both in nutrition and education. As she wrote in the Des Moines Register, ''The key to ending hunger may lie in a little girl's hands. In her left, she holds a bowl of rice; in her right, her school books.'' I strongly support these goals, and share Ms. Bertini's desire to fund fully for fiscal 2004 the McGovern-Dole Food for Education and Child Nutrition Program, which we included in the 2002 farm bill.

Even as we celebrate her achievements, Catherine Bertini is focused on the challenges that lie ahead. She may have left her position at the WFP, but her long-time work to defeat global hunger and poverty continues. Only a few months after her departure from the WFP, she was asked by UN Secretary General Kofi Annan to work for him in New York, as Under Secretary General for Management. Prior to her selection as WFP Executive Director, Ms. Bertini served as Assistant Secretary of Agriculture for Food and Consumer Services in the first Bush Administration.

Ms. Bertini exemplifies the best ideals of public service and reminds us that our fundamental work is not to leave the world as we found it, but as we know it should be—free of deprivation, devoid of want and with equal opportunity for all regardless of who they are or where they are. For her efforts, I salute Ms. Bertini and her dedication to the cause of helping the needy around the world.

The World Food Prize was established in 1986 to provide international recognition for individuals who have made vital contributions to ''improving the quality, quantity, or availability of food throughout the world.'' The World Food Prize embodies the vision of Dr. Norman E. Borlaug, an Iowa native who received the 1970 Nobel Peace Prize for his development of dwarf wheat. Through the adoption of dwarf wheat varieties in the 1960's, developing countries doubled their wheat yields in what became known as the Green Revolution. Dr. Borlaug's achievements and devotion to eliminating world hunger exemplify the ideals honored by the World Food Prize.

Within a few years after the World Food Prize was created, it lost critical sponsorship and its future was in serious doubt. In short, the Prize badly needed a committed benefactor. Iowa businessman and philanthropist John Ruan stepped forward to provide critical funding and to establish a headquarters for the World Food Prize in Des Moines, IA. Under Mr. Ruan's stewardship, and with the leadership of its president, Ambassador Kenneth M. Quinn, the Prize now rests on a solid foundation. The annual awarding of the Prize serves as the anchor to a two-day international symposium and many other activities in support of defeating world famine and hunger.

It is a sobering reality that the world is still plagued with staggering levels of hunger and poverty. The World Food Prize heightens awareness of that reality, but it also inspires hope by recognizing that progress has been made and that much more can be done. Dr. Borlaug and Ms. Bertini, along with previous World Food Prize laureates, serve as examples to inspire and motivate us all to commit ourselves wholeheartedly to ending global hunger and poverty as rapidly as possible.

PARTIAL BIRTH ABORTION BAN ACT OF 2003

Mr. SANTORUM. Mr. President, I ask unanimous consent that these documents related to the Partial Birth Abortion Ban Act of 2003 be made a part of the permanent RECORD for October 21, 2003.

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

MARCH 12, 2003.

Senator RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I have read the letter from Dr. Philip Darney addressed to Senator Feinstein regarding the intact D&E (often referred to as ''intact D&X'' in medical terminology) procedure (partial-birth abortion) and its use in his experience.

As a board certified practicing Obstetrician/Gynecologist and Maternal-Fetal Medicine sub-specialist I have had much opportunity to deal with patients in similar situations to the patients in the anecdotes he has supplied.

In neither of the type of cases described by Dr. Darney, nor in any other that I can imagine, would an intact D&X procedure be medically necessary, nor is there any medical evidence that I am aware of to demonstrate, or even suggest, that an intact D&X is ever a safer mode of delivery for the mother than other available options.

In the first case discussed by Dr. Darney a standard D&E could have been performed without resorting to the techniques encompassed by the intact D&X procedure.

In the second case referred to it should be made clear that there is no evidence that terminating a pregnancy with placenta previa and suspected placenta accreta at 22 weeks of gestation will necessarily result in less significant blood loss or less risk to the mother than her carrying later in the pregnancy and delivering by cesarean section. There is a significant risk of maternal need for a blood transfusion, or even a hysterectomy, with either management. The good outcome described by Dr. Darney can be accomplished at a near term delivery in this kind of patient, and I have had similar cases that ended happily with a healthy mother and baby. Further a standard D&E procedure could have been performed in the manner described if termination of the pregnancy at 22 weeks was desired.

I again reiterate, and reinforce the statement made by the American Medical Association at an earlier date, that an intact D&X procedure is never medically necessary, that there always is another procedure available, and there is no data that an intact D&X provides any safety advantage whatsoever to the mother.

Sincerely,
NATHAN HOELDTKE, MD, FACOG,
Med. Dir., Maternal-Fetal Medicine,
Tripler Medical Center, Honolulu, HI.

REDMOND, WA,
March 12, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: The purpose of this letter is to counter the letter of Dr. Philip Darney, M.D. to Senator Diane Feinstein and to refute claims of a need for an exemption based on the health of the mother in the bill to restrict ''partial birth abortion.''

I am board certified in Maternal-Fetal Medicine as well as Obstetrics and Gynecology and have over 20 years of experience, 17 of which have been in maternal-fetal medicine. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such were performed due to the risk of caesarean delivery (also called hysterotomy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead baby. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

The presence of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney placed those mothers at extremely high risk for catastrophic life-threatening hemorrhage with any attempt at vaginal delivery. Bleeding from placenta previa is primarily maternal, not fetal. The physicians are lucky that their interventions in both these cases resulted in living healthy women. I do not agree that D&X was a necessary option. In fact, a bad outcome would have been indefensible in court. A hysterotomy (cesarean delivery) under controlled non-emergent circumstances with modern anesthesia care would be more certain to avoid disaster when placenta previa occurs in the latter second trimester.

Lastly, but most importantly, there is no excuse for performing the D&X procedure on living fetal patients. Given the time that these physicians spent preparing for their procedures, there is no reason not to have performed a lethal fetal injection which is quickly and easily performed under ultrasound guidance, similar to amniocentesis, and carries minimal maternal risk.

I understand the desire of physicians to keep all therapeutic surgical options open, particularly in life-threatening emergencies. We prefer to discuss the alternatives with our patients and jointly with them develop a plan of care, individualizing techniques, and referring them as necessary to those who will serve the patient with the most skill. Nonetheless I know of no circumstance in my experience and know of no colleague who will state that it is necessary to perform a destructive procedure on a living second trimester fetus when the alternative of intrauterine feticide by injection is available.

Obviously none of this is pleasant. Senator Santorum, I encourage you strongly to work for passage of the bill limiting this barbaric medical procedure, performance of D&X on living fetuses.

Sincerely,
SUSAN E. RUTHERFORD, M.D.,
Fellow, American College of Obstetricians and Gynecologists.

UNIVERSITY OF SOUTHERN CALIFORNIA, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY,
Los Angeles, CA, March 12, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I am writing in support of the proposed restrictions on the procedure referred to as ''partial birth abortion,'' which the Senate is now considering.

I am chief of the Division of Maternal-Fetal Medicine in the Department of Obstetrics and Gynecology at the University of Southern California in Los Angeles. I have published more than 100 scientific papers and book chapters regarding complications of pregnancy. I direct the obstetrics service at Los Angeles County Women's and Children's Hospital, the major referral center for complicated obstetric cases among indigent and under-served women in Los Angeles.

I have had occasion to review the cases described by Dr. Philip Darney, offered in support of the position that partial birth abortion, or intact D&E, was the best care for the patient in those situations. Mindful of Dr. Darney's broad experience with surgical abortion, I nevertheless disagree strongly that the approach he describes for these two cases was best under the circumstances. Such cases are infrequent, and there is not single standard for management. However, it would certainly be considered atypical, in my experience, to wait 12 hours to dilate the cervix with laminaria while the patient was actively hemorrhaging, as was described in his first case. Similarly, the approach to presumed placenta acreta, described in the second case, is highly unusual. Although the mother survived with significant morbidity, it is not clear that the novel approach to management of these difficult cases is the safest approach. It is my opinion that the vast majority of physicians confronting either of these cases would opt for careful hysterotomy as the safest means to evacuate the uterus.

Although I do not perform abortions, I have been involved in counseling many women who have considered abortion because of a medical complication of pregnancy. I have not encountered a case in which what has been described as partial birth abortion is the only choice, or even the better choice among alternatives, for managing a given complication of pregnancy.

Thank you for your consideration of this opinion.

Sincerely,

T. MURPHY GOODWIN, M.D.,
Chief, Div. of Maternal-Fetal Medicine.

MARCH 13, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I have reviewed the letter from Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional ''medical exemption'' for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Program in Human Rights in Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emptying the uterus before fetal viability then I will utilize a medically appropriate method of delivery, including intact D&E.

Though they are certainly complicated, the two cases described by Dr. Darney describe situations that were not initially emergent. This is demonstrated by the use of measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is itself risky and can lead to life-threatening hemorrhage. There may be extenuating circumstances in Dr. Darney's patients but most obstetrical physicians would not attempt dilation of the cervix in the presence of these complications. It is my understanding that the proposed partial birth abortion ban already has an exemption for situations that are a threat to the life of the mother. This would certainly allow all measures to be taken if heavy bleeding, infection, or severe preeclampsia required evacuation of the uterus.

The argument for an additional medical exemption is redundant; furthermore, its inclusions in the legislation would make the ban virtually meaningless. Most physicians and citizens recognize that in rare life-threatening situations this gruesome procedure might be necessary. But it is certainly not a procedure that should be used to accomplish abortion in any other situation.

Passage of a ban on partial birth abortion with an exemption only for life-threatening situations is reasonable and just. It is in keeping with long-standing codes of medical ethics and it is also in keeping with the provision of excellent medical care to pregnant women and their unborn children.

Sincerely,

STEVE CALVIN, MD.

SYNERGY MEDICAL EDUCATION ALLIANCE, DEPARTMENT OF MATERNAL-FETAL MEDICINE,
Saginaw, MI, March 13, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I am writing in response to the letter from Dr. Phillip Darney which was introduced by Senator Feinstein.

I have cared for pregnant patient patients for almost 29 years, and have worked exclusively in the field of Maternal-Fetal Medicine (high risk pregnancy) for over 15 years. I am board certified in Obstetrics & Gynecology, and also in the subspecialty of Maternal-Fetal Medicine. I am an assistant professor in Obstetrics & Gynecology for the Michigan State College of Human Medicine, and co-director of Maternal-Fetal Medicine in Saginaw Michigan.

I have never seen a situation in which a partial birth abortion was needed to save a mother's life. I have never had a maternal death, not ever.

I am familiar with Dr. Darney's letter describing two of his cases. My comments are not meant as a criticism of Dr. Darney as a person or as a physician. I have great respect for anyone in our field of medicine, which is a very rewarding specialty but which requires difficult decisions on a daily basis. We are all working to help mothers and their children make it through difficult pregnancies. Still, I do disagree with his stand that the legal freedom to do partial birth abortions is necessary for us to take good care of our patients. For example, in the second case he describes, I believe that patient could have carried the pregnancy much further, and eventually delivered a healthy child by repeat cesarean section followed by hysterectomy. Hemorrhage is always a concern with such patients, but we have many effective ways to handle this problem, which Dr. Darney knows as well as I. Blood vessels can be tied off at surgery, blood vessels can be occluded using small vascular catheters, cell-savers can be used to return the patients own blood to them, blood may be given from donors, pelvic pressure packs can be used for bleeding following hysterectomy, and other blood products (platelets, fresh frozen plasma, etc) can be given to treat coagulation abnormalities (DIC). His approach of placing laminaria to dilate the cervix in a patient with a placenta praevia is not without its own risk.

If Dr. Darney performed the partial birth abortion on this patient to keep from doing another c-section, or even to preserve her uterus, I'm hopeful he counseled the patient that if she becomes pregnant again, she will once again have a very high risk of having a placenta praevia and placenta accreta.

Lastly, I believe that for some abortionists, the real reason they wish to preserve their ''right'' to do partial birth abortions is that at the end of the procedure they have only a dead child to deal with. If they were to abort these women by either inducing their labor (when there is no placenta praevia present), or by doing a hysterotomy (c-section), they then need to deal with a small, living, struggling child—an uncomfortable situation for someone who's intent was to end the child's life.

Sincerely,

DANIEL J. WECHTER, M.D.,
Co-Director.

ROCKFORD HEALTH SYSTEM,
DIV. OF MATERNAL-FETAL MEDICINE,
Rockford, IL, March 12, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I am writing to contest the letter submitted to Senator Feinstein by Philip D. Darney, MD supporting the ''medical exemption'' to the proposed restriction of the partial birth abortion (or as abortionists call it ''intact D&E'').

I am a diplomate board certified by the American Board of Obstetrics and Gynecology in general Obstetrics and Gynecology and in the sub-specialty of Maternal-Fetal Medicine. I serve as a Visiting Clinical Professor in Obstetrics and Gynecology, University of Illinois at Chicago, Department of Obstetrics and Gynecology, College of Medicine at Rockford, Illinois; as an Adjunct Professor of Obstetrics and Gynecology at Midwestern University, Chicago College of Osteopathic Medicine, Department of Obstetrics and Gynecology; and as an Adjunct Associate Professor of Obstetrics and Gynecology, Uniformed Services University of Health Sciences, F. Edward Hebert School of Medicine, Washington, D.C. I have authored over 50 peer review articles in the obstetric and gynecologic literature, presented over 100 scientific papers, and have participated in over 40 research projects.

In my over 14 years as a Maternal-Fetal Medicine specialist I have never used or needed the partial birth abortion technique to care for any complicated or life threatening conditions that require the termination of a pregnancy. Babies may need to be delivered early and die from prematurity, but there is never a medical need to perform this heinous act.

I have reviewed both cases presented by Dr. Darney, and, quite frankly, do not understand why he was performing the abortions he indicates, yet alone the procedure he is using. If the young 25-year-old woman had a placenta previa with a clotting disorder, the safest thing to do would be to place her in

the hospital, transfuse her to a reasonable hematocrit, adjust he clotting parameters, watch her closely at bed rest, and deliver a live baby. If the patient had a placenta previa, pushing laminaria (sterile sea weed) up into her cervix, and, potentially through the previa, is contraindicated. It is no surprise to anyone that the patient went, from stable without bleeding, to heavy bleeding as they forcibly dilated her cervix to 3 centimeters with laminaria. The use of the dangerous procedure of blindly pushing scissors into the baby's skull (as part of the partial birth abortion) with significant bleeding from a previa just appears reckless and totally unnecessary.

Regarding the second case of the 38-year-old woman with three caesarean sections with a possible accreta and the risk of massive hemorrhage and hysterectomy due to a placenta previa, it seems puzzling why the physician would recommend doing an abortion with a possible accreta as the indication. Many times, a placenta previa at 22 weeks will move away from the cervix so that there is no placenta privia present and no risk for accreta as the placenta moves away from the old cesarean scar. (virtually 99.5% of time this is the case with early previas) Why the physicians did not simply take the women to term, do a repeat cesarean section with preparations as noted for a possible hysterectomy, remains a conundrum. Dr. Darney actually increased the woman's risk for bleeding, with a horrible outcome, by tearing through a placenta previa, pulling the baby down, blindly instrumenting the baby's skull, placing the lower uterine segment at risk, and then scraping a metal instrument over an area of placenta accreta. No one I know would do such a foolish procedure in the mistaken belief they would prevent an accreta with a D&E.

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of sound medical practices that result in a live baby and an unharmed mother.

Sincerely,

BYRON C. CALHOUN, MD, FACOG, FACS.

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

VIABILITY AND THE LAW

(By David Brown, M.D.)

The normal length of human gestation is 266 days, or 38 weeks. This is roughly 40 weeks from a woman's last menstrual period. Pregnancy is often divided into three parts, or ''trimesters.'' Both legally and medically, however, this division has little meaning. For one thing, there is little precise agreement about when one trimester ends and another begins. Some authorities describe the first trimester as going through the end of the 12th week of gestation. Others say the 13th week. Often the third trimester is defined as beginning after 24 weeks of fetal development.

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

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

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

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

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

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

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

EUTHANASIA OF PARTLY BORN HUMAN BEINGS

The greatest number of partial-birth abortions are performed during the latter part of the second trimester, from 20 through 26 weeks—both before and after ''viability.'' (A 1991 NIH survey of selected neo-natal units found that 23% of infants born at 23 weeks now survive.) However, partial-birth abortions have also often been performed in the third trimester, in a wide variety of circumstances, as documented elsewhere.

In a minority of cases involving partial-birth abortions, the baby suffers from genetic or other disorders. (Dr. Haskell estimated that ''20%'' of his 20–24 week abortions were ''genetic'' cases.) It appears that most of these involve non-lethal disabilities, such as Down Syndrome. (Down Syndrome was the most frequent ''fetal indication' on Dr. McMahon's table.)

The sort of cases highlighted by President Clinton—third-trimester abortions of babies with disorders incompatible with sustained life outside the womb—surely account for a small fraction of all the partial-birth abortions. Confronted with identical cases, most specialists would never consider executing a breech extraction and puncturing the skull. Instead, most would deliver the baby alive, sometimes early, without jeopardy to the mother—usually vaginally—and make the baby as comfortable as possible for whatever time the child has allotted to her.

Dr. Pamela Smith, Director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Chicago, testified, ''There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life or health of the mother.'' [Senate hearing record, p. 82]

Dr. Harlan Giles, a professor of ''high-risk'' obstetrics and pereinatology at the Medical College of Pennsylvania, performs abortions by a variety of procedures up until ''viability.'' In sworn testimony in the U.S. Federal District Court for the Southern District of Ohio (Nov. 13, 1995), Prof. Giles said: ''[After 23 weeks] I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent . . . But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt.'' [transcript, page 240]

When American Medical News asked Dr. Haskell why he could not simply dilate the woman a little more and remove the baby without killing him, Dr. Haskell responded: ''The point here is you're attempting to do an abortion . . . not to see how do you manipulate the situation so that I get a live birth instead.''

President Clinton and others have tried to center their arguments on cases in which the baby suffers from advanced hydrocephaly (head enlargement) that would make delivery risky or impossible. (Cases of hydrocephaly accounted for less than 4% of Dr. McMahon's ''series'' of more than 2,000 late-term abortions.) But an eminent authority on such matters, Dr. Watson A. Bowes, Jr., professor of ob/gyn (maternal and fetal medicine) at the University of North Carolina, who is co-editor of the Obstetrical and Gyneocological Survey, wrote to Congressman Canady; ''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 the most severe form of hydrocephalus) are mistaken. In such a procedure a needle is inserted with ultrasound guidance through the mother's abdomen into the uterus and then into the enlarged ventricle of the brain (the space containing cerobrospinal fluid). Fluid is then withdrawn which results in reduction of the size in the head so that delivery can occur. This procedure is not intended to kill the fetus, and, in fact, is usually associated with the birth of a live infant.''

President Clinton said that the five women who appeared with him had ''no choice,'' and two of the women suggested that their babies endangered their lives. However, Claudia Crown Ades and Mary-Dorothy Line have explained that the danger to their lives would have occurred if the baby had died in utero and not been removed. Prof. Watson Bowes says that if a baby dies in utero, it can sometimes cause problems for the mother—after about five weeks. Thus, there is plenty of time to deal with such a situation by removing the body if necessary. Such a procedure is not, legally, an abortion, has never been affected by any kind of abortion law, and raises no ethical questions.

Under closer examination, it becomes clear that in some cases, the primary reason for performing the procedure is not concern that the baby will die in utero, but rather, that he/she will be born alive with disorders incompatible with sustained life outside the womb, or with a non-lethal disability. (Again, in Dr. McMahon's table of ''fetal indications,'' the single largest category was for Down Syndrome.)

In a letter opposing HR 1833, one of Dr. McMahon's colleagues at Cedar-Sinai Medical Center, Dr. Jeffrey S. Greenspoon, wrote: ''As a volunteer speaker to the National Spina Bifida Association of America and the Canadian National Spina Bifida Organization, I am familiar with the burden of raising a significantly handicapped child. . . . The burden of raising one or two abnormal children is realistically unbearable.'' [Letter to Congressman Hyde, July 19, 1995]

Viki Wilson, whose daughter Abigail died at the hands of Dr. McMahon at 38 weeks, said: ''I knew that I could go ahead and carry the baby until full term, but knowing, you know, that this was futile, you know, that she was going to die . . . I felt like I need to be a little more in control in terms of her

life and my life, instead of just sort of leaving it up to nature, because look where nature had gotten me up to this point.'' [NAF video transcript, p. 4]

Tammy Watts, whose baby was aborted by Dr. McMahon in the 7th month, said: ''I had a choice. I could have carried this pregnancy to term, knowing everything that was wrong. [Testimony before Senate Judiciary Committee, Nov. 17, 1995]

''My husband and I were able to talk, and the best that we could, we put our emotions aside and said, 'We cannot let this go on; we cannot let this child suffer anymore than she has. We've got to put an end to this.'' [NAF video transcript, p. 4]

Claudia Crown Ades, who appeared with President Clinton at the April 10 veto, said: ''The purpose of this is so that my son would not be tortured anymore . . . knowing that my son was going to die, and was struggling and living a tortured life inside of me, I should have just waited for him to die—is this what you're saying?''

[material omitted]

''My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary Dorothy-Line and all the other women who were at the White House yesterday. All of our procedures were considered elective.'' [Quotes from transcript of taped appearance on WNTM radio, April 12, 1996]

QUOTE FROM ''ABORTING AMERICA'' BY BERNARD N. NATHANSON, M.D. WITH RICHARD N. OSTLING

How many deaths were we talking about when abortion was illegal? In N.A.R.A.L. we generally emphasized the drama of the individual case, not the mass statistics, but when we spoke of the latter it was always ''5,000 to 10,000 deaths a year.'' I confess that I knew the figures were totally false, and I suppose the others did too if they stopped to think of it. But in the ''morality'' of our revolution, it was a useful figure, widely accepted, so why go out of our way to correct it with honest statistics?

HONORING THE LIFE OF SENATOR MIKE MANSFIELD

Mr. BAUCUS. Mr. President, on October 15, we honored the late Senator Mike Mansfield with the unveiling of the new book, ''Senator Mansfield: The Extraordinary Life of a Great American Statesman and Diplomat,'' by author Don Oberdorfer.

To many, he was Senator Mansfield, Majority Leader Mansfield, or Ambassador Mansfield. To us in Montana, he was just Mike. He was our Mike. He was humble, self effacing, and didn't want people making a big fuss about him.

Although he wouldn't have wanted one, I'd like to thank the University of Montana and their alumni for hosting an event here in the Capitol to commemorate the life and times of Mike through this new book.

Mike had three great loves in his life: his wife Maureen, his State of Montana and serving in the United States Senate. Maureen was the love of his life. He always said that his successes were because of her. The last time I visited Mike in the hospital his face lit up when he talked about her. ''What a gal,'' he said. ''What a gal she was.''

Mike was a good friend and a great inspiration to many people, including myself. Mike encouraged me to get into public service, he was my mentor when I was first elected to Congress, and he provided me sage counsel until his death.

Mike would think that tonight's event was too much. That is just the kind of man he was. But it's our job to keep his memory alive and educate others on what a great impact he had on Montana, the Nation, and the world. It's our responsibility to ensure others can learn from his example of working together to do what's right.

The University of Montana Alumni Association, the Maureen and Mike Mansfield Library, the Maureen and Mike Mansfield Center, and the Maureen and Mike Mansfield Foundation here in Washington, D.C. all put forth a great effort to make this event possible. I greatly appreciate their hard work and dedication to the legacy of Maureen and Mike Mansfield.

And finally, I wish to recognize Don Oberdorfer for his persistence and dedication in writing about Mike's life. I thank Don for honoring a great man, our Mike. Montana's Mike Mansfield. He had the hands of a miner, the mind of a scholar, and the heart of a hero. We pay tribute to him and his beloved Maureen.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Enhancement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a horrific double homicide that occurred in 1996. Two lesbian women hiking in Shenandoah National Park were assaulted and gagged. Their assailant slashed each woman's throat, leaving them for dead in the forest. Although still awaiting trial, the man accused of killing the women stated that they deserved to die because they were homosexuals.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

INTERNATIONAL COFFEE CRISIS

Mr. LEAHY. Mr. President, I rise today to speak about the international coffee crisis. With much of the world focused on Iraq and the Middle East, it is perhaps not surprising that a crisis affecting tens of millions people, on virtually every corner of the Earth, has received little attention.

The worldwide price of coffee has plummeted almost 70 percent over the last several years. This has devastated the economies of poor countries in Asia, Africa, and Latin America; it has ruined the livelihoods of millions of people; and it has damaged our foreign aid and counter-narcotics efforts in these countries.

For example, over the last few years, the United States has provided almost $3 billion to Colombia for counter-narcotics assistance. This has made Colombia the top recipient of U.S. assistance outside of the Middle East.

Even though this is an extremely generous amount of aid, the goals and objectives are being undermined by the collapse of coffee prices. Last year, Colombia's President Alvaro Uribe wrote a letter to me, in which he stated:

[T]he impact of the international coffee crisis on Colombian coffee growers has been devastating. In Colombia, more than 800,000 people are directly employed on coffee farms and another three million are dependent on coffee for their livelihood. Colombian coffee farmers are struggling to cover their cost of production, and the problems of oversupply and a decline in coffee prices has brought poverty and uncertainty to Colombia's coffee-growing regions, which were previously free of violence and narcotrafficking activity. Additional support from the United States will help improve this dire situation in Colombia and other developing countries around the world which are also being impacted by oversupply and falling prices.

A range of humanitarian relief agencies, with operations around the world, further support President Uribe's views. For example, an Oxfam report on the topic found:

The coffee crisis is becoming a development disaster whose impact will be felt for a long time. Famlies dependent on money generated by coffee are pulling their children, particularly girls, out of school, can no longer afford basic medicines, and are cutting back on food. Beyond farming families, national economies are suffering. Coffee traders are going out of business, some banks are in trouble, and governments that rely on the export revenues that coffee generates are faced with dramatically declining budgets for education and health programs and little money for debt repayment.

The United States is, by far, the biggest importer of coffee. At the same time, we provide billions of dollars of foreign aid to nations impacted by the coffee crisis. It is common sense. The United States has a strong interest in finding a solution to this international problem.

A couple of years ago, several of us in Congress started asking questions about what the administration is doing to address this issue. It is safe to say that we were disappointed with the answers.

There are some good programs being run by different agencies within the Government. But, there are so many agencies involved—State, USAID, Agriculture, USTR, Treasury—and there are times when one hand does not seem to know what the other is doing. For example, USAID has programs in Latin America to help coffee farmers find alternative livelihoods, because of the