depression during that time. Certainly my wife did. It is a very difficult thing to go through.

I think this particular procedure is one where these people can fall prey, because in the event you go through some type of depression and you want to have this procedure, think of what that person must go through the rest of her life if she realizes what she has done.

I will conclude by only saying, if we had read that someplace back in ancient history, in some barbaric land or sometime in our history, this procedure had been used to perform abortions or to kill young children, we would look back and say, how in the world, back in those paganistic days, could they have taken a life in such a cruel way?

I think history, 400 years from now or 500 years from now, will reflect back to this moment saying here this body met in a deliberative way to stop this barbaric practice.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, before yielding to the distinguished Senator from Maine, I want to make a few further comments.

I find the comment by the Senator from Oklahoma curious, to put it mildly, that he has never been so thankful he is not a lawyer.

I hope the Senator from Oklahoma never needs a lawyer. But if he does, he might like to have a lawyer, especially a good lawyer, to protect his interests and to protect his constitutional rights. Sometimes we lawyers help to get it right. This is not a matter for broad gestures and grandiose statements. We are dealing here with matters which involve the Constitution. Pardon me——

Mr. INHOFE. Does the Senator yield?

Mr. SPECTER. No. And, pardon me—and pardon me if we need a lawyer or judges to help interpret the Constitution of the United States, which protects the rights of all of us.

Now that I finished my sentence, I will be glad to yield if it is on the time of the opponents of the motion.

Mr. INHOFE. I do want to respond. I hope I have made it abundantly——

Mr. SPECTER. Is it on Senator SMITH's time? I will yield on Senator SMITH's time.

Mr. SMITH. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator from New Hampshire has 54 minutes 30 seconds.

Mr. SMITH. I yield the time.

Mr. INHOFE. Mr. President, I hope the Senator from Pennsylvania was listening when I said I mean nothing personal about it. I have a great deal of respect for him. When I talk about being thankful that I was not a lawyer at this time, I was talking about looking for ways, loopholes around this thing, so this procedure can take place.

I acknowledge to the Senator that on two occasions in my 60-year life I have needed lawyers and I was thankful to have them at that time.

Mr. SPECTER. If I may respond——

Mr. INHOFE. On your time.

Mr. SPECTER. I am not getting involved now, as to whether I take it personally or not. But it has not just been this lawyer. It is the whole profession. It is the whole profession that somehow comes into disrepute, not just when we are talking about tort reform or product liability or medical malpractice—we are talking about the Constitution.

How about those nine lawyers across the street, the Supreme Court of the United States? How about Justice Thomas? Did Justice Thomas ever need a lawyer? How about all those pro-life Justices whom this Senator has supported because, as a matter of principle, they are lawyers and they have some useful function to perform?

So, when the comment is made that this Senator is engaged in legalese—and now, Mr. President, I will go to my time because I want to respond to the Senator from New Hampshire—I am just a little concerned, candidly, about some of the personal invective.

When the Senator from New Hampshire says that the Senator from Pennsylvania does not even want to look to see this, he is wrong. As soon as he puts his chart up, I go down and take a look at it.

When the Senator from New Hampshire says, I don't care what Senator SPECTER says about—legal jargon, I would say to the Senator from New Hampshire two things. First of all, he ought to be concerned about the Constitution. If he wants to call that legal jargon and minimize it, that is up to him. But these are not unimportant matters.

And when the Senator from New Hampshire says that there are people who do not want to see this matter come to the vote, that he is ''sick and tired of the ducking,'' this Senator does not duck. I have proved that again and again and again.

When the Senator from New Hampshire says people do not want to come out here and vote their conscience, I object to that. I do vote my conscience. And I do not call the Senator from New Hampshire an extremist. I do not get involved in those pejorative, name-calling matters. But I do expect that there be an accurate representation, that I am not talking legalese when I start off and I say the first two considerations that I have are the humanitarian matters and the matters of the medical procedure. That is before I get to the Constitution, before I get to statutory interpretation. Not that those matters are insubstantial.

I have heard the Senator from New Hampshire say ''grisly'' three times and ''cruel'' four times and ''brutal'' and ''horrible'' and ''grotesque'' and ''sickening.''

This Senator is very concerned about that. This Senator also witnessed the birth of his two sons, and this Senator held the placenta of his older son right after his son was born. And this Senator has a grandchild. And, like the Senator from Oklahoma, this Senator has another grandchild expected in December. And I am very much concerned about the pain and suffering.

When the Senator from New Hampshire says that there is no anesthetic, no pain killer, he may be right. And if he is right, there ought to be something done about it. That ought to be done in terms of what this body takes into consideration in the law. If the Senator from New Hampshire is right that this is an unacceptable procedure, then let us not just limit it to the vaginal canal. Let us cover C sections or let us cover conditions before it gets to the vaginal canal, if the Senator from New Hampshire is right.

If he says this Senator changed the 45 days, that is not true. Others had talked about the 45 days. My staff had talked about the 45 days. They do not make decisions for me. When I took a look at it, I said we ought to do it as fast as possible. And I will be willing to do it in 9 days. Let the Senate report it back by a week from Friday.

But the fact is, we are going to be in recess for 10 days beyond that time. So the 10 days do not really hurt anyone. It may be necessary in the hearings to call some other witnesses. We may not be able to get it all done in the snap of a finger. It is a matter which may require some time. So what I want to do is find out what this case is all about, what this statute is all about, and what this medical procedure is all about. I do not want to have it decided on a poster with three sentences from two doctors. I want to hear what they have to say. I may have a question or two that I want to ask.

When the Senator from New Hampshire and the Senator from Oklahoma say when the time passes other children are going to be involved—they could have brought this matter to the floor last week, last month, last year if they want to legislate on the subject, if they are concerned about every day. And this Senator is concerned about every day. That is why I talked about 9 days plus the recess time. So that is what I want to accomplish.

I now yield 5 minutes to my distinguished colleague from Maine.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. SNOWE. Mr. President, first of all, I want to thank the Senator from Pennsylvania for offering this motion. I am pleased to join him as a cosponsor to commit this bill to the Judiciary Committee for where it should be so that we can hold hearings on this legislation. As a Member of the Senate, I think it is absolutely critical that we have a hearing on an issue that raises profound constitutional questions. As a woman, I believe the failure of this body to hold hearings on this legislation represents an appalling disregard for the life and health of the mother.

I am concerned that all of a sudden we are saying we do not need to have hearings on this very significant piece of legislation. We have heard that the House has had hearings. The House had debate. The House heard the proponents and the opponents of this legislation. The last time I checked this was the U.S. Senate. We are two distinct bodies, and we are entitled to hold our own hearings, to make our own decisions, to ask our own questions on this very, very important question.

To hear the debate, at times I think that people actually believe that women casually and blithely make this decision about having an abortion under any circumstances. It is a difficult decision, but even more so when we are talking about late-term abortions. They are rare. They are exceptional. They are there because a woman's health is in danger. So it makes this decision all the more tragic. And it certainly is a nightmare for the woman. It is not something that she just does casually.

I think it is unfortunate that many have made this sort of impression about how women arrive at their decision. Twenty-two years ago the U.S. Supreme Court issued a landmark decision in the form of Roe versus Wade. It carefully crafted and balanced that decision, and said that a woman's interest in making the decisions about her reproductivity is paramount. But it also said that imposed a liability; that the States had the right to prohibit abortion so long as they allowed an exception for when a woman and her health is in danger. That is an important exception that this legislation does not allow. No matter what the Senator from New Hampshire says, it does not allow it. Oh, sure. Offer it as an affirmative defense. Once the doctor performs this procedure the doctor ends up in court and then he has to prove that. That burden of proof is going to be enormous.

So that is what we are talking about. There is no exception for the doctor making that medical decision. So now we are saying in this climate today where the doctors have already been killed on the issue of abortion—with death threats, intimidation, and harassment—they are now saying you are going to face criminal prosecution because you performed a procedure in order to save the life of the mother. That is what we are saying in this legislation.

I think they say, ''Well, what are the alternatives to this?''—which is what we should be discussing in the hearings—but what are the alternatives? It is easy for them to say the alternative is a Caesarean section, which interestingly enough has four times the risk of death, or induce labor, or potentially a life-threatening disorder such as cardiac edema, a hysterectomy, which means a woman cannot have any more children.

So that is what we are talking about in terms of tradeoff in this legislation—the life and health of the mother in order to avoid criminal and civil prosecution of her doctor. That is how this legislation is structured.

I hope that we will give this matter serious regard and hearings because this is an unprecedented intrusion in what should be properly a decision made between the doctor and his or her patient on what is a very, very critical decision for a woman having to make in these rare instances. I emphasize that because these are rare instances. And when the Senator from New Hampshire says, ''Well, these are elective procedures, that 80 percent are elective,'' let us talk about that. There is no medical definition for ''elective.'' It is when someone has to make the decision.

For example, if a person had a heart attack and they are in a coma and somebody performed CPR, that is not

elective because they were not involved in the decision. But if a person went to a doctor and the doctor said you have a serious heart condition, if you do not go tomorrow to the hospital and have surgery, you will die, that is elective because that person has made the decision.

So I think that there has been a lot of misrepresentation. This is a serious issue. We should have hearings. I cannot understand why anybody would be afraid of the facts. Why are we so afraid of the facts? Why are we so concerned that we cannot in opposition have hearings and hear the facts, and everybody have a chance to speak before the legislative committee?

So I urge the Members of this Senate to support the motion made by the Senator from Pennsylvania.

Mr. SPECTER. Mr. President, how much time remains?

The PRESIDING OFFICER. Forty-eight minutes.

Mr. SPECTER. Mr. President, I yield 5 minutes to the distinguished Senator from Vermont, Senator JEFFORDS.

The PRESIDING OFFICER. The Senator from Vermont [Mr. JEFFORDS] is recognized for 5 minutes.

Mr. JEFFORDS. Mr. President, I rise today in support of the motion to commit the bill before us to the Judiciary Committee, and in defense of the constitutional right to privacy, as well as to protect the life of mother.

This bill has not been considered by any Senate committee, nor have Senators had the benefit of learning more about this bill from Senate hearings. It passed the House less than a week ago. I suggest that we need more time to study the broad-ranging implications of this bill. This motion suggests a time limit of 19 days, a very short time considering the complexity of this issue. But at least we will have an opportunity to learn more about what this procedure is, and why it is being utilized.

Mr. President, for the committee to consider and hold hearings on this far-reaching bill is of critical importance. I am disturbed by the misinformation that is floating around about this bill. This bill outlines a particular late-term abortion procedure subjecting the doctor who performs it to both criminal and civil suits. It matters not whether a procedure is medically necessary to save the life or health of the woman. That is the critical question here.

We all need to be clear about what exactly it is that we are not voting on today. We are not voting on whether or not we believe in the sanctity of human life. We are not voting on whether or not certain medical procedures can be described in grisly detail. We are not voting on whether or not we will intercede between pregnant women and their doctors to determine what medical procedures are or are not personally medically and ethically appropriate for all women in all circumstances. No. The women who have had these procedures speak passionately about their children, their families, and their sorrow at losing their pregnancy.

They also speak patiently in defense of keeping this procedure, this best of several difficult options for them and their families—to keeping it safe, available, and legal. Their lives were, and their lives are at stake.

This is an unprecedented intrusion into the practice of medicine. Congress has never before acted to ban any medical procedure. The American College of Obstetrics and Gynecologists, in writing about the bill—and I quote them:

> . . . does not support H.R. 1833, the Partial-Birth Abortion Ban Act of 1995. The college finds it very disturbing that Congress would take any action that would supersede the medical judgment of trained physicians and criminalize medical procedures that may be necessary to save the life of the woman.

Twenty-two years ago, the U.S. Supreme Court handed down a landmark decision, Roe versus Wade. The Court's decision established, under the right to privacy, a woman's right of self-determination in matters regarding her pregnancy and reproductive health, and I emphasize ''especially when her right to life is threatened.'' Since that time, we have seen many challenges to Roe in both Congress and in the courts, but the wisdom and structure of that decision has for the most part endured.

This bill has been designed as a direct challenge to that historic decision's protection of women's lives and health. While the decision acknowledged a State interest in fetuses after viability, the Court wisely left restrictions on postviability abortions up to the States. This strikes me as quite consistent with much of the legislation we have recently considered on many other matters, choosing to leave regulation to the States.

Roe versus Wade had a caveat, though, about these State-imposed postviability restrictions. States may not—may not—under any circumstances outlaw abortions necessary to preserve the life or health of the woman.

Also, subsequent Supreme Court decisions have held that States may not outlaw using specific abortion procedures in cases that endanger the woman's life or health.

These court decisions and, in my view, decency and common sense dictate that doctors must be able to put the welfare of their patient, the woman, first. Doctors must be able to use whatever procedure will, in their professional judgment, be safest for their patients.

This is a basic tenet of the practice and regulation of medicine in this country.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. JEFFORDS. There are expert professional licensing boards, accreditation councils, and medical associations that guide doctors' decision-making in the complicated and difficult matters of life and death. Let us continue to leave it to the professionals.

The PRESIDING OFFICER. Who yields time?

Mr. EXON addressed the Chair.

The PRESIDING OFFICER. Who yields to the Senator from Nebraska?

Mr. EXON. Will the Senator yield?

The PRESIDING OFFICER. Does the Senator from New Hampshire yield time? Who yields time to the Senator from Nebraska?

Mr. SMITH. I yield to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. EXON. I thank the Chair and I thank my friend. I have been following this debate with great and keen interest, and I have listened to the ''Nightline'' program last night that featured Senator BOXER and Senator SMITH. I have listened to the debate this morning as much as I could.

After the remarks just made by my great friend and colleague from Vermont, it leads me to ask this question which is troubling to this Senator. I have heard lots of remarks about people's experience in this regard in this Chamber. I do not know that I am a champion, but for 25 straight years I have been privileged to represent my constituents in high public office, and during that 25 years the matter of abortion keeps coming up again and again and again, and here we are again. It is one of these things that troubles America today. I am not sure that regardless of where you fall on the pro-life or pro-choice spectrum, anyone is always totally comfortable with their position. But we have to make these decisions, and therefore I think this is a very important vote.

As a father of three and a grandfather of eight, I have had some experience with regard to family and to family values that I hold very, very dear. From the very beginning on abortion, I have held, rightly or wrongly, that I was not in support of abortion except to save the life of the mother—underline that, save the life of the mother—or in promptly reported cases of rape or incest.

Now, a lot of people disagree with me, but at least that has been my position from the beginning all the way through these 25 years. What I come back to is the matter of conscience that I am very much dedicated to. So I ask this question of my friend and colleague from New Hampshire with regard to the saving the life of a mother.

I have heard the Senator from New Hampshire say on numerous occasions that if the life of the mother is in jeopardy, under the procedures that we are debating right now, there are provisions in the bill that would allow the doctor to proceed even with this late-term abortion, call it what you will, the doctor could do that if the doctor was convinced that this was the only procedure that would likely save the life of the mother if, indeed, the life of the mother was in danger.

Would the Senator from New Hampshire please explain to me if I have this correctly interpreted because it will be a key factor in the way I vote on this matter.

Mr. SMITH. I respond to the Senator from Nebraska by saying the Senator has it exactly right. There is a life-of-the-mother exception here. I will specifically refer to it in a moment. I would just say that in this process, this partial-birth abortion process, a lot of the medical experts that we have have indicated it is a very rare opportunity when the mother's life would be in danger, but if it is, we take care of that, and I will point that out in a second.

However, the issue here is that where you forcibly stop a birth by not allowing the head to be delivered, it would just seem to me, if the mother's life was threatened at that point, you would allow the baby to be born. Whatever happens to the baby after that, if your focus is on the mother, then let the baby be born. I cannot see how keeping the baby from being born and then going through the process that we have already described here helps or enhances the mother's health or life.

Mr. EXON. If I might interrupt then, if I understand what the Senator is saying, since for all practical purposes under the procedure outlined the birth has already taken place and therefore the mother's life could not be more in danger by allowing the head to emerge into the world—in other words, at this particular point it is not a test of whether or not the mother's life is in danger?

Mr. SMITH. At that point. Were that to be the case, then there are provisions here, and let me specifically refer to it so that the Senator will not have any concerns.

If it were to be the case—and I cannot imagine where it would be, but were it to be the case in subsection (e) of the bill, which we have here, it says that if a doctor reasonably believes that a partial-birth abortion is necessary to save the life of the mother, then he or she, that doctor, simply proceeds and cannot be convicted of the violation of the law, simple as that. So the life of the mother exception is there.

Again, I just want to point out that where you have a procedure that takes a period of 3 days, including dilation and anesthesia and all the things in preparation for this, the preparation is for the abortion so this is not an emergency as has been described on the floor by others in the sense there is some immediacy to save the life of the mother. Were there to be a complication—I am not a doctor, I do not want to interfere with the doctor-patient—this is a matter that the doctor would deal with and simply would not be convicted.

We have the right of self-defense. If someone broke into your home and you shot them, somebody could accuse you of murder, but you certainly were within your rights to do what you did to protect yourself, as a mother would be within her rights to protect her rights should this child, fetus, whatever, be an immediate threat to her life. We protect that.

Mr. EXON. I thank my friend for that explanation, and I thank him for yielding time to straighten this out to make sure I understood what I thought I understood. After listening to the Senator, I think that he has given me a satisfactory explanation of the legitimate concern in this Senator's mind.

Mr. SMITH. I appreciate the Senator's inquiry, and I am delighted to respond to it.

The PRESIDING OFFICER. Who yields time?

Mr. SMITH. Madam President, no one else at the moment is interested in time. How much time is remaining?

The PRESIDING OFFICER (Mrs. HUTCHISON). The Senator from New Hampshire has 47 minutes, 48 seconds.

Mr. SMITH. Madam President, I yield myself whatever time I may consume.

I just want to respond to a couple of points; they are minor points at this point in the debate. But in response to Senator SPECTER regarding this motion, we received a copy of a motion to commit with 45 days written on it. We came here today on the floor expecting to see that. Then it was changed to 19. It was crossed out. I will accept the Senator from Pennsylvania's word that he changed his mind or overruled his staff. That is fine. But this Senator received information from the Senator's staff that said 45 days, which would have delayed the bill on to the next year.

But regardless, in any case, the issue here is still dilatory and it is also the issue of killing the bill. You would have to not have any sense of humor whatsoever to not realize what is going on here.

There was a press conference yesterday with Kate Michelman.

Question: ''Do you have any read on the breakdown on the Judiciary Committee if it goes to the Judiciary Committee?'' [That is the bill.] ''And does it differ from the Senate as a whole? Do you have a better shot at getting the kind of changes you might want in it?''

Michelman: ''Which is our goal, is to have it end there.''

Question: ''What is the read on the committee makeup?''

Michelman: ''So the committee, the constitution of the Judiciary Committee and where we hope to see the demise of this legislation really is a mirror of the Senate as a whole. There—I think that there are some anti-choice Democrats, some pro-choice Republicans, but I think the committee—I don't remember the whole committee—but I would say it's going to be very close, a very close vote. But it does give us the possibility of really making some very important rational arguments, presenting some expert testimony that we won't have the opportunity to do if this bill comes up today in such a rush, a mad rush to pass this legislation.

''So I think there's a great chance of, again, having a more moderating influence over the House-passed legislation if we can get it to the committee today.''

In other words, it is to kill the bill. That is all there is to it. I respect the right of the Senate to defeat the bill. I respect that. Of course, I do. That is democracy. But I would also like to have Senators step up to the plate and vote yes or no.

I am going to again repeat that this Senate will vote on this before we go out for the Thanksgiving recess. We will vote on it on the debt limit, or on Bosnia, or on anything else that comes hear. The next vote that comes through here that I can get this on, it is going on if this thing goes to committee. We are going to vote on it because I want Senators on record either saying yes to this procedure or no to this procedure.

We are going to have that vote. I make that commitment. I promise you we will have this vote. So I am hopeful that we are not going to have this thing referred to committee to basically repeat a process that has been going on for weeks and weeks and weeks, months in the House of Representatives.

There has been plenty of materials written and plenty of studies, been plenty of hearings—a hearing in the House, markups, committee meetings, and so forth. So that is not the issue. If we were going to use as a prerequisite in the U.S. Senate not voting on anything that has never had a hearing, we could reduce the votes around here dramatically, believe me, probably by as much as 75 percent, because about 75 or 80 percent of our votes are on things we never had hearings on. So when it comes to something like this, one of the most important issues of our time, we want to shuffle it off to committee and try to kill it, because that is exactly what the goal is here as stated by Kate Michelman and other opponents of this bill.

Madam President, at this time I yield whatever time the Senator may consume to the Senator from Indiana.

Mr. SPECTER addressed the Chair.

Mr. COATS. I thank the Senator for yielding.

I wonder if my colleague from Pennsylvania has a question or——

Mr. SPECTER. No.

Mr. COATS. I would be happy to yield for a question.

Mr. SPECTER. I would be glad to withdraw my request for recognition.

Mr. COATS. Madam President, I thank the Senator from New Hampshire for yielding. I had asked him for some time, and I appreciate the opportunity to speak to this issue.

This is not a pleasant issue to debate on the Senate floor. It is not a comfortable issue to debate on the Senate floor, but we are not elected to come here just to discuss and debate pleasant issues. We are likely to face some

of the most difficult issues that the country has to face, face them honestly and openly, and in the end cast our position either for or against.

There probably is no issue that is potentially more divisive and certainly more emotional than the issue of abortion because it goes to the issue of the meaning of life itself. I am a pro-life Senator. I have argued on this floor a number of times that we, as a nation, as elected representatives of the American people, as individuals of conscience and conviction ultimately need to confront the issue of abortion, its impact on the question of life, and the meaning of life, to talk about the broader issue itself.

Advances in science and medical technology clearly will require that we will confront, both now and in the future, some ethical questions and some judgmental questions that are profoundly disturbing and profoundly important.

Science and medical technology reveals the unborn child as undeniably and uncomfortably human. We treat the unborn as a patient. We provide it with blood transfusions. We perform surgery. We know it is sensitive to pain. We know that it can be a victim of drug and alcohol abuse. And I think all of our best impulses are to reach out to help those that are considered the weakest in society.

Our history as a nation, our history as a Senate, has been to broaden access to participation in this wonderful experiment in democracy. Our history has been one of inclusion, not exclusion, and to try the find ways to incorporate into the human family ever-larger classes, to reach out to the disadvantaged and to the weakest. I find it somewhat ironic that some of the most outspoken, courageous, forward leaders of the movement of inclusion takes such a firm stand against inclusion of the weakest in our society.

And I think that is a debate that we have to pursue and continue. However the debate today is not on that issue. The debate today is on a much more specific medical procedure. It has been well-discussed on the floor, well-documented on this floor. It is difficult to discuss, difficult to view the graphic illustration of the procedure itself. Yet I think it is necessary. I will not repeat that graphic discussion.

But I think it is incumbent on every Senator before they vote to fully understand the medical procedure involved, fully understand just exactly what is taking place surgically and medically in the partial-birth abortion, or whatever term any Senator wants to place on this procedure. You do not have to call it partial-birth abortion. You do not have to label it at all. But it is extraordinarily important, I believe, for everyone to at least avail themselves of an understanding of what is taking place here medically, what the procedure is, because I think an understanding of this procedure, regardless of what label you give it, has to do more than just give us pause. It forces us to ask ourselves some very basic questions concerning whether or not we, as a society, have an obligation to state in law whether or not we condone or support such a procedure.

If this procedure were done in another country, we would not be standing here labeling it as a violation of human rights. If it were done in a war, we would call it a crime against humanity. But here we are trying to calmly, rationally discuss a procedure which is shocking in its description and which many have called descent into almost barbarism.

Madam President, I do not believe this is just another skirmish in the running debate between left and right. I believe this is an issue that raises some of the most basic questions that ought to be asked in any democracy: Who is my neighbor? Who is my brother? Who do I define as inferior and cast beyond my sympathy and beyond my protection? Who do I embrace and who do I value in both law and in love?

I do not believe this should be a matter of ideology. I think it is a matter and a question of humanity. It should not be a matter of what constituency we ought to side with. This is not just a matter of our Nation's politics, but a matter of our Nation's soul and how our Nation will be judged by God and by history.

In this body, we can agree and disagree on other matters of social policy, yet I think we ought to come together and agree on this: That a born child should not be subject to violence and to death. Surely, there is no disagreement on that. The question is, should an unborn child be subject to the same protection?

I hope that at least in this body we could come together, Republicans and Democrats, liberals and conservatives, and begin to define those situations in which an unborn, yet almost born, seconds from being technically born, but clearly a child defined by its physical appearance, defined by its medical condition, defined by its very aliveness can receive some protection from violence, can receive some protection which every other human being in this country receives.

Can we at least acknowledge there is a line that we will not cross, a line that we can say, ''While we may have disagreement over other aspects of when life begins, whether abortion is appropriate or not, at least here with this procedure, with this so obvious, visible view of the beginning at least of life that we will not terminate that, that we will refuse as a body to cross that line''?

This vote today is an opportunity to take a different path, an opportunity for Republicans and Democrats, liberals and conservatives, even for those who oppose abortion and those who support it, because by voting for this measure, we can begin to define some common ground: that every child born in America will be embraced by our community; that no one is expendable; that no one will be turned away from participation in this experiment in freedom and democracy.

We are faced with a vote in a short amount of time on a motion to commit. We have all participated in this exercise. We all know what it means. It means that we do not want to vote, we do not want to vote on the issue itself, we do not want to stand up and be counted on one side or the other; it is too politically sensitive, it is too uncomfortable, it is too difficult; I do not want to have to deal with this issue. So we are attempting to retreat to a time-honored procedural technique: We need to know more about this; we need to consign this to a committee so that they can study it and they can have hearings.

There is not anybody in this body who does not know what we are dealing with here. There is not anybody who has not had an opportunity to examine the medical procedure, to think through the question, to come to a conclusion. We are not elected to commit difficult issues, uncomfortable issues to an abyss of committee consideration that we know will paper over and delay and push a decision to some unknown point in the future. There is no lack of information available to Members. There are no unanswered questions outstanding relative to this procedure. All the materials are available for every Senator to look at and to discuss and to examine and to form a conclusion over.

So the motion to commit is what it is: It is a procedure to allow us to avoid dealing with an uncomfortable subject. Everyone needs to know that a motion to commit is simply an unwillingness to take a stand, to let people know where you stand.

There is nothing that is going to be gained by committing this to a committee so that they can deep six the issue. It is an issue we are going to be confronted with in the future anyway, so we might as well deal with it now. Let us have some courage to stand on our convictions one way or the other. Those who have spoken on the floor both for and against this procedure speak out of conviction. I am not here to question their motives. I accept their conviction. But we are not elected to avoid expressing that conviction by our vote. If cynicism exists in our electorate, it is because we keep playing these games.

The scriptural injunction is let your yea be yea and your nay be nay. Do we not at least have the courage to let our yea be yea and our nay be nay on the most fundamental question and issue probably facing this body, the very issue of the meaning of life? Are we going to take a pass? Are we going to say that is too tough for us to take? Are we going to say it is politically too sensitive?

Now, if we have learned anything about the opinion of the electorate toward this elected body, it is that it has

almost gotten to the point of dangerous cynicism about our ability to stand up and say what we believe and accept the consequences of that. I think what the public is looking for are some people with conviction one way or another, who are willing to stand up in front of a group of people back home and say, ''Look, this is what I believe. If you support that, I would like your vote. If you do not support that, that is fine, my life does not begin or end on whether or not I am elected to this office or any other office.'' But this is what I believe. We are not here to bide our time. We are here to express our convictions, as supported by the people in our States.

If this legislation is passed, it will mean that the circle of protection in our democracy begins to expand just a little bit more. We have brought in people of different ethnic backgrounds, different racial backgrounds, people with disabilities, an ever-expanding circle of protection provided by a democracy that promotes independence and liberty, but also guarantees the right to life.

This is a test of a just civilization. I think it is a standard by which each of us is going to be tested as well.

Madam President, I thank the Senator from New Hampshire for the time.

I yield the floor.

Mr. SPECTER. Madam President, before yielding to my colleague from Michigan, I want to make a few comments in response to what has been argued in opposition to the pending motion.

I agree with a good bit of what the distinguished Senator from Indiana just had to say, and I think that it is necessary to draw a line. I am prepared to do that. I must say that this Senator is not unwilling to take a stand. This Senator is not unwilling to have the courage of my convictions. I understand that I have been elected to take stands on tough issues and not to avoid expressing my views. And I concur that on the meaning of life, life does not begin or end on an election to the U.S. Senate. I have lost my share of elections, and I am prepared to do so in the future if my constituents do not agree with my views. I intend to express them forcefully and forthrightly.

But I point to the calendar here—if I may have the attention of the Senator from Indiana—as to what happened. This is not a matter of delay. This is not a matter to kill this bill in the Judiciary Committee. Whatever may be said by others—and the Senator from New Hampshire has quoted a Miss Michelman, who is not on the committee, and the idea to commit was ARLEN SPECTER's idea. My staff had a lot of ideas, like for 45 days, but we all know that sometimes Senators make their own decisions as to how we are going to proceed. The Senator from New Hampshire chuckles, and we agree on one item. Occasionally, it is healthy and helpful for Senators to make decisions instead of staffers.

So when the Senator from Indiana talks about sending this to an abyss, delay it until some unknown time in the future, that is not what is going to happen here. Under the express terms of the motion to commit, it has to be reported back and it has to be reported back, really, what is in 9 days of the life of the Senate. We would go out on recess on the 17th, so it is 9 days from today that we will be in session and 10 days when we come back, and it has to be reported on the 27th. It may be that in the interim, during Thanksgiving week, we will have hearings on that. I am prepared to do that in the Judiciary Committee. But it will be back in this Chamber, so that when the Senator from Indiana talks about the meaning of life, I am prepared to come to terms with that.

I would just like to know what the medical profession says about the pain and suffering, what the medical profession says about alternatives, if it is a C section, if it is not in the vaginal canal. I am not prepared to accept the debate on ''Nightline.'' I have been on ''Nightline,'' and sometimes on ''Nightline'' not a whole lot of usefulness is accomplished. So that when you have the sequence of events in the House of Representatives—this is really quite a sequence—I think we ought to focus on it.

This bill was introduced on June 14 in the House. The next day they had a 2½-hour hearing and did not get some medical experts on the other side of the issue. They marked it up the same day. That is on June 15. Then we know what our congressional schedule has been. It has been hectic, to put it mildly. We did have some time off in August and in September, and October we have been fully occupied on the reconciliation bill and the budget. Then it came up on November 1, where they voted. That is the state of the record. Now it comes to this body and we are asked to pass upon it without any hearing having been held. I have taken a look at the rules of the Senate—rule XIV and rule XV. It was only relatively recently in the life of the Senate that we have had no hearings on a bill. It used to be mandatory that the bill be referred under rule XXV. And now there is more latitude under rule XIV. But I question the propriety, or at least the wisdom if not the propriety, of putting this bill on the calendar for this kind of action. But I am not going to delay.

Mr. COATS. Will the Senator yield for an observation?

Mr. SPECTER. Yes, on the time of Senator SMITH.

Mr. COATS. My only observation is that the Senator indicated that a 45-day procedure is only 9 days of Senate time. Only in the U.S. Senate could an institution take 45 days to accomplish 9 days of work. I understand that is how this process works.

I thank the Senator for his explanation of the procedure in terms of the way this bill will be handled.

Mr. SPECTER. I thank my colleague from Indiana for those comments. I think we are entirely too dilatory around here. We had an issue that came to my Judiciary subcommittee on the Bureau of Alcohol, Tobacco and Firearms, and we had some problems with the Justice Department getting the witnesses in. We got them in and we did it in prompt time. Whenever we could find hearing days, we did it. We are about ready to issue a report. I think we ought to move with dispatch.

I am prepared to see us work on the Thanksgiving recess to come to terms here. When the Senator from New Hampshire says he is going to get a vote on it, he may or may not. This may be a matter of filibuster. I suggest we will not lose any time in this commitment.

I yield 5 minutes to the Senator from Michigan.

How much time remains on our side?

The PRESIDING OFFICER. The Senator has 36 minutes. There are 26 minutes on the other side.

The Senator from Michigan is recognized.

Mr. LEVIN. I thank my friend from Pennsylvania. I, too, think the Senate should vote, but only after there has been a reasonable length of time, and a few weeks is a reasonable length of time for the Judiciary Committee to consider and to report back to us on a number of very, very important issues in this case.

Under this bill, the Congress would be imposing a determination not of when an abortion may be performed, but of how it may be performed. The procedure addressed by this bill would be prohibited from being used even in the second trimester.

So this is a question of whether or not we should make a particular procedure criminal, whenever it is used. There are a number of important issues. Why have the States—with, I think, one exception—not criminalized this procedure? Under Roe versus Wade, States are given the authority to regulate abortions in the third trimester, except they cannot prohibit an abortion where the life or the health of the mother is at risk. Why have 49 States not made this particular procedure illegal, even in the third trimester?

The States are the place where Roe v. Wade says that abortion should be regulated in the third trimester, and yet with, I think, one exception States have left this particular procedure legal.

Now, this bill not only makes illegal and criminal a procedure that is not made criminal in all but one State, this bill leaves legal other procedures which can be used in the third trimester.

Are those other procedures as safe for the mother? Are those other procedures different in terms of the vividness as to the impact on the fetus? What are those other procedures? Why are they left legal, although at least

arguably, less safe for the mother, while one procedure, which in the eyes of many doctors is the safest for the mother, is made criminal?

Surely, it would be worth spending a few weeks to have a hearing in the Judiciary Committee to find out why one procedure is made criminal and other procedures are not. Other procedures, including inducing labor and delivery with drugs, is left legal despite the evidence of risk to the mother. Other procedures, including a Caesarean operation called a hysterotomy, is left legal even in the third trimester to save the life or protect the health of the mother.

Another procedure left legal by this bill is called standard D and E. This procedure does not deliver the fetus intact, but instead removes the fetus from the uterus piece by piece. Again, this procedure is left legal by this bill.

Should we not be told by the Judiciary Committee following a hearing from medical witnesses as to why other procedures, arguably in many cases apparently less safe for the mother, are left legal while this one procedure is made criminal, again, although all but one State has left the procedure at issue in this bill legal? That is worth finding out.

Of course, we should vote. I happen to agree with my good friend from Indiana; we should vote on this issue. But there is something else we should do. We should vote based on information from reliable and credible sources that have had an opportunity to present evidence at a hearing before a Judiciary Committee that can explore these kinds of issues.

There are other issues which I think we can usefully obtain some guidance on. One of those is the question of the affirmative defense. Of course, affirmative defenses have been approved by the Supreme Court in many cases but not in cases where there is a constitutional right as exists here, a right to have an abortion even in the third trimester where the life of the mother is involved.

We have a Congressional Research Service opinion on this issue. The Congressional Research Service has written us that cases that have permitted affirmative defenses have not permitted a Government to turn a constitutional right into an affirmative defense. If you have a constitutional right to an abortion to save the life of the mother, can we then make it a crime to provide such an abortion unless the doctor carries the burden of proof that he is acting constitutionally? Not according to the cases analyzed by the CRS.

Madam President, I ask unanimous consent that I have printed in the RECORD at the end of my statement the full report of the CRS on this issue and a Department of Justice letter that also addresses this issue.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. LEVIN. I simply say that there are a number of very important issues for which we should have at least some guidance and witnesses in a report from the Judiciary Committee. This is not a case of trying to evade an issue. It is a case of trying to deal with an issue based on a record of witnesses testifying on some very, very critical issues and some excruciatingly difficult issues for everyone.

In the situation we are discussing, the Supreme Court has ruled that the Constitution prohibits the Government from criminalizing abortions that are necessary to save the life of the mother. In the context of this bill Congress cannot constitutionally criminalize the abortion procedure at issue if such abortion were necessary to save the life of the mother.

The CRS memo explains it this way:

> In *Patterson* and *Martin* [the leading cases authorizing affirmative defenses in criminal cases], the Court specifically noted that the legislature was fully within its legislative authority to establish all the elements of the underlying offense, and that the defenses were established as affirmative grants to a defendant. As one commentator has indicated, a key factor in the Court's holding in *Patterson* was that the state could have constitutionally criminalized and punished the crime in question as defined, even absent the defense provided.

The opposite is true here. Under established law the Government cannot criminalize an abortion necessary to save the life of the mother. It would seem, therefore, that under the applicable Supreme Court cases, the Government must prove beyond a reasonable doubt that the mother's life was not at risk. It cannot, it would seem, shift its burden on this element of the case to the defendant the way the bill before us does. Surely we should at least have the benefit of a hearing to address this issue, and the benefit of a Judiciary Committee report.

Finally, even if an affirmative defense approach is allowed, the vagueness of the bill's affirmative defense language requiring the defendant to prove that no other procedure would suffice, leaves it unclear how a physician defendant would prove that no other procedure except intact D and E would have sufficed. What if the physician defendant could have performed another procedure that would have doubled the risk of death to the mother? Does that suffice? Under the bill before us, what is the measure of how much greater risk another procedure would or could impose on the mother's life in order not to suffice?

I don't think doctors facing criminal charges when acting to save a woman's life should face such uncertainties. But what do experts think? What does the Judiciary Committee think? Is it worth taking a few weeks to find out? I think so.

There are a number of serious issues raised by this legislation. We should send this bill to the Judiciary Committee for prompt hearings and report back. We should then vote. The impact of this legislation is potentially too grave to do less.

U.S. DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
Washington, DC, November 7, 1995.

Hon. ROBERT DOLE,
Majority Leader, U.S. Senate, Washington, DC.

DEAR MR. LEADER: This letter represents the Department's views on H.R. 1833, a bill that would ban what it calls ''partial-birth abortions.'' This legislation violates constitutional standards recently reaffirmed by the Supreme Court. Most significantly, the bill fails to make adequate exception for preservation of a woman's health. Even in the post-viability period, when the government's interest in regulating abortion is at its weightiest, that interest must yield both to preservation of a woman's life and to preservation of a woman's health. *Planned Parenthood* v. *Casey*, 112 S. Ct. 2791, 2804, 2821 (1992). This means, first of all, that the government may not deny access to abortion to a woman whose life or health is threatened by pregnancy. *Id*. It also means that the government may not regulate access to abortion 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 and Gynecologists*, 476 U.S. 747, 769 (1986) (invalidating restriction on doctor's choice of abortion procedure because could result in increased risk to woman's health). That is, the government may not enforce regulations that make the abortion procedure more dangerous to the woman's health. *Id.; see also Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 79 (9176) (invalidating ban on abortion procedure after first trimester in part because it would force ''a woman and her physician to terminate her pregnancy be methods more dangerous to her health than the method outlawed'').

If Congress were to ban this method of abortion, it appears that ''in a large fraction of the cases'' in which the ban would be relevant at all, *see Casey*, 112 S. Ct. at 2830 (discussing method of constitutional analysis of abortion restrictions), its operation would be inconsistent with this constitutional standard. It has been reported that doctors performing this procedure believe it often poses fewer medical risks for women in the late stages of pregnancy.[1] If this is true, then it is likely that in a ''large fraction'' of the very few cases in which the procedure actually is used, it is the technique most protective of the woman's health. Accordingly, a prohibition on the method, in the absence of an adequate exception covering such cases, impermissibly would require women to ''bear an increased medical risk'' in order to obtain an abortion.

H.R. 1833 would provide for an affirmative defense to criminal prosecution or civil claims when a partial-birth abortion is both (a) necessary to save the life of the woman, and (b) the only method of abortion that would serve that purpose. This provision will not cure the bill's constitutional defects. First, as discussed above, the provision is too narrow in scope, as it fails to reach cases in which a woman's health is at issue. Second,

[1] *See Hearings on H.R. 1833 Before the Subcomm. on the Constitution of the House Judiciary Comm.* (June 23, 1995) (statement of James T. McMahon, M.D., Medical Directive, Even Surgical Centers) (procedure shown to be safest surgical alternative late in pregnancy); *Id*. (June 15, 1995) (statement of J. Cortland Robinson, M.D., M.P.H.) (same); *see also* Tamar Lewin, *Wider Impact is Foreseen for Bill to Ban Type of Abortion*, The New York Times, November 6, 1995, at B7; Diane M. Gianelli, *Shock-Tactic Ads Target Late-Term Abortion Procedure*, American Medical News, July 5, 1993, at 3; Karen Hosler, *Rare Abortion Method Is New Weapon in Debate*, Baltimore Sun, June 17, 1995, at 2A.

the provision does not actually except even life-threatening pregnancies from the statutory bar. *Cf. Casey*, 112 S. Ct. at 2804 (even in post-viability period, abortion restriction must ''contain[] exceptions for pregnancies which endanger a woman's life or health''). Instead, the provision would require a physician facing criminal charges to carry the burden of proving, by a preponderance of the evidence, both that pregnancy threatened the life of the woman and that the method in question was the only one that could save the woman's life. By exposing physicians to the risk of criminal sanction regardless of the circumstances under which they perform the outlawed procedure, the statute undoubtedly would have a chilling effect on physicians;' willingness to perform even those abortions necessary to save women's lives.

Sincerely,

ANDREW FOIS,
Assistant Attorney General.

EXHIBIT 1

LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, DC, November 6, 1995.

To: Senator Carl Levin, attention: Peter Levine.

From: American Law Division.

Subject: Validity of requiring a defendant to bear the burden of persuasion regarding a constitutionally mandated defense.

This is to respond to your rush request to evaluate the validity of requiring a defendant to bear the burden of persuasion regarding a constitutionally mandated defense. Specifically, you requested an analysis as to the constitutionality of the requirement under S. 939[1] that, in order to avoid criminal liability, a defendant prove that the performance of a ''partial-abortion'' was necessary to save the life of the mother.[2]

H.R. 1833 provides that a person who performs a ''partial-birth'' abortion shall be fined or imprisoned not more than two years.[3] If the person can prove, however, that the ''partial-birth'' abortion was necessary to save the life of the mother, and that no other procedure would suffice for that purpose, then the person is relieved of criminal liability.[4] Under the proposed bill, the defendant must carry the burden of persuading the judge or jury of this defense by a preponderance of the evidence.

The Supreme Court has held that the Due Process Clause of the Fourteenth Amendment protects a defendant against conviction unless the government establishes every fact necessary to constitute the crime beyond a reasonable doubt.[5] The Court has extended this reasoning to provide that legislation may not impose a burden of persuasion upon a defendant regarding an element of a crime which the government is required under the relevant statute to prove as part of its case.[6] Thus, in the case of *Mullaney* v. *Wilbur*, the Court held that because the Maine homicide statute included a requirement of malice aforethought in order to obtain a murder conviction, that the government could not then require a defendant to carry the burden of disproving malice aforethought by showing that a killing occurred in the heat of passion.[7]

Two years later, however, the Court held that a state could require a defendant accused of murder to carry the burden of persuasion that the defendant had acted under the influence of extreme emotional disturbance. In *Patterson* v. *New York*, the Court distinguished the case by noting that the definition of murder under New York law merely required an intentional killing, and did not include a requirement of malice aforethought.[8] Consequently, the defense of extreme emotional disturbance did not go to disproving an element of the underlying crime, but was a separate issue which the defendant could be required to carry as the burden of persuasion.[9]

The Court reaffirmed this holding in *Martin* v. *Ohio*, noting that even if the elements of a case and a defense overlapped, that a statute which did not shift the full burden of that element to the defense would be valid.[10] In *Martin*, the Court upheld an aggravated murder statute which required that the government prove that the killing had been planned, but which also required a defendant pleading self-defense to carry the burden of proving self-defense.[11] The Court held that, because a defendant could theoretically have planned a murder but then have subsequently killed the victim in self-defense, the defense was not inherently inconsistent with an element of the crime.[12] Thus, the requirement that the defendant prove that the killing was in self-defense was upheld.

In the bill in question, it could be argued that the proposed crime of knowingly committing a ''partial-birth'' abortion, like the New York statute, simply forbids the intentional performance of the described procedure. Consequently, the proposed defense, that the procedure was necessary to save the life of the mother, does not appear to require the defendant to negate any of the elements of the proposed crime. Thus, the argument can be made that under *Patterson* and *Martin*, the affirmative defense requirement as set forth in S. 939 is constitutional.

It would appear, however, that the cases of *Patterson* and *Martin* can be distinguished. In *Patterson* and *Martin*, the Court specifically noted that the legislature was fully within its legislative authority to establish all the elements of the underlying offense,[13] and that the defenses were established as affirmative grants to a defendant.[14] As one commentator has indicated, a key factor in the Court's holding in *Patterson* was that the state could have constitutionally criminalized and punished the crime in question as defined, even absent the defense provided.[15] Thus, the question arises as to whether the Congress has the authority to pass S. 939 without including a defense for when a ''partial-birth abortion'' is necessary to save the life of the mother.

It would appear that Congress does not have the authority to punish a person for performing a ''partial-birth'' abortion which is necessary to save the life of a mother. In the case of *Roe v. Wade*, the Supreme Court held that the ''privacy'' interest of the Constitution limited the ability of a state to restrict a woman's ability to have an abortion during the first two trimesters, and provided that even in the third trimester a state could not restrict a woman from having an abortion that is necessary to preserve her life and health.[16] Consequently, it would appear that Congress could not pass a statute banning ''partial-birth'' abortions where such an abortion was necessary to save the life of the mother.

As the government would appear to be constitutionally required to include an exception for abortions to save the life of the mother, it can be argued that it is a required element of the government's case, and that the reasoning of *Patterson* and *Martin* does not apply. Consequently, should a court find that *Patterson* and *Martin* are distinguishable, it would appear that the government would be under an obligation to carry the burden of persuasion that a ''partial-birth'' abortion was not necessary to save the life of a mother, and that a requirement that a defendant carry such a burden would be unconstitutional.

KENNETH R. THOMAS,
Legislative Attorney, American Law Division.

FOOTNOTES

[1] 104th Cong., 1st Sess.

[2] This memorandum does not address the issue of whether the prohibition on ''partial-birth abortions'' contained in S. 939 is a violation of the right to privacy protected under the Fourteenth Amendment.

[3] S. 939, 104th Cong., 1st Sess. §2(a) & (b) provides the following:

(a) Whoever, 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.

(b) 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.

[4] S. 939, 104th Cong., 1st Sess. §2(e) provides the following:

(e) It is an affirmative defense to a prosecution or a civil action under this section, which must be proved by a preponderance of the evidence, that the partial-birth abortion was performed by a physician who reasonably believed. (1) the partial-birth abortion was necessary to save the life of the woman upon whom it was performed; and

(2) no other form of abortion would suffice for that purpose.

[5] *In Re* Winship, 397 U.S. 358, 364 (1969).

[6] Mullaney v. Wilbur, 421 U.S. 684, 701 (1974).

[7] 421 U.S. at 704 (1974).

[8] 432 U.S. 197, 212–16 (1976).

[9] 432 U.S. at 207 (1976).

[10] Martin v. Ohio, 480 U.S. 228 (1996).

[11] 480 U.S. at 230 (1986).

[12] 480 U.S. at 234.

[13] 480 U.S. at 233 (''[t]he State did not excess its authority in defining the crime of murder as purposely causing the death of another with prior calculation and design''); 432 U.S. at 197 (1976) (''[b]ut in each instance of a murder conviction under the present law, New York will have proved beyond a reasonable doubt that the defendant has intentionally killed another person, an act which it is not disputed the State may constitutionally criminalize and punish'').

[14] 432 U.S. at 197 (''[i]f the State nevertheless chooses to recognize a factor that mitigates the degree of criminality or punishment, we think the State may assure itself that the fact has been established with reasonable certainty).

[15] Paul Robinson, *Criminal Law Defenses* §5(b)(3)(1984).

[16] 410 U.S. 113, 163–64 (1972).

Mr. SPECTER. Madam President, I am delighted to yield 5 minutes to the Senator from Washington.

Mrs. MURRAY. Thank you, Madam President.

Madam President, I rise in strong support of the motion offered by my colleague from Pennsylvania, Senator SPECTER, to commit S. 939 to the Judiciary Committee for a public hearing. This legislation deserves full and comprehensive hearings before we vote on it, and I am very concerned about the implications of proceeding without the benefit of a full, open committee process.

I was very disturbed by the debate on this bill in the House of Representatives; the misinformation and factual distortions put forth by the proponents of this legislation were staggering. And, now here in this Chamber, there is an effort to bring the bill before the full Senate without first going through the traditional committee process.

There is no justification for moving ahead without fully examining the consequences of this bill. I appeal to my colleagues to send this bill to committee where we can hear from the public

Footnotes at end of article.

and the experts about its impact and ramifications.

Because, make no mistake, this bill has dangerous, far-reaching, and precedent-setting implications.

Madam President, this is the first time in our Nation's history that Congress is even attempting to get involved in telling physicians what medical procedures are and are not acceptable. And this is the first time in our Nation's history that Congress is considering banning an abortion procedure. This bill directly challenges the Supreme Court ruling, Roe versus Wade. And this bill carries with it severe consequences for the women of this country whose health and lives will be compromised, and possibly even sacrificed, to further the agenda of an extreme few.

I cannot imagine the U.S. Senate would railroad this bill through without a single public hearing. To do so would be an appalling disrespect for the legislative process, and for the lives and health of the women involved.

This legislation sets a dangerous precedent—it criminalizes doctors for performing a legal, rare, and medically necessary procedure. Surely, there is not a Member of this body who could defend the notion that a bill with this intent is not worthy of a committee hearing. Surely, I am not the only Member of this Senate with questions, concerns, and reservations.

I do not want to get into the details of this bill. We have all seen the graphic photographs; we have heard the vivid and disturbing rhetoric. But, what many of us haven't seen or heard are the tragic stories of the women who have lived through the tragedy of a difficult pregnancy, or of a life-threatening complication which required them to have this procedure.

And, many of us have not had the benefit of the facts—as presented by the doctors and health professionals who can set the record straight.

I have spoken with women who had no choice but to give up a baby they desperately wanted to have. I have listened to their tragic stories. And, I have heard from doctors who are angry and offended by the misrepresentation of facts and mischaracterization of a life-saving, emotionally traumatic medical procedure.

That is what is at issue here today; we have the ability to ensure access to accurate and complete information. We need to do the right thing, and let the public and all the Members of this body have a real opportunity to look at this bill, and examine what it will mean for doctors, for women, their lives and their health.

I urge my colleagues to vote for the Specter motion to commit, so that we can have the opportunity to fully understand what this bill means for our Nation. Madam President, it is the right thing to do.

I yield my time back to the Senator from Pennsylvania.

Mr. SMITH. How much time is remaining?

The PRESIDING OFFICER. The Senator from New Hampshire has 26 minutes and 30 seconds; the other side has 25 minutes.

Mr. SMITH. In just a moment I will yield to the Senator from Ohio.

I might just ask the Senator from Washington while she is here if she wishes to respond and answer a question on my time, I am happy to have her do it.

Does the Senator from Washington support an abortion for the purpose of sex selection? If a woman wanted to have an abortion because she was having a female baby, would the Senator from Washington say that she has a right to do that?

Mrs. MURRAY. I will comment on the time of the Senator from New Hampshire and respond to the question that that is not what is being debated on this floor.

The procedure that we are debating is a medical procedure that is done at the end of a pregnancy or midterm of a pregnancy when a woman's life is at stake. That is a critical decision that we have not had the information on to make a decision at this time.

Mr. SMITH. Assume she wants to make that decision herself, which you say she has the right to do because it is a female baby, is that all right?

Mrs. MURRAY. I respond to my colleague, the legislation in front of us has to do with women making a decision because of a medical procedure that is involved, not because of sex.

Mr. SMITH. I am willing respond to the Senator from Washington back on my time. She did not answer my question, of course, which is typical in this debate. This is not a medical procedure that deals with the life of a woman. This is a medical procedure—it is a procedure that takes the life of a child.

We have had all kinds of testimony here on the Senate floor saying how one can explain to me—I have not had it explained to me yet—why preventing a fetus from being born, literally restraining the fetus from coming into the world, how that helps the life or protects the life of the mother? I am intrigued by the fact that no one will answer that question. Senator BOXER refused to answer it last night on "Nightline," and we see it not answered again today on the floor.

I will, at this time, yield 5 minutes to the distinguished Senator from Ohio.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. DEWINE. Madam President, I have had the opportunity to listen to this debate on the last 2 days. I will try very briefly to respond to a couple of points that have been made on the other side.

Yesterday, the senior Senator from Massachusetts very eloquently said the proponents of this bill employ terminology that is not recognized by the medical community. He said that the term "partial-birth abortion" is not found in medical school textbooks or in medical schools. I would say he is absolutely correct. I guess he and I come to a different conclusion, though, as to what relevance this has.

The Senator is correct. This procedure does not have an official medical name. The medical schools do not have a name for it. The medical textbooks do not have a name for it and doctors do not call it by that name. That really is exactly the point. The reason medical authorities do not have a name for it and the reason schools do not teach it is because the procedure is so inappropriate, so medically unnecessary, so bad that the medical community never had a reason to name it.

The doctors, the healers, will not even give it a name. They will not put it in their textbooks. They will not described it in their medical journals. It is so bad, in fact, that in September the American Medical Association, council on legislation, described the procedure as "basically repulsive," and voted unanimously this procedure was "not a recognized medical technique." That is why the procedure should clearly be banned.

Let me turn to another point that has been brought up by my friend and colleague from Maine as well as my friend and colleague from Michigan, that has to do with the affirmative defense issue.

It was stated earlier today by my colleague from Maine that having the affirmative defense in this bill creates an enormous burden on the defense. I respectfully disagree. It does not create an enormous burden. In fact, we have over 30 examples in the code, in the Federal Code, where the affirmative defense is used.

I know, as a former prosecutor at the State level and county level, it is used in virtually every State in the Union. The burden it places on the defense is a very, very low burden. It says, basically, in those instances where the defense has a unique capability of knowing and understanding the facts of what this defense would be, it is peculiarly in the knowledge of that person, that they then, after the prosecution has proven everything beyond a reasonable doubt, they have to prove by a preponderance of the evidence, the defendant does, which basically means it is more likely than not, that the procedure was in fact reasonable.

If you do not do it this way and if you place it into the statute, do not have an affirmative defense but put the exception in the statute, what it means is the prosecution would have to prove beyond a reasonable doubt that the partial-birth abortion was not necessary to save the life of the mother and would have to prove beyond a reasonable doubt that it was not true that no other procedure would suffice for that purpose. So this is, in the law, a commonly accepted way of dealing with this particular issue.

Let me conclude, if I could, by commenting on some of the debate I have heard. It seems to me the debate on the other side of the issue has really been

stretching, really been reaching to try to justify this procedure. Maybe a more fair way of describing their argument is not that they were trying to justify the procedure—because I really did not hear very much of that, if any of that—but rather that we just should not talk about it, we just should not deal with it.

My reaction to that, to my pro-choice friends, is simply this. Even if you are pro-choice, is there some limit to what a civilized society will accept? Is there not something that you view as so bad, so repulsive that in limited cases we say no, you simply cannot do this?

Let me just say that we spent a lot of time on this floor. I think my colleague from New Hampshire did a great job of stripping away the rhetoric and getting to the facts of this procedure. I would like to do the same thing about this motion to commit. Let no one who comes on this floor in the next hour and votes have any misconception about what this vote is about. This is not a procedural vote. It may be technically a procedural vote but what it really is, is a vote on the merits. This is the vote. This is the defining moment. As we vote, I would simply ask my colleagues to recall—particularly my colleagues on the other side of the aisle—one of my favorite quotes.

Madam President, I ask unanimous consent for 1 additional minute?

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator is recognized for 1 additional minute.

Mr. DEWINE. Hubert Humphrey, in 1977, defined the proper role of Government. This is what he said. I think, when you listen to this, it summarizes very well what this debate is all about.

> It was once said that the moral test of government is how that government treats those who are in the dawn of life, those who are in the twilight of life, and those who are in the shadow of life—the sick, the needy, the handicapped.

That is what this debate and vote is all about. This is a vote that we will be casting on the merits. It is not just a procedural vote. This vote will determine whether or not this bill moves forward or does not.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SPECTER. Madam President, I agree totally with the Senator from Ohio, there should be no misconception what this vote is about. And it is not to eliminate the bill. It is to send it to committee where there has been no hearing, and to do so for 9 days plus another 10-day recess. That is what the vote is about.

I agree totally with the Senator from Ohio about having a civilized society. What we are trying to do is to figure out what is an appropriate course in terms of humanitarian considerations on this matter. There was a colloquy earlier today about whether there was an exception for the life of the mother. I submit that the answer given by the Senator from New Hampshire to the question by the Senator from Nebraska was not correct. A number of Senators have raised this with me in the interim.

I have sent for the statute which shows how you make it an exception. In the current bill there is not an exception for the life of the mother. It is an affirmative defense, which is totally different. The way you provide an exception for the life of the mother is the way it was done in Public Law 103–333, on September 30, 1994, as follows:

> None of the funds appropriated under this Act shall be expended for any abortion except [then some irrelevancies] that such procedure is necessary to save the life of the mother * * * That is the way to provide an exception on the life of the mother, not by having it as an affirmative defense.

Before yielding to the distinguished Senator from Kansas, Madam President, I inquire as to how much time remains?

The PRESIDING OFFICER. The Senator from Pennsylvania has 23 minutes.

Mr. SPECTER. How much time would the Senator from Kansas like?

Mrs. KASSEBAUM. Madam President, if I could have 4 minutes.

Mr. SPECTER. So granted.

The PRESIDING OFFICER. The Senator from Kansas is recognized for 4 minutes.

Mrs. KASSEBAUM. Madam President, I heard earlier today on the floor that those of us who would support the amendment to commit to the Judiciary Committee are not willing to take a stand. I would like to just say that I do not believe that is the case. This has always been a very difficult and troubling issue. But most of us have taken a stand. For myself, I have always believed abortion should be legal. I also think there should be restrictions. But I have always been really very concerned when the life of the mother and the life and health of the mother are at stake.

In Kansas, we have a law which bans third trimester abortions except for the health and the life of the mother. I do not have a problem with that personally, and I support the Kansas law, but there is an exception for the life and the health of the mother. Those are rare cases, and they should be rare cases.

It was debated here earlier between Senator EXON and Senator SMITH about whether there really is an exception for the life of the mother. I would suggest there is not an exception for the life of the mother. There is an affirmative defense after the doctor has been charged with criminal action. The burden of proof then would be on the doctor, as I understand it, at that point. So there is not an exception. There is merely a matter of legal procedure with affirmative defense.

I believe that is an important distinction, Madam President, because I think we here in the Congress cannot get into trying to determine medical procedures, no matter how tragic it appears. That should be left to the medical community, and with the consultation of the mother, the family, and the doctor.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition?

Mr. SMITH. Madam President, I yield 5 minutes to the distinguished Senator from Texas, Senator GRAMM.

The PRESIDING OFFICER. The distinguished Senator from Texas, Senator GRAMM.

Mr. GRAMM. Madam President, let me thank you for the recognition.

I want to begin by congratulating our dear colleague, the senior Senator from New Hampshire. I want to thank him for his leadership on this issue.

I first spoke on this issue when I came over to the floor of the Senate to speak on another issue. The distinguished Senator from New Hampshire was talking about partial-birth abortions. He was explaining how the process worked in its total gruesome details, and another Senator rose and talked about how offended that Senator was by the description that Senator SMITH had given. I felt compelled at that point to make what I think is the relevant point. If we are offended by the description of this brutal, violent act that the Senator's bill seeks to stop in America, should we not also be offended that the act is occurring? If the description of the act is offensive to us, then the fact that it is happening to living babies should be doubly offensive to us.

I think this is a very fundamental issue, Madam President. We have all heard the distinguished Senator from New Hampshire describe the partial-birth abortion, but it really comes down to this: This is a baby that is several inches away from the protection of the law. This is a baby that is in the process of being delivered. Only its head remains in the birth canal. It is several inches away from being protected by the law and by the Constitution as currently interpreted by the courts. And at this very moment, when the decision is life or death, this abortion process occurs which terminates the life of the child and crushes its skull. This is a process that I believe is offensive to any civilized society.

So the issue we are debating here, it seems to me, can be reduced down to a very simple issue. This is an act that any civilized society should find offensive. Even those who support allowing this to occur are offended by its description.

I believe America and the civilized world should be offended by the fact that it is occurring in our country. I think no civilized society can condone this action. I think it is very clear that if this bill is sent to the committee, it is going to be killed. We have an opportunity, since the House has acted by an overwhelming vote, to adopt this bill and to send it to the President.

I want to urge my colleagues to vote against the effort to send this bill to a

committee where we will not see it again, where we will not have the opportunity to vote on it again, and where the righteous indignation of a civilized people will be thwarted because we do not take action to stop what we know is wrong and unacceptable in a civilized society.

I want to conclude, Madam President, by again congratulating Senator SMITH. I think it took great political courage to raise this issue. I think it is always very difficult when you are talking about the kind of act that we are debating here today. It is offensive. It is hard to talk about. I do not feel comfortable talking about it. But most importantly, I do not feel comfortable about the fact that it is happening in the United States of America. That is the point.

If it is hard for us to talk about in the environment of the greatest deliberative body in the history of the world, it seems to me that it ought to be hard for us to continue to condone. I do not condone it. I want it to stop. And that is why I am going to vote for the Smith bill. That is why I am going to vote against this motion to kill it.

I believe this bill should be passed, and we, as a civilized nation, should say no to these partial-birth abortions.

Thank you, Madam President.

Mr. SPECTER. Madam President, if the Senator from California seeks recognition, she may have 5 minutes of our time. But first let me inquire how much time remains.

The PRESIDING OFFICER. The Senator has 20 minutes and 40 seconds.

Mr. SPECTER. I yield 5 minutes to the Senator.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. BOXER. Thank you very much, Madam President. I want to thank the Senator from Pennsylvania for offering us this very sensible amendment.

We have never in this Senate voted to outlaw a medical procedure. We have never, never voted to outlaw a medical procedure. When I was debating this issue with the Senator from New Hampshire, yes, we voted to outlaw the mutilation of the genitals of a girl. We voted a sense of the Senate. I was glad to do that. That is a battery; that is not a life-saving procedure. We have never voted to ban a life-saving procedure. And if that is what we are going to do, we are going to become physicians, and we are going to go down that slope.

We ought to have a hearing and have people who know what they are talking about appear before the Judiciary Committee, which is very fairly divided between people who vote pro-choice and people who vote anti-choice.

So what is before us is a bill to outlaw a medical procedure that is rare, that is used in the most tragic circumstances. It is not used for sex selection.

Let me repeat that. It is not used for sex selection. It is not used as a whim. It is not used because a woman at the end of her pregnancy said, ''You know, maybe I shouldn't have done that.''

It is a dangerous procedure, a late-term abortion. It is a rare thing that happens. To make it look like it is a whim is a great disservice to the families of this country, deeply religious families often, that are faced with these terrible circumstances.

In Roe v. Wade, the judges in their wisdom knew that late-term abortion was a different situation, and so they gave the States full authority to regulate late-term abortions. And what are we doing? We are stepping right in, big brother. And of course, it was most of my friends on the other side who said let the States decide everything else. They even voted to repeal nursing home standards, Federal nursing home standards because the States know better. But now they are saying we are going to step over all of these State laws and get into the operating room and tell a doctor that he or she cannot use an emergency procedure.

There is no exception in this bill for life of the mother. I tell my friends to turn to page 3. We have made exception for life of the mother before in Medicaid funding. This is an affirmative defense. In other words, you arrest the doctor, charge him if he uses the procedure, and then you tell him:

> Oh, yes, Doctor. By the way, when you are in court, you can use as a defense the fact that this was your only choice, and you have to show a preponderance of evidence and that there was no other procedure.

Very nice. Very nice way to treat someone who has just saved a life. My friend from Ohio quoted Hubert Humphrey. I love Hubert Humphrey. I just got a Hubert Humphrey award. I am so proud of that. The shadow of life, we must think of someone in the shadow of life, and a woman whose life is threatened is in the shadow of life. Whether that call comes in to any Senator here, I say to my friends, think about it, that it is your daughter. I am a grandma, and we have a lot of grandmas and grandpas here. It is your baby; it is your daughter who is going to have a child, and the doctor calls in the middle of the night and says, ''There is a horrible emergency. If I do not end this pregnancy, you will lose your child''—your baby.

I got a call yesterday during the debate from a woman from Santa Barbara who said, ''Remind these Senators that I have a baby''—yes, she is 36 and she got pregnant—''she is always going to be my baby, and we had to make that horrible choice.''

People like Viki Wilson, a registered nurse, a practicing Catholic, and her husband, Bill, a physician, were the parents of two children and planning a third. In the 8th month of pregnancy, they found out the baby's brain was growing outside the skull. The brain was twice the size of her actual head and lodged in Viki's pelvis.

May I have unanimous consent for 2 additional minutes off Senator SPECTER's time.

The PRESIDING OFFICER (Mr. THOMPSON). Without objection, it is so ordered.

Mrs. BOXER. The brain was twice the size of her actual head and lodged in Viki's pelvis, causing pressure on what little brain the baby had. If Viki had carried Abigail to term—yes, they had a name for the baby—Viki's cervix could not have expelled Abigail. Viki's cervix would have torn or ruptured causing massive hemorrhages and possible infection, and, yes, Viki would have been in the shadow of life. And if Viki was your daughter and the call came in, you would say to the doctor, ''Did you do everything? Are you sure? Did you check? Did you doublecheck? Is there another way? Can we save the baby? Can we do an operation to save the baby?'' And if the answer came back no, I believe in my heart, subject to anyone who wants to say anything different, that, yes, you, as a United States Senator, would say, ''By the grace of God, save my child.''

The PRESIDING OFFICER. The Senator's 2 minutes have expired.

Mrs. BOXER. We should support the Senator from Pennsylvania. He is rational about this. Let us bring forward the people who know about this and then let us vote.

I thank my friend.

Mr. PELL. Mr. President, in recent weeks, there has been much press attention given to a heretofore obscure procedure used to terminate late-term pregnancies. With this attention has come substantial public distress and alarm regarding the nature of this procedure, a discomfort that indeed, I share and understand. I must certainly agree that the procedure, as described by the proponents of the pending legislation, is repugnant on its face and one that is hopefully resorted to in only the rarest circumstances.

But today as the Senate considers legislation to ban the use of this procedure, we must make sure that our deliberations are thoughtful, reasoned, and considered.

It is very unfortunate that we are here debating this bill without having the benefit of the normal, established procedure of committee referral, hearings, and review from which a comprehensive record would have evolved detailing the pros and cons of the many complex and controversial issues at stake. This is particularly troubling because the issue at hand is so divisive and charged with emotion that, absent a thorough airing of the issues involved, it would be all too easy to retreat to a position on doctrinaire certitude and defiantly declare normal victory regardless of whether or not it is appropriate public policy.

The Senate has a long and established tradition of careful deliberation precisely because of its rules and procedures for legislating such difficult issues with thorough and adequate review. It is only rarely that we circumvent those procedures and then

only when the matters are noncontroversial and relatively noncomplex.

Here, the bill was introduced and not referred to any Senate committee. Consequently, no hearings have been held in the Senate despite a myriad of questions that need to be answered about the bill's provisions. These include: What are the alternatives? What are the ramifications for other abortion procedures as a consequence of the current vague definitions in the bill? Is it wise or desirable to create a Federal criminal statute governing medical procedures? I believe that it would be premature to attempt to come to a conclusion about whether to support or oppose this legislation without having the answers to these and other troubling questions.

Therefore, I intend to support the motion to refer this legislation to the Judiciary Committee where I hope it will be thoroughly reviewed and made the subject of public hearings to discuss the issues involved. At that point, the Senate will have a much more adequate record than it does now upon which it can make the reasoned, careful decision that is incumbent upon us as elected representatives to make.

Mr. KERRY. Mr. President, the U.S. Government is one of the least intrusive governments in the world. We pay the lowest taxes of any industrialized country. We have a constitution that guarantees an extensive list of freedoms upon which the government cannot infringe. Many believe that one of the causes of the 1994 election results was a desire by the public to minimize government's role in the everyday lives of its citizens. Yet Senators have brought a bill to the floor that would require women to risk their lives.

Perhaps the sponsors of this bill do not understand the issue at hand. The Supreme Court has ruled that abortions are legal. It is completely legal for a woman who wants to have an abortion to obtain the services of a doctor who is willing to provide an abortion. Now we as a legislature are going to start decreeing to both pregnant women and their physicians which procedures a woman can choose? This is not our role. We are not obstetricians, and we should not insert ourselves in this picture.

Yet proponents of this bill come to the floor to introduce legislation that would force women whose lives are most at danger, whose fetuses are usually malformed in some way, to either endure the painful and life-threatening procedure of birth or to endure another form of abortion that may be more dangerous or painful. This is tantamount to torture and I am appalled that we are standing here debating this issue.

But I know why we are here. In fact, every Member of this body knows why we are here. We are here because abortion opponents are exploiting this painful, rare surgical procedure to try to convince the public that all abortions are similar to this procedure.

Mr. President, any surgical procedure is disgusting if described to a layman. I could stand here and describe any number or legal medical procedures and probably convince someone out there that the procedure sounds terrible and wrong. But describing and discouraging a legal medical procedure is not my job. I could also stand here and describe the horrible details of a birth of a malformed fetus that kills both the fetus and the mother and does so in the worst and most chilling fashion. But unlike others who have held this floor, I see no benefit to scare tactics.

Mr. President, proponents of this bill hope that this bill and the proceedings surrounding it will further stigmatize abortion and humiliate women who have had or who may someday have legal abortions. They also hope to chip away one piece at a time the constitutional right to terminate a pregnancy. Theirs is an unbecoming effort.

I believe this effort will fail. I believe that the public knows more and is more perceptive than this bill's proponents think. I urge my colleagues to stand in opposition to this bill. Send it to the Judiciary Committee when it can be properly analyzed.

Mr. CRAIG. Mr. President, there are very few issues that provoke the kind of passionate debate abortion policy continues to provoke. It's unfortunate the debate has deteriorated into pro-choice and pro-life labels because, in reality, it is a hugely significant conflict over when life begins and what life comprises. That's perhaps why it divides people along unpredictable lines; even in my State of Idaho, people of like political beliefs can take different positions on this issue.

I mention this because today we are dealing with an aspect of the abortion issue that even causes divisions among those who generally find abortion acceptable. What we saw in the House of Representatives just a few days ago demonstrated this. The overwhelming vote in support of the bill included many who usually identify themselves as pro-choice.

Let me repeat that: Even those who accept abortion found this particular procedure so objectionable they voted in favor of banning it.

A ban is an extraordinary step for Congress to take—but then, this is an extreme and hideous abortion procedure. We've heard it described in detail; we've seen diagrams that those performing this procedure have certified to be accurate. And Mr. President, I have seen strong men and women look away, to avoid dealing with the reality of this procedure.

I urge any of my colleagues who have reservations about this bill to take the time to understand exactly what's involved. Then you will understand why even abortion proponents draw the line here.

To put it simply, we're talking about causing and then stopping a delivery, to kill a baby mere inches and seconds before he or she is protected by our laws as a living human being.

Some would like to defend this procedure by claiming it is only used when the life of the mother is at stake or when the baby is shown to have genetic deformities. However, the testimony from those who perform these late-term abortions contradicts these arguments. Even Dr. Martin Haskell, who originated the technique, estimated as many as 80 percent of the procedures he performed were elective, not for genetic or life-saving reasons.

It's important to note that this bill contains an exception for situations in which the life of the mother truly is at stake and no other procedure can save it. Those who are honestly worried about this issue should be reassured. But it's also important to note that this procedure is hardly risk-free to the mother; medical professionals agree it poses dangers to both the lives and the future reproductive health of the women involved.

Mr. President, we all are thankful for today's life-saving advances in medical technology. It's appalling to think this particular procedure twists those advances in a legalistic game, with a human life in the balance.

In closing, I urge all my colleagues not to let political labels blind them to the facts. This radical, barbaric procedure goes much too far. Let's draw the line here, now, and pass the Partial-Birth Abortion Ban Act.

Mr. ABRAHAM. Mr. President, during the debate on the partial-birth abortion ban, opponents have made claims about this procedure and this legislation that simply are not supported by the facts. I ask unanimous consent that a fact sheet by the National Right to Life entitled ''Partial-Birth Abortions: A Look Behind the Misinformation'' and a letter from Barbara Bolsen of the American Medical News along with the accompanying material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

PARTIAL-BIRTH ABORTIONS: A LOOK BEHIND THE MISINFORMATION

(Congress is currently considering legislation that would place a national ban on the partial-birth abortion method (H.R. 1833, S. 939). The bill was approved by the House Judiciary Committee on July 18. Pro-abortion lobbying groups have made claims regarding this abortion method, and about the legislation, that are contradicted by substantial evidence. Yet, some of these erroneous claims have been uncritically adopted by various editorial commentators and reporters. This factsheet addresses some of the major disputed issues. All documents quoted in this factsheet may be obtained from the National Right to Life Committee, Federal Legislative Office, (202) 626–8820)

WHAT TYPE OF ABORTION IS BANNED BY H.R. 1833/S. 939?

H.R. 1833 is sponsored by Congressman Charles Canady (R–Fl.), with 150 House cosponsors. The companion bill, S. 939, is sponsored by Senator Bob Smith (R–NH). The

purpose of the legislation is to ban those abortions that are performed by (1) partially delivering a living fetus into the vagina, and then (2) killing him or her. Under the bill, this method of killing a human fetus/baby could only be used if there was no other way to save a woman's life.

The bill is aimed at the basic method described and practiced by Dr. Martin Haskell of Dayton, Ohio, and Dr. James McMahon of Los Angeles—and by some other abortionists who have not chosen to widely publicize the fact.

The Los Angeles Times accurately described this abortion method in a June 16 news story: ''The procedure requires a physician to extract a fetus, feet first, from the womb and through the birth canal until all but its head is exposed. Then the tips of surgical scissors are thrust into the base of the fetus' skull, and a suction catheter is inserted through the opening and the brain is removed.''

In 1992, Dr. Haskell wrote a paper on this abortion method, which was sent out to members of the National Abortion Federation (those being abortionists and abortion clinics). The paper (''Dilation and Extraction for Late Second Trimester Abortion'') described in detail, step-by-step, how to perform the procedure, which Dr. Haskell said that he employed beginning at 20 weeks—4½ months in layman's parlance—through 26 weeks into pregnancy. (Dr. McMahon uses essentially the same procedure to a much later point—in some cases, to 40 weeks, which is full term.) [1]

Dr. Haskell's ''how-to-do-it'' paper was obtained and publicized by the National Right to Life Committee. The National Abortion Federation (NAF) quickly claimed that NRLC was making distorted claims about the procedure. During the course of investigating this controversy, the American Medical News—the official newspaper of the American Medical Association—in 1993 conducted tape-recorded interviews with both Dr. McMahon and Dr. Haskell. These interviews originally were quoted in an article titled ''Shock-tactic ads target late-term abortion procedure,'' which appeared in the July 5, 1993 edition of American Medical News. The American Medical News article is often quoted by supporters of the proposed legislation; the article is cited several times in this factsheet.

Recently, for the first time, the National Abortion Federation and Dr. Haskell attempted to disavow some of the most revealing quotes from the article. In response, on July 11, 1995, American Medical News released transcripts of the portions of a tape-recorded 1993 interview to prove that Dr. Haskell was indeed quoted accurately on certain key points (e.g., that ''80%'' of the partial-birth abortions he performs are ''purely elective''), and that the fetuses are usually alive when he performs the procedure on them.

ACTIONS BY THE AMERICAN MEDICAL ASSOCIATION

On September 23, the national Council on Legislation of the American Medical Association (AMA) voted unanimously to recommend AMA endorsement of the Partial-Birth Abortion Ban Act (H.R. 1833). (Congress Daily, Oct. 10.) The Council on Legislation is made up of about 12 physicians of different specialities, who are charged with studying proposed federal legislation with respect to its impact on the practice of medicine. According to an October 23 letter from AMA headquarters in Chicago, ''The AMA Board of Trustees has determined that it will not take a position on H.R. 1833 at this time.''

THE CASE OF VIKI AND ABIGAIL WILSON

Critics of the bill have relied heavily on the personal account of Viki Wilson, whose unborn daughter Abigail died at the hands of Dr. McMahon during the ninth month of the pregnancy. Abigail's brain had developed partly outside of her skull. Setting aside for the moment all that might be said about the ethics of what was done to Abigail, the procedure utilized in this case, if performed as described in published accounts quoting Mrs. Wilson, would not be banned by the Partial-Birth Abortion Ban Act. That is because the baby's life was ended before the baby was moved into the birth canal (according to Mrs. Wilson); under the bill, this is not a ''partial-birth abortion.'' Moreover, Mrs. Wilson has asserted that continuing the pregnancy ''possibly'' would have endangered her life. H.R. 1833 allows a physician to utilize the defined procedure on the basis of a reasonable belief that no alternative medical intervention would save the mother's life.

HOW MANY PARTIAL-BIRTH ABORTIONS ARE PERFORMED?

Dr. Haskell said in his 1992 paper that he begins using the procedure at 20 weeks (4½ months). There are 13,000 abortions annually after 4½ months, according to the Alan Guttmacher Institute (New York Times, July 5, 1995), which should be regarded as a conservative estimate. The National Abortion Federation now says that Drs. McMahon and Haskell between them perform about 450 such abortions every year. [2]

Both practitioners have been enthusiastic advocates for the method; Dr. Haskell's paper explains in detail how to perform it, and Dr. McMahon is director of abortion training at a major teaching hospital. There is no way to know how many other abortionists are now using the method, but without writing papers or giving interviews on the subject as Drs. Haskell and McMahon have done. The National Abortion Federation acknowledges that the method is probably employed at times by other practitioners, and the 1993 American Medical News report spoke of ''a handful of other doctors'' employing the method. In short, there is insufficient information on which to base a reliable estimate of how many partial-birth abortions are performed in the United States.

Even with respect to Drs. Haskell and McMahon alone, the figure of ''450'' may be low. Dr. McMahon has circulated literature in which he refers to having performed a ''series'' of ''more than 2,000'' abortions by the method. However, in the article by Karen Tumulty that appeared in the January 7, 1990 issue of Los Angeles Time Magazine, Dr. McMahon was quoted as saying, ''Frankly, I don't think I was any good at all until I had done 3,000 or 4,000,'' referring to abortions ''in later pregnancies.'' That article also reported that Dr. McMahon performs 400 ''later abortions'' a year. In literature he has circulated seeking abortion referrals, Dr. McMahon strongly advocates the partial-birth method for later abortions, so presumably most of his late abortions are being done using this method.

As for Dr. Haskell, he said in his 1992 paper that he had performed ''over 700'' such abortions.

His wife recently told an Ohio paper that he performs ''less than 200'' a year.

Defenders of partial-birth abortions often stress that they are ''a small percentage'' of all abortions. Yet, for each individual, unique human being who ends up at the pointed end of the surgical scissors, each such procedure is a 100 percent proposition.

SHOULD THE PROCEDURE BE CALLED THE ''PARTIAL-BIRTH ABORTION METHOD,'' OR BY SOME OTHER TERM?

In his 1992 paper, Dr. Haskell referred to the method as ''dilation and extraction'' or ''D&X''—noting that he ''coined the term.'' However, that nomenclature is rejected by Dr. McMahon, who refers to the method as ''intact dilation and evacuation'' and (in an interview in the Los Angeles Times Magazine in 1990) as ''intrauterine cranial decompression.'' There are also some variations in the procedure as performed by the two doctors. Dr. Haskell's 1992 paper refers to Dr. McMahon's approach as ''a conceptually similar technique.''

Some critics of the bill, such as the National Abortion Federation (a trade association of abortion providers) complain that the term ''partial-birth abortion'' is ''a non-medical term,'' is ''inaccurate,'' and is ''offensive and upsetting.'' They also insist that it is ''vague.'' It is quite evident, however, that NAF's problem with the term ''partial-birth abortion'' is not that it is too vague, but precisely that it is much too explicit. They prefer euphemistic pseudo-medical jargon that conveys nothing substantive regarding the nature of the procedure.

However, none of the terms that the abortion practitioners prefer would be workable as a legal definition. The bill creates a legal definition of ''partial-birth abortion,'' and would ban any variation of that method—no matter what new idiosyncratic name any abortionist may invent to refer to it—so long as it is ''an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

Congress establishes such legal definitions all the time—often, in ways not entirely pleasing to the industries or practices being regulated. For example, by act of Congress, firearms that incorporate certain specified features are now legally defined as ''assault weapons,'' even though manufacturers, gunsmiths, and users refer to these same firearms in other fashions. Likewise, if H.R. 1833/S. 939 is enacted, abortions that involve partial vaginal delivery of a live baby, followed by killing, will be legally defined as ''partial-birth abortions,'' even if apologists for late-term abortions would continue to prefer a term that is not so explicitly descriptive.

Beyond the legal point, the term ''partial-birth abortion'' is accurate and in no way misleading. In explaining how to perform the procedure in his 1992 instruction paper, Dr. Martin Haskell wrote: ''With a lower [fetal] extremity in the vagina, the surgeon uses his fingers *to deliver* the opposite lower extremity, then the torso, the shoulders and the upper extremities.'' [Haskell paper at page 30, emphasis added]

Dr. J. Courtland Robinson, a self-described ''abortionist'' who testified on behalf of the National Abortion Federation at a June 15 hearing before the House Judiciary Constitution Subcommittee, said, ''Never in my career have I heard a physician who provides abortions refer to any technique as a 'partial-birth abortion.'" But Dr. Robinson's objection seems a mere quibble in light of his later testimony: ''In our tradition we have other terms. I am surprised the word 'partial-extraction' was not used. This is a standard term in obstetrics that we use for delivering. That [term] could have been used.''

Professor Watson Bowes of University of North Carolina at Chapel Hill School of Medicine, co-editor of the Obstetrical and Gynecological Survey and a leading authority on maternal and fetal medicine, wrote in a letter dated July 11, 1995: ''The term 'partial-

birth abortion' is accurate as applied to the procedure described by Dr. Martin Haskell in his 1992 paper entitled 'Dilation and Extraction for Late Second Trimester Abortion,' distributed by the National Abortion Federation. . . There is no standard medical term for this method. The method, as described by Dr. Haskell in his paper, involves dilation of the uterine cervix followed by breech delivery of the fetus up to the point at which only the head of the fetus remains undelivered. At this point surgical scissors are inserted into the brain through the base of the skull, after which a suction catheter is inserted to remove the brain of the fetus. This results in collapse of the fetal skull to facilitate delivery of the fetus. From this description there is nothing misleading about describing this procedure as a 'partial-birth abortion,' because in most of the cases the fetus is partially born while alive and then dies as a direct result of the procedure . . . ''

IN WHAT CIRCUMSTANCES ARE PARTIAL-BIRTH ABORTIONS PERFORMED?

Misinformation: The New York Times (June 19, 1995): ''[H.R. 1833/S. 939 is] a bill to outlaw one of the rarest types of abortions—a highly specialized procedure that is used in the latter stages of pregnancy to abort fetuses with severe abnormalities or no chance of surviving long after birth.'' National Public Radio Morning Edition (July 14, 1995): ''Anti-abortion groups call it partial-birth abortions . . . Doctors resort to this rare procedure only for late-term abortions if the fetuses have severe abnormalities and no chance of survival.''

Critique: Alarmed by the progress of H.R. 1833 in Congress, lobbying groups representing the abortion industry and pro-abortion advocacy groups have recently claimed that the partial-birth abortion method is used mainly in rare circumstances involving danger to the life of the mother or very grave disorders of the fetus. Many editorial writers and columnists (e.g., Ellen Goodman, Richard Cohen) have uncritically embraced such claims. So have some reporters, such as those quoted above. Indeed, the NPR assertion that the procedure is used ''only . . . if fetuses have severe abnormalities and no chance of survival'' is an even more egregiously erroneous statement than the claims made by the abortion-clinic lobby itself.

In truth, there is ample documentation to establish that many—indeed, most—partial-birth abortions do not involve ''severe abnormalities and no chance of survival'' or danger to the life of the mother.

In 1992, after NRLC's publicizing of Dr. Haskell's paper engendered considerable controversy, the American Medical News—the official newspaper of the AMA—conducted a tape-recorded interview with Dr. Haskell, in which he said: ''In my particular case, probably 20% [of this procedure] are for genetic reasons. And the other 80% are purely elective.''

This single statement from Dr. Haskell's own lips shreds the most widely disseminated piece of disinformation regarding partial-birth abortions. But there is much more.

Dr. James McMahon—who has performed at least 2,000 of these procedures—told American Medical News that he also uses the method to perform what he calls ''elective'' abortions up to 26 weeks (six months). Moreover, after the 26-week point, Dr. McMahon said, he uses the method to perform ''non-elective'' abortions (all the way to 40 weeks, which is full term). In materials provided in June to the House Judiciary Constitution Subcommittee, Dr. McMahon revealed that his definition of ''non-elective'' is extremely expansive. For example, he listed ''depression'' as the largest single ''maternal indication'' for such so-called ''non-elective'' abortions.

Dr. McMahon's materials also show that he uses the method to destroy ''flawed fetuses,'' as he calls them. These include unborn humans with a wide variety of disorders, including conditions compatible with a long life with or without disability (e.g., cleft palate, spina bifida, Down syndrome). True, some of the babies have more profound disorders that will result in death soon after birth. But these unfortunate members of the human family deserve compassion and the best comfort-care that medical science can offer—not a scissors in the back of the head. In some such situations there are good medical reasons to deliver such a child early, after which natural death will follow quickly.

After conducting interviews with Dr. McMahon, reporter Karen Tumulty wrote in the Los Angeles Times Magazine (January 7, 1990): ''If there is any other single factor that inflates the number of late abortions, it is youth. Often, teen-agers do not recognize the first signs of pregnancy. Just as frequently, they put off telling anyone as long as they can.''

It is also noteworthy that when NRLC originally publicized the partial-birth abortion procedure in 1993, the then-executive director of the National Abortion Federation (NAF) distributed an internal memorandum to the members of that organization which acknowledged that such abortions are performed for ''many reasons'': ''There are many reasons why women have late abortions: life endangerment, fetal indications, *lack of money or health insurance, social-psychological crises, lack of knowledge about human reproduction, etc.*'' [emphasis added]

Likewise, a June 12, 1995 letter from NAF to members of the House of Representatives noted that late abortions are sought by, among others, ''very young teenagers . . . who have not recognized the signs of their pregnancies until too late,'' and by ''women in poverty, who have tried desperately to act responsibly and to end an unplanned pregnancy in the early stages, only to face insurmountable financial barrier.''

DOES THE BILL MAKE ALLOWANCE FOR JEOPARDY TO THE LIFE OF THE MOTHER?

The bill contains a provision under which a doctor could utilize the partial-birth abortion method if no other medical procedure would suffice to save the mother's life. Eminent medical authorities, including Prof. Watson Bowes of the University of North Carolina at Chapel Hill and Dr. Pamela Smith, head of the obstetrics teaching program at Mt. Sinai Hospital in Chicago, have said that no such case would ever arise—nevertheless, the bill makes allowance for such a circumstance. In a letter to Congressman Charles Canady (R-Fl.), prime sponsor of HR 1833, Prof. Bowes said: ''Critics of your bill who say that this legislation will prevent doctors from performing certain procedures which are standard of care, such as cephalocentesis (removal of fluid from the enlarged head of a fetus with most severe form of hydrocephalus) are mistaken. This procedure is not intended to kill the fetus, and, in fact, is usually associated with the birth of a live infant . . . [Also,] the technique of the partial-birth abortion could be used to remove a fetus that had died in utero of natural causes or accident. Such a procedure would not be covered by the definition in your bill, because it would not involve partially delivering a live fetus and then killing it.''

ARE THE DRAWINGS OF THE PARTIAL-BIRTH ABORTION METHOD CIRCULATED BY NRLC ACCURATE, OR ARE THEY MISLEADING?

Misinformation: On June 12, the National Abortion Federation—an association of abortion providers—sent a letter to House members in which NAF claimed—on the authority of Dr. J. Courtland Robinson of Johns Hopkins Medical School—that the drawings of the partial-birth abortion procedure distributed by Congressman Canady in a letter to House members were ''highly imaginative'' and ''misleading.'' These drawings had earlier been distributed by the National Right to Life Committee.

Critique: Three days after the mailing of the letter quoted above, Dr. Robinson testified before the House Judiciary Constitution Subcommittee, representing the National Abortion Federation. However, under questioning from subcommittee chairman Rep. Charles Canady, Dr. Robinson admitted he had not to that day even read Dr. Martin Haskell's unique 1992 paper describing how to perform the procedure. Questioned by Mr. Canady about the drawings—which were displayed in poster size next to the witness table—Dr. Robinson agreed that they were ''technically accurate,'' and added: ''That is exactly probably what is occurring at the hands of the two physicians involved.''

Moreover, American Medical News (July 5, 1993) reported: ''Dr. Haskell said the drawings were accurate 'from a technical point of view.' But he took issue with the implication that the fetuses were 'aware and resisting.'

Professor Watson Bowes of the University of North Carolina at Chapel Hill, wrote in a letter to Congressman Canady: ''Having read Dr. Haskell's paper, I can assure you that these drawings accurately represent the procedure described therein. Furthermore, Dr. Haskell is reported as saying that the illustrations were accurate 'from a technical point of view.' Firsthand renditions by a professional medical illustrator, or photographs or a video recording of the procedure would no doubt be more vivid, but not necessarily more instructive for a non-medical person who is trying to understand how the procedure is performed.''

IS THE BABY ALREADY DEAD BEFORE BEING PULLED INTO THE BIRTH CANAL DURING THE PROCEDURE?

In the partial-birth abortion method, a woman visits the abortion clinic on three successive days. On the first two days, her cervix (the opening to the uterus) is mechanically dilated with materials called laminaria. The baby is removed on the third day. American Medical News reported in 1993, after conducting interviews with Drs. Haskell and McMahon, that the doctors ''told AM News that the majority of fetuses aborted this way are alive until the end of the procedure.''

Recently, after introduction of the proposed federal ban, Dr. Haskell and NAF for the first time disputed this and other revealing quotes in the American Medical News story. In response, the editor of American Medical News sent a letter to the Judiciary Committee, dated July 11, stating: ''AM News stands behind the accuracy of the report. . . . We have full documentation of these interviews, including tape recordings and transcripts.'' She also released the transcript of the tape recording of the pertinent portions of the interview with Dr. Haskell. The transcript contains the following exchange:

American Medical News. Let's talk first about whether or not the fetus is dead beforehand.

Dr. HASKELL. No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress—intrauterine stress during, you know, the two days that the cervix is being dilated [to permit extraction of the fetus]. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken. And

so in my case, I would think probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not.

In another interview, quoted in the Dec. 10, 1989 Dayton News, Dr. Haskell again conveyed that the scissors thrust is usually the lethal act: ''When I do the instrumentation on the skull * * * it destroys the brain tissue sufficiently so that even if it (the fetus) falls out at that point, it's definitely not alive, Dr. Haskell said.''

On July 9, 1995, Brenda Pratt Shafer, R.N., sent a letter Congressman Tony Hall (D-Ohio), in which she related her experience as a nurse whose agency assigned her to work at Dr. Haskell's Dayton abortion clinic in 1993. Nurse Shafer said she had no difficulty accepting the assignment because she was strongly ''pro-choice.'' But she quit after witnessing three partial-birth abortions close up. ''It was the most horrifying experience of my life,'' she wrote.

Here''s how Nurse Shafer described the end of the life of one six-month-old ''fetus'': ''The baby's body was moving. His little fingers were clasping together. He was kicking his feet. All the while his little head was still stuck inside. Dr. Haskell took a pair of scissors and inserted them into the back of the baby's head. Then he opened the scissors up. Then he stuck the high-powered suction tube into the hole and sucked the baby's brains out. I almost threw up as I watched him do these things.''[3]

That the babies are generally alive at the time of their ''extraction'' is further supported by the account of an eyewitness very sympathetic to Dr. McMahon: Dr. Dru Elaine Carlson, who is a perinatologist and director of Reproductive Genetics at Cedars-Sinai Medical Center in Los Angeles. In a June 27, 1995 letter to Congressman Henry Hyde opposing the bill, Dr. Carlson wrote: ''Since I refer Dr. McMahon a large number of families, I have gone to his facility and seen for myself what he does and how he does it * * * Essentially he provides analgesia for the mother that removes anxiety and pain and as a result of this medication the fetus also is *sedated*. When the cervix is open enough for a safe delivery of the fetus he uses altrasound guidance to gently deliver the fetal body up to the shoulders and then very quickly and expertly performs what is called a cephalocentesis. Essentially this is removal of cerebrospinal fluid from the brain *causing instant brain herniation and death*'' [emphasis added]

It is impossible to reconcile eyewitness accounts such as those of Nurse Shafer and Dr. Carlson with the claim made by NAF in a July 27 letter to Congress that ''fetal demise does in fact occur early on in the [three-day] procedure.''

DOES THE BABY FEEL PAIN DURING THE PARTIAL-BIRTH ABORTION PROCEDURE?

In his 1992 paper, Dr. Haskell says that he performs the procedure after giving the woman ''local anesthesia'' and nitrous oxide (''laughing gas''), neither of which would prevent pain in the baby.

Dr. McMahon says in a June 23 written submission to the House Judiciary Constitution Subcommittee: ''The fetus feels no pain through the entire series of procedures. This is because the mother is given narcotic analgesia at a dose based upon her weight. The narcotic is passed, via the placenta, directly into the fetal bloodstream. Due to the enormous weight difference, a medical coma is induced in the fetus. There is a neurological fetal demise. There is never a live birth.''

The New York Times (July 5, 1995) interpreted this statement by Dr. McMahon to mean that the drug causes ''brain death'' in the baby, which does indeed seem to be the impression that Dr. McMahon attempts to convey. But his claim cannot survive critical scrutiny.

Dr. Watson Bowes, an internationally recognized authority on maternal and fetal medicine, is a professor of both obstetrics/gynecology and pediatrics at the University of North Carolina at Chapel Hill School of Medicine. In a July 11 letter, Professor Bowes wrote: ''Dr. James McMahon states that narcotic analgesic medications given to the mother induce 'a medical coma' in the fetus, and he implies that this causes 'a neurological fetal demise.' This statement suggests a lack of understanding of maternal/fetal pharmacology. It is a fact that the distribution of analgesic medications given to a pregnant woman result in blood levels of the drugs which are less than those in the mother. Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know that they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die. . . . Although it is true that analgesic medications given to the mother will reach the fetus and presumably provide some degree of pain relief, the extent to which this renders this procedure pain free would be very difficult to document. I have performed in-utero procedures on fetuses in the second trimester, and in these situations the response of the fetuses to painful stimuli, such as needle sticks, suggest that they are capable of experiencing pain.''

In June 15 testimony before the House Judiciary Constitution Subcommittee, Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, said: ''The fetus within this time frame of gestation, 20 weeks and beyond, is fully capable of experiencing pain.'' Prof. White analyzed the partial-birth procedure step-by-step and concluded: ''Without question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure.''

DOES THE BILL CONTRADICT SUPREME COURT PRECEDENTS?

In written testimony submitted to the House Judiciary Constitution Subcommittee, David Smolin, a professor at Cumberland Law School at Samford University, testified that he believed that the Partial-Birth Abortion Ban Act could be upheld even under the Supreme Court precedents that block most government limitations on abortion. ''The spectre of partially delivering a fetus, and then suctioning her brains, may mix the physician's disparate roles at childbirth and abortion in such a way as to particularly shock the conscience. . . . It is possible that at least some of the fetuses killed by partial-birth abortions are constitutional persons. The Supreme Court in *Roe* v. *Wade* held that the word 'person', as used in the Fourteenth Amendment, does not include the unborn.'' The Court, however, has never addressed the constitutional status of those who are ''partially born.'' [Prof. Smolin's complete testimony is available on request.]

However, pro-abortion advocacy groups insist that even the partial-birth abortion procedure is completely protected by *Roe* v. *Wade*. If this is true, it will be news to a lot of people—and it is a powerful argument for re-examining *Roe* v. *Wade*.

ENDNOTES

[1] Unfortunately, some lawmakers and some other observers demonstrate bias or ''denial mechanisms'' that resist exposure even to impeccable documentation. For example, after sitting through a July 12 House Judiciary Committee meeting in which many of the documents quoted herein were cited and circulated, Associated Press reporter Nita Lelyveld wrote, ''Opponents of the bill say the scissors method is very rare if it exists at all.'' Actually, however, not even the National Abortion Federation has been audacious enough to suggest that the ''scissors method'' may not ''exist at all.'' Dr. Haskell's readily available paper, which has been provided to Ms. Lelyveld and other reporters, refers five times to the use of scissors. For example, Dr. Haskell writes, ''the surgeon forces the scissors into the base of the skull.'' The scissors are described as a Metzenbaum surgical scissors, which is about seven inches long.

[2] Some press accounts have mistakenly reported that the bill would affect only ''third-trimester'' abortions. In fact, the bill would ban use of the partial-birth abortion method in either the second or the third trimester of pregnancy. It is noteworthy that there is a dispute over how many third-trimester abortions, by all methods, are performed every year. American Medical News (July 5, 1993) reported. ''Former Surgeon General C. Everett Koop, MD, estimated in 1984 that 4,000 *third-trimester* abortions are performed annually. The abortion federation [National Abortion Federation] puts the number at 300 to 500. *Dr [Martin] Haskell says that 'probably Koop's numbers are more correct.'* '' *[Emphasis added]*

[3] At a July 12 meeting of the House Judiciary Committee, Congresswoman Patricia Schroeder (D-Co.) charged, based on a July 12 letter from Dr. Haskell, that Brenda Shafer had never worked at the clinic. Rep. Schroeder abandoned this charge (although without apology) after committee members were provided with copies of the bill sent to Dr. Haskell's clinic by the nursing agency, which contained the nurse's license and social security numbers. Dr. Haskell's letter also disputed Shafer's account of witnessing abortions at 25 and 26½ weeks because, he claimed, he observes a ''self-imposed and established limit of 24 weeks.'' But Dr. Haskell's own 1992 paper, explaining how to perform the procedure, said that he employs the method from 20 to 26 weeks into pregnancy.

AMERICAN MEDICAL NEWS,
Chicago, IL, July 11, 1995.

Hon. CHARLES T. CANADY,
Chairman, Subcommittee on the Constitution, Committee on the Judiciary, House of Representatives, Washington, DC.

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

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

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

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

Let me also note that in the two years since publication of our story, neither the

organization nor the physician who complained about the report in testimony to your committee has contacted the reporter or any editor of AMNews to complain about it. AMNews has a longstanding reputation for balance, fairness and accuracy in reporting, including reporting on abortion, an issue that is as divisive within medicine as it is within society in general. We believe that the story in question comports entirely with that reputation.

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

Respectfully yours,

BARBARA BOLSEN,
Editor.

Attachment.

AMERICAN MEDICAL NEWS TRANSCRIPT

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

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

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

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

AMN. I mean, you couldn't dilate further? Or is that riskier?

HASKELL. Well, you could dilate further over a period of days.

AMN. Would that just make it . . . would it go from a 3-day procedure to a 4- or 5-?

HASKELL. Exactly. the point here is to effect a safe legal abortion. I mean, you could say the same thing about the D&E procedure. You know, why do you do the D&E procedure? Why do you crush the fetus up inside the womb? to kill it before you take it out?

Well, that happens, yes. But that's not why you do it. You do it to get it out. I could do the same thing with a D&E procedure. I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. He point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

AMN, wrapping up the Interview. I want to make sure I have both you and (Dr.) McMahon saying 'No' then. That this is misinformation, these letters to the editor saying it's only done when the baby's already dead, in case of fetal demise and you have to do an autopsy. But some of them are saying they're getting that misinformation from NAF. Have you talked to Barbara Radford or anyone over there? I called Barbara and she called back, but I haven't gotten back to her.

HASKELL. Well, I had heard that they were giving that information, somebody over there might be giving information like that out. The people that staff the NAF office are not medical people. And many of them when I gave my paper, many of them came in, I learned later, to watch my paper because many of them have nver seen an abortion performed of any kind.

AMN. Did you also show a video when you did that?

HASKELL. Yeah. I taped a procedure a couple of years ago, a very brief video, that simply showed the technique. The old story about a picture's worth a thousand words.

AMN. As National right to Life will tell you.

HASKELL. Afterwards they were just amazed. They just had no idea. And here they're rabid supporters of abortion. They work in the office there. And . . . some of them have never seen one performed.

Comments on elective vs. non-elective abortions:

HASKELL. And I'll be quite frank: most of my abortions are elective in that 20–24 week range . . . In my particular case, probably 20% are for genetic reasons. and the other 80% are purely elective . . .

[From the American Medical News, July 5, 1993]

SHOCK-TACTIC ADS TARGET LATE-TERM ABORTION PROCEDURE—FOES HOPE CAMPAIGN WILL SINK FEDERAL ABORTION RIGHTS LEGISLATION

(By Diane M. Gianelli)

WASHINGTON.—In an attempt to derail an abortion-rights bill maneuvering toward a congressional showdown, opponents have launched a full-scale campaign against late-term abortions.

The centerpieces of the effort are newspaper advertisements and brochures that graphically illustrate a technique used in some second- and third-trimester abortions. A handful of newspapers have run the ads so far, and the National Right to Life Committee has distributed 4 million of the brochures, which were inserted into about a dozen other papers.

By depicting a procedure expected to make most readers squeamish, campaign sponsors hope to convince voters and elected officials that a proposed federal abortion-rights bill is so extreme that states would have no authority to limit abortions—even on potentially viable fetuses.

According to the Alan Guttmacher Institute, a research group affiliated with Planned Parenthood, about 10% of the estimated 1.6 million abortions done each year are in the second and third trimesters.

Barbara Radford of the National Abortion Federation denounced the ad campaign as disingenuous, saying its "real agenda is to outlaw virtually all abortions, not just late-term ones." But she acknowledged it is having an impact, reporting scores of calls from congressional staffers and others who have seen the ads and brochures and are asking pointed questions about the procedure depicted.

The Minneapolis Star-Tribune ran the ad May 12, on its op-ed page. The anti-abortion group Minnesota Citizens Concerned for Life paid for it.

In a series of drawings, the ad illustrates a procedure called "dilation and extraction," or D&X, in which forceps are used to remove second- and third-trimester fetuses from the uterus intact, with only the head remaining inside the uterus.

The surgeon is then shown jamming scissors into the skull. The ad says this is done to create an opening large enough to insert a catheter that suctions the brain, while at the same time making the skull small enough to pull through the cervix.

"Do these drawings shock you?" the ad reads. "We're sorry, but we think you should know the truth."

The ad quotes Martin Haskell, MD, who described the procedure at a September 1992 abortion-federation meeting, as saying he personally has performed 700 of them. It then states that the proposed "Freedom of Choice Act" now moving through Congress would "protect the practice of abortion at all stages and would lead to an increase in the use of this grisly procedure."

ACCURACY QUESTIONED

Some abortion-rights advocates have questioned the ad's accuracy.

A letter to the Star-Tribune said the procedure shown "is only performed after fetal death when an autopsy is necessary or to save the life of the mother." And the Morrisville, Vt., Transcript, which said in an editorial that it allowed the brochure to be inserted in its paper only because it feared legal action if it refused, quoted the abortion federation as providing similar information. "The fetus is dead 24 hours before the pictured procedure is undertaken," the editorial stated.

But Dr. Haskell and another doctor who routinely use the procedure for late-term abortions told AMNews that the majority of fetuses aborted this way are alive until the end of the procedure.

Dr. Haskell said the drawing were accurate "from a technical point of view." But he took issue with the implication that the fetuses were "aware and resisting."

Radford also acknowledged that the information her group was quoted as providing was inaccurate. She has since sent a letter to federation members, outlining guidelines for discussing the matter. Among the points:

Don't apologize: this is a legal procedure.

No abortion method is acceptable to abortion opponents.

The language and graphics in the ads are disturbing to some readers. "Much of the negative reaction, however, is the same reaction that might be invoked if one were to listen to a surgeon describing step-by-step almost any other surgical procedure involving blood, human tissue, etc."

LATE-ABORTION SPECIALISTS

Only Dr. Haskell, James T. McMahon, MD, of Los Angeles, and a handful of other doctors perform the D&X procedure, which Dr. McMahon refers to as "intact D&E." The more common late-term abortion methods are the classic D&E and induction, which usually involves injecting digoxin or another substance into the fetal heart to kill it, then dilating the cervix and inducing labor.

Dr. Haskell, who owns abortion clinics in Cincinnati and Dayton, said he started performing D&Es for late abortions out of necessity. Local hospitals did not allow inductions past 18 weeks, and he had no place to keep patients overnight while doing the procedure.

But the classic D&E, in which the fetus is broken apart inside the womb, carries the risk of perforation, tearing and hemorrhaging, he said, So he turned to the D&X, which he says is far less risky to the mother.

Dr. McMahon acknowledged that the procedure he, Dr. Haskell and a handful of other doctors use makes some people queasy. But he defends it. "Once you decide the uterus must be emptied, you then have to have 100% allegiance to maternal risk. There's no justification to doing a more dangerous procedure because somehow this doesn't offend you sensibilities as much."

BROCHURE CITES N.Y. CASE

The four-page anti-abortion brochures also include a graphic depiction of the D&X procedure. But the cover features a photograph of 16-month-old Ana Rosa Rodriquez, whose right arm was severed during an abortion attempt when her mother was 7 months pregnant.

The child was born two days later, at 32 to 34 weeks' gestation. Abu Hayat, MD, of New York, was convicted of assault and performing an illegal abortion. He was sentenced to up to 29 years in prison for this and another related offense.

New York law bans abortions after 24 weeks, except to save the mother's life. The

brochure states that Dr. Hayat never would have been prosecuted if the Federal ''Freedom of Choice Act'' were in effect, because the act would invalidate the New York statute.

The proposed law would allow abortion for any reason until viability. But it would leave it up to individual practitioners—not the state—to define that point. Postviability abortions, however, could not be restricted if done to save a woman's life or health, including emotional health.

The abortion federation's Radford called the Hayat case ''an aberration'' and stressed that the vast majority of abortions occur within the first trimester. She also said that later abortions usually are done for reasons of fetal abnormality or material health.

But Douglas Johnson of the National Right to Life Committee called that suggestion ''blatantly false.''

''The abortion practitioners themselves will admit the majority of their late-term abortions are elective,'' he said. ''People like Dr. Haskell are just trying to reach others how to do it more efficiently.''

NUMBERS GAME

Accurate figures on second- and third-trimester abortions are elusive because a number of states don't require doctors to report abortion statistics. For example, one-third of all abortions are said to occur in California, but the state has no reporting requirements. The Guttmacher Institute estimates there were nearly 168,000 second- and third-trimester abortions in 1988, the last year for which figures are available.

About 60,000 of those occurred in the 16- to 20-week period, with 10,660 at week 21 and beyond, the institute says. Estimates were based on actual gestational age, as opposed to last menstrual period.

There is particular debate over the number of third-trimester abortions. Former Surgeon General C. Everett Koop, MD, estimated in 1984 that 4,000 are performed annually. The abortion federation puts the number at 300 to 500. Dr. Haskell says that ''probably Koop's numbers are more correct.''

Dr. Haskell said he performs abortions ''up until about 25 weeks'' gestation, most of them elective. Dr. McMahon does abortions through all 40 weeks of pregnancy, but said he won't do an elective procedure after 26 weeks. About 80% of those he does after 21 weeks are nonelective, he said.

MIXED FEELINGS

Dr. McMahon admits having mixed feelings about the procedure in which he has chosen to specialize.

''I have two positions that may be internally inconsistent, and that's probably why I fight with this all the time,'' he said.

''I do have moral compunctions. And if I see a case that's later, like 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.'

''On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother.''

Dr. McMahon says he doesn't want to ''hold patients hostage to my technical skill. I can say, 'No, I won't do that,' and then they're stuck with either some criminal solution or some other desperate maneuver.''

Dr. Haskell, however, says whatever qualms he has about third-trimester abortions are ''only for technical reasons, not for emotional reasons of fetal development.''

''I think it's important to distinguish the two,'' he says, adding that his cut-off point is within the viability threshold noted in Roe v. Wade, the Supreme Court decision that legalized abortion. The decision said that point usually occurred at 28 weeks ''but may occur earlier, even at 24 weeks.''

Viability is generally accepted to be ''somewhere between 25 and 26 weeks,'' said Dr. Haskell. ''It just depends on who you talk to.

''We don't have a viability law in Ohio. In New York they have a 24-week limitation. That's how Dr. Hayat got in trouble. If somebody tells me I have to use 22 weeks, that's fine. . . . I'm not a trailblazer or activist trying to constantly press the limits.''

CAMPAIGN'S IMPACT DEBATED

Whether the ad and brochures will have the full impact abortion opponents intend is yet to be seen.

Congress has yet to schedule a final showdown on the bill. Although it has already passed through the necessary committees, supporters are reluctant to move it for a full House and Senate vote until they are sure they can win.

In fact, House Speaker Tom Foley (D, Wash.) has said he wants to bring the bill for a vote under a ''closed rule'' procedure, which would prohibit consideration of amendments.

But opponents are lobbying heavily against Foley's plan. Among the amendments they wish to offer is one that would allow, but not require, states to restrict abortion—except to save the mother's life—after 24 weeks.

Ms. MOSELEY-BRAUN. Mr. President, today, as it has been since the landmark 1973 Supreme Court Decision of Roe versus Wade, the concept of reproductive freedom is under assault.

Choice is a matter of freedom. Choice is a fundamental issue of the relationship of female citizens to their Government. Choice is a barometer of equality and a measure of fairness. Choice is central to our liberty. While I do not believe in abortion, I do believe, fundamentally, in choice.

In spite of the fact that the majority of the American people embrace the freedom to choose reproduction, the efforts to use Government intervention as a bar to the right to choice have taken on a new ferocity. And today, some in the U.S. Senate would prevent Senators and citizens alike from the chance to even hold hearings on the latest assault on a woman's right to choose.

The newest assault is H.R. 1833/S. 939, an unconstitutional, vague ban on a rare medical procedure used to terminate pregnancies late in the term, when the life or health of the mother is at risk, and or when the fetus has severe abnormalities.

The procedure that is the intended focus of this bill involves giving anesthesia to a mother over a period of days while gradually dilating her cervix—the fetus dies during the first dose of anesthesia—then draining the brain fluid after death so that the cervix is forced to withstand less trauma as the fetus is removed, preserving the woman's ability to conceive.

H.R. 1833/S. 939 would make it a criminal offense to perform certain types of late term abortions. A doctor who performed such an abortion would face up to 2 years in prison and fines.

The doctor and the hospital or clinic where he or she worked would also be liable for civil action brought by the father of a fetus or the maternal parents of the woman if she was under 18.

Instead of providing an exception for cases where the banned procedure is used to save the life of the mother, doctors would be required, after being reasonably believed that no other method would have saved the woman's life.

Before I talk about the constitutional and policy implications of H.R. 1833/S. 939, I want to tell the story of Vikki, she is from Naperville, in my home State of Illinois.

Vikki and her husband were expecting their third child. At 20 weeks she went for a sonogram and was told by her doctor that she and her child were healthy. She named the boy Anthony.

At 32 weeks Vikki took her two daughters with her to watch their brother on the sonogram. The technician did not say a word during the sonogram and then asked Vikki to come upstairs to talk with the doctor. Vikki thought maybe it was because the baby was breach. She is a diabetic and any complications could be serious.

The doctor was too busy to see Vikki, but called at 7 a.m. the next morning to say that the femurs—leg bones—seemed a little short. He assured her that there was a 99 percent chance that nothing was wrong, but asked her to come in for a level 2 ultrasound.

Vikki and her husband found out that their child had no brain. There were eight abnormalities in all.

Vikki had to make the hardest decision of her life. This is how she explained it: ''I had to remove my son from life support —that was me.''

For Vikki, the hardest thing for a parent to do is to watch her child hurt. It is hard enough just watching a child get teased at the bus stop.

The procedure took four visits to the doctor. She received anesthesia on the first visit. Her son stopped moving the first night. She knew he was gone. This was before the procedure to remove the fetus took place.

Having an D&E procedure was particularly important because Vikki wanted to know if this was something that she would pass on to her two daughters.—With a D&E an autopsy can be performed.—Luckily, it was just one of those things and her girls will be able to have children of their own.

Vikki's D&E was the closest thing for her body to natural birth. She was able to preserve her fertility, and I am happy to say is now 30 weeks pregnant. The baby looks fine.

I wanted to tell my colleagues that story, because it is true, it is about a real woman, and it is about a family handling an awful, horrible situation in the best way that it can.

This is the kind of case where my colleagues want to substitute their judgement for the judgement of the family and their doctor.

Now what are the implications for banning these abortions, beyond the affect that it would have on the lives of women like Vikki and their families?

Doctors are going to be too scared to perform legal abortions and medically necessary abortions because of the threat of criminal or civil prosecution. H.R. 1833/S. 939 is vague. The definition of abortions covered under this legislation is ''partial-birth.'' That is a term used for its shock value, not its medical value. There is no such medical term and doctors cannot agree on what the legislation is intended to ban.

Women are going to face life and health risks as well as the loss of fertility as they undergo more dangerous procedures. H.R. 1833/S. 939 is dangerous. If a doctor chooses to perform an abortion covered by this bill, it is because he or she considers the procedure to be the most medically sound for the woman. By choosing to arbitrarily prohibit one type of procedure, but not others, regardless of which procedure most protects the life, health, and fertility of the woman, Congress is micro-managing decisions best made in a doctor's office.

Women's constitutional rights will be taken away. H.R. 1833/S. 939 is unconstitutional. Under Roe versus Wade and Planned Parenthood versus Casey, the Supreme Court standard is that a state may not prohibit post-viability abortions necessary to preserve the life or health of a woman. Under H.R. 1833/S. 939, there is an exception only for life and then only by way of an affirmative defense.

While H.R. 1833/S. 939 is focused on late-term abortions, doctors who perform early-term abortions by the loosely defined means covered by the bill are subject to the same liability. Choosing to have an abortion when the fetus is not yet viable is clearly a constitutionally protected right under Roe versus Wade.

These are some of the policy implications of H.R. 1833/S. 939. This threat to a doctor's ability to care for his or her patient, disregard of a woman's health, and attack on a woman's constitutional rights are all part of a broader attack on choice.

The 104th Congress has already seen a dramatic erosion in the right of a woman to choice.

First came the Hyde amendment. Poor women were limited in their reproductive choices because Government contributed to payment of their health care. Their rights became more than their pocketbooks could protect.

Then came the battle of parental notification. Very young women were limited in their reproductive choices, except in cases of rape or incest, because of their age—not their condition—teens became the victims of bad timing and thus the State asserted a right to intervene.

Then came the women in the military—who by virtue of their own decision, or that of their spouse, to serve their country, would be limited in their reproductive choices.

Then came legislation earlier this year, which eliminated abortion coverage from Federal health insurance. Employee benefits for Federal workers are now restricted in ways which, I hope, would be unthinkable in the private sector.

Now comes a bill to fine or jail doctors who perform abortions for women who need them late in their term because their life and health are in danger or because of the severity of the deformities of their fetus.

These actions remind me of a famous poem by Martin Niemoller, a Protestant minister interred in a German concentration camp for 7 years. I would like to read you my own, more contemporary version of his parable. I call it ''The Assault on Reproductive Rights.''

First they came for poor women
and I did not speak out—
because I was not a poor woman.
Then they came for the teenagers
and I did not speak out—
because I was no longer a teenager.
Then they came for women in the military
and I did not speak out—
because I was not in the military.
Then they came for women in the federal government
and I did not speak out—
because I did not work for the government.
Then they came for the doctors
and I did not speak out
because I was not a doctor.
Then they came for me—
and there was no one left
to speak out for me.

What we are faced with here today is another attempt to erode a woman's right to choose. And we must remember, the fight for choice is a quintessential fight for freedom.

I do not favor abortion. My own religious beliefs hold life dear, and I would prefer that every potential child have a chance to be born.

But I am not prepared to substitute the Government's judgement for the judgements of women, their families, and their doctors in this most personal of all decisions.

When Vikki made the decision to remove her child from life support—her body—she made a decision, with the help of her husband and her doctor, that only she could make.

And the fact that the Senate would even consider placing our judgement above hers without holding hearings—without fully understanding the consequences of our actions, without hearing from women, their families, and their doctors first hand—is appalling.

For the first time in history, the Senate is attempting to make a specific medical procedure criminal, and none of the work has been done. The Senate is attempting to prohibit a woman from undergoing a medical procedure that could save her life and her ability to conceive, and none of the work has been done. Well I say, we must do the work.

The State has no right to intervene in this relationship between a woman and her body, her doctor, and her God.

At the very least, I urge my colleagues to support Senator SPECTER's motion to commit this legislation to the Judiciary Committee.

Ms. SNOWE. Mr. President, I rise to speak as a cosponsor of the motion made by my colleague from Pennsylvania, Senator SPECTER, to commit this bill to the Senate Judiciary Committee for hearings.

I rise to speak because I am deeply concerned that we stand here on the floor today to discuss legislation on such a serious issue, without ever having held any hearings on the matter.

As a Member of the Senate, I am deeply concerned that hearings have not been held on this legislation which raises significant constitutional questions.

But as a woman, I believe that the failure of this body to hold hearings demonstrates an appalling disregard for the lives and health of women across this Nation.

There is no question that any abortion is an emotional, wrenching decision for a woman and her family under any circumstance. When a woman must confront this decision during the later stages of a pregnancy because she knows that the pregnancy presents a direct threat to her own life, such a decision becomes a nightmare.

Mr. President, 22 years ago, the Supreme Court issued a landmark decision in Roe versus Wade, carefully crafted to be both balanced and responsible while holding the rights of women in America paramount in reproductive decisions.

This decision held that women have a constitutional right to abortion, but after viability, States could ban abortions as long as they allowed exceptions for cases in which a woman's life or health is endangered.

Let me repeat—as long as they allowed exceptions for cases in which a woman's life or health is endangered.

The Supreme Court has reaffirmed this decision time and time and time again. And to date, 41 States—including my home State of Maine—have exercised their right to impose restrictions on post-viability abortions. All, of course, provide exceptions for the life or health of the mother, as constitutionally required by Roe.

H.R. 1833, however, does not provide an exception for the life or health of the mother. Let me repeat, it does not provide an exception for the life or health of the mother. And, as a result, it represents a direct, frontal assault on Roe and on the reproductive rights of women everywhere.

And despite the apparent unconstitutionality of this legislation, the Senate has not held hearings on the subject. Not in the Judiciary Committee. And not in the Labor and Human Resources Committee.

I find the Senate's lack of hearings on this issue deeply disturbing for another reason as well. Not since prior to Roe versus Wade has there been efforts to criminalize a medical procedure in this country. But that's exactly what this bill does.

This legislation is an unprecedented expansion of congressional regulation of women's health care. Never before has Congress intruded directly into the practice of medicine by banning a safe and legal medical procedure that is absolutely vital to protect the health or lives of women.

In effect, the Senate is clearly attempting to substitute congressional judgment for that of a medical doctor regarding the appropriateness of a medical procedure.

As quoted in the New York Times, one doctor said: ''I don't want to make medical decisions based on congressional language. I do not want to be that vulnerable. And it is not what I want for my patients.'' He is right.

This legislation sets new, frightening precedents for congressional action to limit on a wide range of medical procedures. It is open to even wider legal interpretations that may have an even broader impact on women's lives.

Because of the vagueness of the bill, doctors across the Nation may interpret the language differently at the expense of the health and life of the mother involved.

Now, some of my colleagues may rise to insist that the legislation somehow contains an exception for the life of the mother. However, this is simply untrue, and I urge my colleagues not to be misled by this rhetoric.

As it now reads, the legislation only provides doctors with a so-called affirmative defense. I say so-called because there is nothing affirmative about this law for doctors. And there is no genuine defense allowed for them under this legislation because the guilty verdict is rendered the moment they attempt the medical procedure.

It means that a doctor cannot avoid criminal prosecution if he or she uses their best medical judgment and decides that it is necessary to perform this procedure to save the life of a patient.

Mr. President, it is only after that doctor is on trial that he is finally given an opportunity to prove that the procedure was necessary to save the life of that patient and that no other procedure would have sufficed—an almost impossible burden to prove. But that is exactly the intent of this bill.

In other words—in a twisted angle on one of our most cherished judicial tenets—these doctors are presumed guilty until proven innocent. Thus, doctors will refuse to perform this procedure, which they know to be medically safer for their patient, even when the woman's life is threatened.

Not only that, but doctors would also be subject to civil lawsuits brought on by the parents of the mother who undergoes the procedure or by the father. This opens up an entire new realm of judicial proceedings and civil lawsuits.

Even if a doctor is able to survive the trial phase of affirmative defense, then he or she would be subjected to a further judicial hurdle of civil lawsuits. The possibilities go on and on.

But—in the larger context—look at what this legislation does overall, and its intent is perfectly clear: First, intimidate doctors with prison terms.

Second, threaten them with horrendous Federal fines in the vicinity of $250,000. Third, harass them with possibility of civil lawsuits—and that should keep anyone from wanting to perform any kind of medical procedure involving women's reproductive health.

We're going to do this in a climate where—according to a recent statistic—94 percent of all American counties no longer have or never had a provider of full reproductive services for women. We're going to do this in a climate where doctors already face demonstrations, death threats against them and their family, and even violence.

Now, we are telling them they must face the additional concern of criminal prosecution, jail, and costly trials. We are doing this to doctors who are only really trying to save the lives of women in dire circumstances to the best of their medical expertise. In this sense, it is a chilling frontal assault on every women's rights.

How chilling? The proponents of this legislation are willing to risk the lives and health of women facing medical emergencies.

My opponents will say that a number of other alternatives are available to these women.

What alternatives? The only alternatives I know of are far more dangerous and traumatic. Has anyone asked the physicians? Has anyone looked at the medical evidence? This is another reason why we should be holding hearings:

Are C-sections, which cause twice as much bleeding and carries four times the risk of death as a vaginal delivery—really an option?

Is induced labor, which carries its own potentially life-threatening risks such as cardiac edema—really an option?

Are hysterectomies, which leave women permanently unable to conceive—really an option?

In the end, this legislation would order doctors to set aside the paramount interests of the woman's health, and to trade-off her health and life and future fertility in order to avoid the possibility of criminal prosecution.

Yes, despite these significant risks to a woman's life and health created by this legislation—and despite the historic new precedents that are set—the Senate has never held hearings on this subject.

We enter this debate today on H.R. 1833 with profound and critically important questions—legal, moral, and medical—unanswered and unconsidered. Why the rush? Why the hurry?

That's why hearings deserve to be held. And that's the course of action that this Chamber must take. No one truly knows the legal ramifications. No one here truly knows the medical statistics or facts. No one has had the time to ask questions and receive answers. No one has anticipated the court challenges that will ensue.

Doctors will be threatened. Physicians will be intimidated. The medical profession will wonder where the next assault on health care by the Federal Government will come from or where it will be felt.

And what about the women? Who has thought about them? They will be more scared than ever before. Their rights will be more restricted than ever before. Their lives—their lives—will be more threatened than ever before.

Mr. President, I urge my colleagues to think of the women who are faced with this procedure. I urge my colleagues to consider the effect on doctors. And I urge my colleagues to support the motion to commit this bill to the Judiciary Committee.

Thank you, Mr. President. I yield the floor.

Mr. HATCH. Will the Senator from New Hampshire yield some time to me?

Mr. SMITH. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 12 minutes, 45 seconds.

Mr. SMITH. How much time does the Senator need?

Mr. HATCH. If the Senator will yield 5 minutes, I will try to conserve that.

Mr. SMITH. I will yield 5 minutes to the distinguished chairman of the Judiciary Committee, Senator HATCH.

Mr. HATCH. I thank my dear friend.

Mr. President, a number of my colleagues have inquired of my view toward referring the pending bill to the Judiciary Committee. I have no objection to the full Senate taking up H.R. 1833 at this time, and I intend to vote against this motion.

The Senate over the years has conducted a lot of hearings on the subject of abortion. The other body has done the same. There is nothing unique about this bill except its approach toward what really amounts to third trimester abortions, something that I have trouble understanding why anybody would fight.

I remind my colleagues that on February 10, 1964, the other body overwhelmingly voted in favor of the Civil Rights Act of 1964, a sweeping landmark civil rights bill—one that I would have voted for had I been here at the time. Then-Senate majority leader Mike Mansfield placed the bill on the Senate Calendar, just like this one was. A motion was made to refer the bill to the Judiciary Committee. The Senate rejected the motion. Why? Because it was sincerely believed that such a referral would kill a landmark civil rights bill.

Today, the strategy for killing the pending measure is the same—send it to the committee. As a matter of procedure, if the Senate could take up the sweeping Civil Rights Act of 1964 directly from the Senate Calendar, it can today do the same with a bill that addresses one aspect of the whole abortion issue.

My present purpose in mentioning the procedural precedent of the 1964 Civil Rights Act is not to engage in a comparison of the rights at stake then and the ones at stake in the Chamber today.

I understand that there are strong views on both sides of the underlying issue. I respect those who disagree with my views on this issue. But many of us believe that the rights of the unborn present important enough issues to justify a procedure allowing the Senate to vote up and down on the merits of H.R. 1833. There is, indeed, Senate precedent for doing so if the cause is urgent enough.

I believe the cause is sufficiently urgent, and I ask my colleagues to keep in mind we are talking about one particular abortion procedure that kills the fetus in the most heinous way by sucking the brain out of the baby. It is hard for me to understand why anybody would fight this bill. We are not even talking about the entire framework of abortion rights here, but just one procedure.

Let me also say that if I had my way, we would abolish all late-term abortions except to save the life of the mother. There are between 14,000 and 20,000 of those abortions a year. I think morally it is very difficult to justify that type of a thing.

One final thing. As the chairman of the Judiciary Committee, I must correct a legal misunderstanding being expressed here. The Clinton administration and other opponents of this bill claim that this bill is unconstitutional because it permits a doctor to justify a partial-birth abortion only as an affirmative defense to a prosecution. The fact that the bill provides the exception required by the case law in an affirmative defense does not unduly burden the right to an abortion.

Many of our constitutional rights arise only as an affirmative defense. Many of the protections of the Bill of Rights—freedom of speech, freedom of religion, freedom of assembly, freedom of petition, the right to bear arms, freedom from unreasonable searches and seizures, the right to grand jury, the right against double jeopardy, the right against self-incrimination, the right to a speedy trial, the right to indictment, the right to assistance of counsel—sometimes can only be raised as a defense to a prosecution. Indeed, any of us may be innocent of a crime and prosecuted and make our claim of innocence only as a defense in court.

To claim that the right to an abortion is not protected by an affirmative defense demeans the explicit protections of the Bill of Rights, and it raises abortion above any right mentioned in the Constitution.

The PRESIDING OFFICER. The Senator has spoken for 5 minutes.

Mr. HATCH. I ask unanimous consent that I be given another 1 minute.

Mr. SMITH. I yield 1 more minute.

Mr. HATCH. Accordingly, I will vote against the motion to commit to the Judiciary Committee this bill that I believe is fully legal under the true meaning of the Constitution and under the Supreme Court's current abortion jurisprudence.

To me it is amoral, except to save the life of the mother, to kill these infants in this way. We are talking about children after 20 weeks in the mother's womb, most of whom are capable of living outside the womb. We are not talking about when the spirit comes into the body or any of the other questions that have arisen concerning the abortion issue. We are talking about fully developed children.

Now, I can understand both sides of the abortion issue. I know how sincere are those who are on the other side. But on this issue I have trouble understanding the logic that they are using. I know my colleague from Pennsylvania is sincere in his motion here today, but I do not see any reason why we need to go to that motion. I think we ought to face it, and vote up or down. Everybody understands this issue. We ought to face it right here and now.

I yield the floor.

Mr. FEINGOLD addressed the Chair.

The PRESIDING OFFICER. Who yields time to the Senator from Wisconsin?

Mr. SPECTER. How much time remains?

The PRESIDING OFFICER. The Senator has 13 minutes 47 seconds.

Mr. SPECTER. I yield 5 minutes to the Senator from Wisconsin.

Mr. FEINGOLD. I thank the Senator from Pennsylvania.

Mr. President, I support the motion to commit this bill to the Judiciary Committee for hearings before the Senate acts upon this measure. And I want to particularly thank the senior Senator from Pennsylvania and the junior Senator from California for their leadership and courage in trying to do the right thing on this issue, making sure that there is a proper hearing in the Judiciary Committee on the matter.

This bill, as it is currently drafted, would criminalize the actions of physicians who perform medical procedures which they believe may be necessary to save the life or protect the health of their patient. It is a very serious matter that the Senate ought not to act upon without deliberation and consideration.

There have been no Senate hearings on this measure. The chairman of the Judiciary Committee refers to hearings on abortion as a general subject. But there have been no hearings on this particular and very difficult topic. The bill before us was simply placed on the Senate Calendar.

Unfortunately, there has been a fair amount of misinformation communicated concerning the nature of the procedure being considered. There has been little focus by the proponents of the bill on the risk to the health of women if this alternative is not available, the types of health problems that compel late-term abortions in the first place, and the important question of the constitutional implications of withholding access to a procedure that may, in fact, be necessary to save the life or preserve the health of a pregnant woman facing a tragic pregnancy.

Mr. President, let me stress that I have very grave reservations about the wisdom of this body acting upon a measure that would insert the Federal Government into the decisionmaking process of physicians as to what medical procedures are appropriate in a particular case.

In just this last Congress we had an extensive and heated debate over whether Congress or the Federal Government ought to be designing a national health care system. Yet today many of the very same individuals who argued strenuously against the Federal Government's role in health care policy are now urging that we literally legislate the specific procedure that a doctor may choose in dealing with a very difficult and painful pregnancy. I think the decision about abortion ought to remain a private and personal decision between a woman and her doctor.

I recognize that this is a tremendously divisive and emotional area. And I do respect the views of people on both sides of the issue. But, fundamentally, I do not think we should be substituting the judgment of Members of Congress for the judgment of those directly involved, particularly where issues of the life and health of the woman are at stake.

Late-term abortions under Roe versus Wade can be restricted to those cases where the woman's life or health are at stake. That means that the procedures at issue take place in those most tragic circumstances where a pregnancy threatens a woman's life or health. For the Senate today to step into this area and legislate without even the benefit of hearings, where all sides of this issue can be heard, seems, to me, to be irresponsible at a minimum.

It is particularly important that we exercise caution in this area that is so emotionally charged. The proponents of this measure have made assertions about the procedures at issue that have been strenuously challenged by the opponents. And the opponents have raised a number of serious issues about the circumstances under which alternative procedures will increase the risk to the woman's life or health. These are important questions that actually should be addressed before we vote. If the Senate decides to legislate in this area, it certainly ought to do so only on the basis of a significant record which thoroughly explores these issues.

For example, Mr. President, we need to know what alternatives, if any, would be available to women who must have a late-term abortion. What are the increased risks for these alternative procedures for the survival of the woman or her future ability to bear children? Those are just a couple of the

questions that, at a minimum, must be asked before the Senate acts upon this measure. It is also important that a record be developed which sets out the reason why late-term abortions are performed in the first place. It is estimated we are talking about roughly 600 abortions per year that take place under the most dire circumstances.

Now, some of the proponents of this legislation have distorted the debate by asserting that the majority of late-term abortions are elective, misusing medical terminology to imply that the termination of pregnancy at this stage is somehow by choice. In fact, these abortions take place only when the life or health of the woman is at risk. We need to be fully aware of the pain and suffering that is endured by these families when a much-wanted pregnancy turns into a nightmare. We need to be careful that the Federal Government does not make these tragic situations even more difficult and painful for these families.

Mr. President, let me also say that if the motion to commit this bill to the committee fails, I will support amendments to be offered that will make it clear that this legislation is not to be construed to prohibit any physician from carrying out any medical procedure which the physician in his or her medical judgment determines necessary to preserve the life or health of a woman.

At a minimum, no physician should be placed in a position where he must sacrifice the life or health of his patient, because the Federal Government has chosen to substitute its judgment for professional medical judgment.

I yield the floor.

Mr. ASHCROFT addressed the Chair.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. SMITH. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 6 minutes 28 seconds.

Mr. SMITH. I will yield 4 minutes to the Senator from Missouri.

Mr. ASHCROFT. Thank you.

Abortion is, and always has been, one of the most divisive moral issues of our day. It strikes at the very core of who we are as a people and as a nation. It challenges us to define life and to measure liberty—difficult things both. But it is an issue that will not go away and so it demands of us civil debate and reasoned discourse. And so I rise to speak today in tempered tones about the untempered terror of partial-birth abortions.

Lest there be any confusion, what we are talking about is an abortion procedure that allows a child to be partially removed from the mother's womb only to have its skull crushed and brain extracted by a doctor pledged to ''do no harm.''

What message do we send by allowing this slaughter of innocents to continue? What does it say about who we are? What does it say about the moral condition of America when people of faith are unfaithful to the most vulnerable among us? I would suggest that a nation that allow this mindless brutality to continue is a nation out of touch with the most basic dictates of humanity.

The procedure in question is so cruel and so inhumane as to defy rational, reasoned support. Advocates of partial-birth abortions are attempting to defend the indefensible—and they cannot. So, instead, they raise the specter of confusion, introduce rhetorical nonsense, and obfuscate with absurdity. We are almost tempted to forget that which we are debating. This amendment is not about the right of choice, it is about the right of this Nation to act in a manner befitting its founding. It is about the right of America to say that it will not allow the brutality of partial-birth abortions to continue.

Over 30 million lives have perished since Roe versus Wade became the law of the land. An almost incomprehensible number. I am pained to my core by this tragedy and stand ready to reverse it. We can begin by putting an end to a medical procedure which takes an unborn child, one able to be sustained outside the womb, and kills it.

The question is simple: Do we want to continue to allow that procedure or do we want to outlaw it? The American people clearly want the latter. They overwhelmingly oppose this barbarism. They know to be true that which we are forced to debate. Namely, that this procedure has no place in a civilized society.

A final point. There is a legitimate place for hearings. They can be important. They can be illustrative. They can be used for probing areas of uncertainty. Mr. President, there is no uncertainty here. We do not need hearings to determine that partial-birth abortions are the monstrous, barbaric, and hideous destruction of human life. We do not need hearings to say, ''No more partial-birth abortions.''

The House of Representatives passed this measure last week with 288 votes. Let us lend our voice to their cause. For our party must be about more than a higher standard of living. It must also be about a higher standard of character.

The task before us is a simple one. It is to reaffirm humanity, reject brutality, and ban partial-birth abortions.

I yield the floor and reserve the remainder of the time.

The PRESIDING OFFICER. Who yields time? The Senator from Pennsylvania has 8 minutes. The Senator from New Hampshire has 2 minutes 30 seconds.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, there have been requests from other Senators to speak in support of the motion. I remind my colleagues that if they choose to do so, we are in the last stage of the debate—it is now 12:22—under a 3-hour time agreement, with the time having started at 9:30.

In the absence of any of my colleagues who choose to speak, I will make a comment or two with respect to the issue on the life of the mother.

I tried to write down what the Senator from Missouri had said contemporaneously with his statement when he said the issue of the life of a mother is nonsense, I believe he put it. I strenuously disagree with him about that. The life of the mother has been a recognized exception to any prohibition on abortion of all time, and the current legislation does not provide for an exception for the life of a mother.

There is a major difference between having an affirmative defense and between having an exception. The customary language that is used in the appropriations bill was cited earlier and illustrated by Public Law 103–333, September 30, 1994, where there is an exception. The language is plain:

> None of the funds appropriated under this act shall be expended for any abortion except—

And then irrelevant language, but commenting on any abortion except—

> . . . that procedure is necessary to save the life of a mother.

In the pending legislation, there is no such exception. There is a provision only for an affirmative defense so that the criminal prosecution can be brought against the doctor under this statute, because there is no exception for the life of a mother.

After the criminal prosecution is brought, then it is a matter of affirmative defense which has to be proved by the defendant doctor as opposed to having an exception in the statute.

Mr. President, how much time remains?

The PRESIDING OFFICER. Five minutes twenty seconds. The Senator from New Hampshire has 2 minutes 30 seconds.

Mr. SPECTER. Mr. President, in the absence of any other Senator seeking recognition, permit me to summarize briefly, and I yield myself 2 minutes, reserving the remainder of the time for others.

What we have here is a bill which has been placed on the calendar in an unusual way. Until relatively recently, the provisions of rule XXV of the Senate require a referral to committee. That has been changed by an interpretation of rule XIV, but I question the propriety and especially the wisdom of having this matter proceed without having a hearing.

In the House of Representatives, the bill was introduced on June 14 and one day later, there was a hearing, and on the same day there was a markup. Very limited testimony was presented.

The House was then engaged virtually continuously on the budget matters, except for the August recess. They took the matter up on November 1, and they passed the bill. Then it came to the Senate, and now we are on November 8, just 7 days later, when action is requested on this bill without any hearing in the Judiciary Committee.

I have made a motion for referral to committee on a very limited basis, really for 9 days, between today, November 8, and November 10 when the Senate is scheduled to go out of session, and then the extended time over the recess for 10 more days, from November 17 until November 27.

There are very important considerations which we need to inquire into on humanitarian grounds. The question has been raised of anesthetic, which has to be fairly taken up, a very substantial controversy on the medical evidence, complex issues on medical procedures, as well as the humanitarian concept, and then the formulation of the law itself, since this statute can be circumvented in a number of ways on medical procedures through C section or otherwise.

Mr. President, how much time remains?

The PRESIDING OFFICER. Two minutes thirty seconds.

Mr. SPECTER. I yield the floor and reserve the remainder of my time.

Mr. SMITH. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. Two minutes twenty-five seconds.

Mr. SMITH. I yield the remainder of my time to the only physician in the U.S. Senate, Dr. FRIST.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I rise today in support of the partial-birth abortion ban and against the motion to refer this bill to committee. I have had the opportunity over the last several weeks to consult with a number of my colleagues in obstetrics and gynecology, and with those at academic health care centers and tertiary health care centers who would most likely be faced with performing this procedure. And I can say after these consultations that I know of no doctor who uses or approves of this procedure as described in this bill.

Among these colleagues that I contacted are people who perform abortions in the third trimester under very selected circumstances, and they have told me that they condemn this procedure. They tell me that it is an unnecessary procedure and has no place in the medical armamentarium.

Mr. President, it is understandable that over the last 2 days a number of people have expressed concern for the life of the mother. But this bill provides for the mother. It only requires a doctor to show that he or she reasonably believed that this procedure was necessary to save the mother's life. I will repeat, this bill does not endanger the life of a mother in any way.

I do not want new laws. As a physician, I can tell you that physicians do not want new laws dictating their practice in any way. No physician does. But this procedure is so brutal, so uncalled for, so inhumane, and so unnecessary that this ban is justified.

We have broad bipartisan support for this bill, both pro-life and pro-choice, and I think that shows this is an important issue that goes beyond the debates of pro-life and pro-choice. We have that support because the partial-birth abortion procedure, as described specifically in the bill, deeply offends our sensibilities as human beings, and as people who care for one another and feel people deserve to be treated with respect, dignity, and compassion.

The PRESIDING OFFICER. The Senator's time has expired. The Senator may ask for additional time with consent.

Mr. FRIST. I ask unanimous consent for an additional 1 minute.

Mrs. BOXER. Reserving the right to object, and I will not object. I want to make sure that I can ask my friend a question before he gets the additional minute. I ask unanimous consent to make it a 2-minute request.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I say to my friend, he said he talked to a lot of doctors—gynecologists and obstetricians. Is he aware that the American College of Obstetricians and Gynecologists has written a letter to Senator DOLE objecting very strenuously to this bill?

Mr. FRIST. Yes, he is.

Mrs. BOXER. I thank the Senator.

Mr. FRIST. Mr. President, this procedure, as described, is a brutal procedure. It is a procedure that I consider inhumane, as do a number of people, including obstetricians. I just got off the telephone with one who, again, performs abortions in that third trimester. He told me, point blank, that "it is unnecessary."

Those of us who oppose this procedure do care deeply about women, about their health care, and about the horrific circumstances and situations they face. But how can we answer to our children, to our patients, to our constituents, and to others if we continue to allow babies to be aborted through this unnecessarily brutal partial-birth procedure?

Mr. President, it is with compassion, but with steadfast resolve, that I register my support for the partial-birth abortion ban.

The PRESIDING OFFICER. The Senator from Pennsylvania has 2 minutes 30 seconds.

Mr. SPECTER. Mr. President, I express my very high regard for the distinguished Senator from Tennessee, who is our only doctor in the Senate. I can understand the consultations which he has had, but I emphasize as forcefully as I can that consultations that anyone has are not the same as having hearings. The Senate has had no hearing on this matter. The House had only one limited hearing, and the pending motion is a very limited one, for 9 working days in the Senate, from today, November 8, until November 17, including the weekend and then the recess period. I think the comprehensive answer to the submission by Senator FRIST is from the American College of Obstetricians and Gynecologists, who wrote to Senator DOLE on November 6.

I ask unanimous consent that this be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE AMERICAN COLLEGE OF,
OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, November 6, 1995.

Hon. ROBERT DOLE,
Majority Leader,
Washington, DC.

DEAR MAJORITY LEADER DOLE: The American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 35,000 physicians dedicated to improving women's health care, does not support HR 1833, the Partial-Birth Abortion Ban Act of 1995. The College finds very disturbing that Congress would take any action that would supersede the medical judgment of trained physicians and 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, HR 1833 employs terminology that is not even recognized in the medical community—demonstrating why Congressional opinion should never be substituted for professional medical judgment.

Thank you for considering our views on this important matter.

Sincerely,

RALPH W. HALE, MD,
Executive Director.

Mr. SPECTER. Mr. President, I ask unanimous consent that the opinion of the U.S. Department of Justice that the pending legislation is unconstitutional be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. DEPARTMENT OF JUSTICE,
Washington, DC, November 7, 1995.

Hon. ROBERT DOLE,
Majority Leader,
U.S. Senate, Washington, DC.

DEAR MR. LEADER: This letter represents the Department's views on H.R. 1833, a bill that would ban what it calls "partial-birth abortions." This legislation violates constitutional standards recently reaffirmed by the Supreme Court. Most significantly, the bill fails to make an adequate exception for preservation of a woman's health. Even in the post-viability period, when the government's interest in regulating abortion is at its weightiest, that interest must yield both to preservation of a woman's life and to preservation of a woman's health. *Planned Parenthood* v. *Casey*, 112 S. Ct. 2791, 2804, 2821 (1992). This means, first of all, that the government may not deny access to abortion to a woman whose life or health is threatened by pregnancy. Id. It also means that the government may not regulate access to abortion in a manner that effectively "require[s] the mother to bear in increased medical risk" in order to serve a state interest. *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986) (invalidating restriction on doctor's choice of abortion procedure because could result in increased risk to woman's health). That is, the government may not enforce regulations that make the make the abortion procedure more dangerous to the woman's health. Id,; see also Planned *Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 79 (1976) (invalidating ban on abortion procedure after first trimester in part because would force "a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed").

If Congress were to ban this method of abortion, it appears that "in large fraction

of the cases'' in which the ban would be relevant at all, see Casey 112 S. Ct. at 2830 (discussing method of constitutional analysis of abortion restrictions), its operation would be inconsistent with this constitutional standard. It has been reported that doctors performing this procedure believe it often poses fewer medical risks for women in the late stages of pregnancy.[1] If this is true, then it is likely that in a ''large fraction'' of the very cases in which the procedure actually is used, it is the technique most protective of the woman's health. Accordingly, a prohibition on the method, in the absence of an adequate exception covering such cases, impermissibly would require women to ''bear an increased medical risk'' in order to obtain an abortion.

H.R. 1833 would provide for an affirmative defense to criminal prosecution or civil claims when a partial-birth abortion is both (a) necessary to save the life of the woman, and (b) the only method of abortion that would serve that purpose. This provision will not cure the bill's constitutional defects. First, as discussed above, the provision is too narrow in scope, as it fails to reach cases in which a woman's health is at issue. Second, the provision does not actually except even life-threatening pregnancies from the statutory bar. Cf. Casey, 112 S. Ct. at 2804 (even in post-viability period, abortion restrictions must ''contain [] exceptions for pregnancies which endanger a woman's life or health''). Instead, the provision would require a physician facing criminal charges to carry the burden of proving, by a preponderance of the evidence, both that pregnancy threatened the life of the woman and that the method in question was the only one that could save the woman's life. By exposing physicians to the risk of criminal sanction regardless of the circumstances under which they perform the outlawed procedure, the statute undoubtedly would have a chilling effect on physicians' willingness to perform even those abortions necessary to save women's lives.

Sincerely,

ANDREW FOIS,
Assistant Attorney General.

Mr. SPECTER. Mr. President, on a matter of this enormous import, where we are talking about the meaning of life, as articulated by the Senator from Indiana earlier, we ought to have a hearing in a limited period of time. We ought not to rely upon hearsay statements that are brought to the floor of the Senate, where we do not have an opportunity to question and elicit more detailed information.

We ought not allow ''Nightline,'' as urged by some on the floor of this body, to substitute for deliberations by the U.S. Senate. This is a matter which could have been brought to the floor at any earlier time, and certainly for the world's greatest deliberative body, it is not asking too much to have a very brief period of time—some 19 days—for the Judiciary Committee to hold hearings, report this matter back, and then the Senate could express its will in accordance with Senate procedures.

The PRESIDING OFFICER. The controlled time has expired.

Mr. SPECTER. Has all time expired on the amendment, Mr. President?

The PRESIDING OFFICER. The time for controlled debate has expired.

Mr. SPECTER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SMITH. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

Mrs. BOXER. I object.

The PRESIDING OFFICER. Objection is heard.

The legislative clerk continued with the call of the roll.

Mr. NICKLES. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

Mrs. BOXER. Mr. President, I object.

The PRESIDING OFFICER (Mr. KEMPTHORNE). Objection is heard. The clerk will continue to call the roll.

The bill clerk continued with the call of the roll.

Mr. PRESSLER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded, that I be allowed to speak for 5 minutes as if in morning business, and that the business of the Senate will then return to a quorum call and to its present state.

The PRESIDING OFFICER. Is there objection?

Mrs. BOXER. Mr. President, reserving the right to object—I will not object—I want to make sure from my friend that morning business is nothing about the pending bill.

Mr. PRESSLER. It is nothing about the pending bill.

Mrs. BOXER. I shall not object.

The PRESIDING OFFICER. Without objection, it is so ordered, and the Senator from South Dakota [Mr. PRESSLER] is recognized to speak as if in morning business for 5 minutes.

AIR SERVICE OPPORTUNITIES IN CONTINENTAL EUROPE

Mr. PRESSLER. Mr. President, I rise today to discuss existing and emerging air service opportunities on the European Continent for U.S. passenger and cargo carriers. These opportunities include not only serving destinations within Europe, but also points beyond such as the Middle East and Asia-Pacific markets. As the British continue to refuse to open their skies to our carriers, developments in other countries represent alternatives that are increasingly attractive and are taking on greater significance.

Unfortunately, recent negotiations with the United Kingdom seeking to liberalize our air service relationship with that country have hit an impasse. At this time, it is unclear whether that impasse is insurmountable. As is often the case with the British, the primary sticking point is our request for greater access to London Heathrow Airport, the main hub of British Airways. Access to Heathrow is particularly important to our carriers since it is an international gateway airport offering connecting service opportunities beyond the United Kingdom to markets virtually worldwide.

Another key and often overlooked area of disagreement is our request for full liberalization of air cargo services between and, importantly, beyond our two countries. Currently, the ability of our cargo carriers to serve the United Kingdom, load additional freight there, and fly on to other countries is severely limited by the United States-United Kingdom bilateral aviation agreement. British negotiators continue to reject our requests for fully liberalized air cargo opportunities, despite a March 1994 recommendation by the House of Commons Transport Committee to that effect. What does all this mean?

The answer to that question is contained in the insights of one aviation authority who wrote recently ''[a]irlines and passengers are free agents. If extra capacity is not developed at Heathrow, the airport will not be able to satisfy demand and airlines will expand their business at continental airports.'' The author added ''if airlines are denied the opportunity to grow at Heathrow, many will choose Paris, Frankfurt, or Amsterdam.''

Mr. President, this is not rhetoric. It is not a threat by U.S. interests designed to gain negotiating leverage. To the contrary, the author of these quotes is BAA plc, the British company that owns and operates Heathrow as well as other United Kingdom airports. BAA is very perceptive. Obviously, BAA recognizes that in today's global economy the long-term consequence of protecting one's air service market amounts to little more than the stimulation of competitive opportunities elsewhere. One need only look across the English Channel to continental Europe to confirm that already is taking place.

There was a time when geographic factors and the limited range of commercial aircraft made the United Kingdom the international gateway of necessity for United States carriers serving Europe and beyond. Times have changed. New generation long-range aircraft have made the option of overflying the United Kingdom viable from both an operational and economic standpoint. Simply put, if the British do not want the business of our air carriers, United States carriers can and will look to the European Continent for new gateway airport opportunities. Today, I wish to discuss a few of these existing, emerging, and potential air service opportunities.

First, there is tremendous growth in international passenger traffic at Amsterdam's Schiphol Airport. This is

[1] *See Hearings on H.R. 1833 Before the Subcomm. on the Constitution of the House Judiciary Comm.* (June 23, 1995) (statement of James T. McMahon, M.D., Medical Director, Eve Surgical Centers) (procedure shown to be safest surgical alternative late in pregnancy); *id.* (June 15, 1995) (statement of J. Cortland Robinson, M.D., M.P.H.) (same); *see also* Tamar Lewin, *Wider Impact is Foreseen for Bill to Ban Type of Abortion*, The New York Times, November 6, 1995, at B7; Diane M. Gianelli, *Shock-Tactic Ads Target Late-Term Abortion Procedure*, American Medical News, July 5, 1993, at 3; Karen Hosler, *Rare Abortion Method Is New Weapon in Debate*, Baltimore Sun, June 17, 1995, at 2A.