□ 1700

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore [Mr. ROGERS] at 5 p.m.

SENATE AMENDMENTS TO H.R. 1833, PARTIAL–BIRTH ABORTION BAN ACT

Mrs. WALDHOLTZ. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 389 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

Resolved, That upon adoption of this resolution it shall be in order to take from the Speaker's table the bill (H.R. 1833) to amend title 18, United States Code, to ban partial-birth abortions, with Senate amendments thereto, and to consider in the House a single motion to concur in each of the Senate amendments. The Senate amendments and the motion shall be considered as read. The motion shall be debatable for one hour equally divided and controlled by the chairman and ranking minority member of the Committee on the Judiciary. The previous question shall be considered as ordered on the motion to final adoption without intervening motion or demand for division of the question.

The SPEAKER pro tempore. The gentlewoman from Utah [Mrs. WALDHOLTZ] is recognized for 1 hour.

Mrs. WALDHOLTZ. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from California [Mr. BEILENSON] pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 389 provides for consideration of the Senate amendments to the Partial-Birth Abortion Ban Act, H.R. 1833. The rule provides for 1 hour of debate on a single motion to concur in each and all of the Senate amendments. The rule further provides that the previous question is considered as ordered on the motion for final adoption.

Mr. Speaker, this rule will allow the House to consider amendments adopted by the Senate to the partial-birth abortion ban including an amendment offered by Senator DOLE that ensures doctors will be able to use this procedure when the life of a woman is in danger.

During consideration of this bill by the House last fall, serious concerns were raised about the affirmative defense provision included in the House bill that said that a doctor could not be convicted of using the partial-birth abortion procedure if the doctor can prove that the procedure was necessary to protect a woman's life. The affirmative defense, however, would not have protected a doctor from being arrested and prosecuted for using the procedure.

The Dole amendment adopted by the Senate addresses and ameliorates this concern. It clearly states that, without fear of prosecution, a doctor may use this procedure, when no other procedure is adequate, in order to protect the life of a woman.

Mr. Speaker, the rule is narrowly drawn so that we can adequately work with the Senate on changes that they have adopted to the bill and to expeditiously move the bill for final action. It is appropriate, Mr. Speaker, to limit debate on the measure to amendments that have been adopted in the Senate and not to use this bill as a vehicle for debating the enormous range of contentious issues relating to abortion.

Abortion is clearly one of the most emotionally charged issues that our Nation faces. People with the best of intentions who have carefully considered this issue come to opposite conclusions, and it is difficult to find areas of common ground. I would hope that this particular bill is an area where we can find that elusive common ground and prohibit a procedure that partially delivers a live child before killing it and completing the procedure, a procedure that one practitioner admits he uses for purely elective abortions about 80 percent of the time he uses this procedure.

Mr. Speaker, the procedure that we are talking about today is one that is gruesome and horrific. Without wishing to offend other Members or the people who may be watching these proceedings, I think it is critical, Mr. Speaker, that we describe exactly what it is we mean by a partial-birth abortion so that people will understand that we are not talking about a series of other issues that are related to the abortion debate, but we are talking in this bill about one very clearly described procedure that should be banned.

In this procedure, which is used during the second and third trimesters of a pregnancy, the practitioner takes 3 days to accomplish the death of the child. For the first 2 days the woman's cervix is dilated so as to promote the ease with which the doctor will perform the abortion. On the third day the woman goes into the doctor's office and through the use of ultrasound the physician locates the legs of the child. Using a pair of forceps, the physician then seizes one of those legs and drags that leg through the birth canal. The doctor then delivers the rest of the child, legs, torso, arms, and stops when the head is still in the birth canal. One practitioner who uses this procedure says the child's head usually stops before being delivered because, of course, the cervix has not been dilated to the point that a regular vaginal delivery would occur because that is not the point of this exercise.

So, once the child's head is stopped in the birth canal, the doctor reaches down to the base of the child's skull, inserts a pair of scissors, ending the child's life, yanks those scissors open to enlarge the hole and uses a vacuum catheter to suck out the contents of the child's cranium.

That is the procedure that we are talking about in this bill, Mr. Speaker, the partial delivery of a living fetus whose life is ended with its head still in the birth canal by the deliberate insertion of a pair of surgical scissors so that an abortion may be accomplished.

That is what we are talking about in this bill, Mr. Speaker. We are not talking about any other type of abortion. We are not dealing with Federal funding. We are not talking about any of the other issues with which we have to grapple in the abortion debate. But we are talking about a so-called procedure that measures life in inches, and we need to agree with the Senate amendments and move this legislation forward, hopefully for signature by the President.

Mr. Speaker, the rule that this bill has attached to it allows for fair consideration of the amendments adopted in the Senate, and I urge my colleagues to support this rule.

Mr. Speaker, I reserve the balance of my time.

Mr. BEILENSON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the gentlewoman from Utah [Mrs. WALDHOLTZ] for yielding to me the customary half hour of debate time.

Mr. Speaker, we oppose the closed process that would make in order consideration of the Senate amendments to H.R. 1833, the so-called and misnamed partial-birth abortion ban. This is a bill that on the pretense of seeking to ban certain vaguely defined abortion procedures is, in reality, an assault on the constitutionally guaranteed right of women to reproductive freedom and on the freedom of physicians to practice medicine without Government intrusion.

Those of us, Mr. Speaker, who fought for many, many years to secure, and then to preserve and protect, the right of every woman to choose a safe medical procedure to terminate a wanted pregnancy that has gone tragically wrong, and when her life or health are endangered, are deeply troubled by the legislation before us today and by the rule under which it is being considered.

We say at the outset that the other body improved the bill by agreeing to the Smith-Dole amendment which does shield doctors from prosecution if they perform the procedure when the life of the mother was in danger, but only under certain circumstances. However, this is an extremely narrow so-called life exception that requires that the woman's life be endangered by, quote, a ''physical disorder, illness or injury,'' end of quote, and it requires, further, that no other medical procedure would suffice.

It appears that if the mother's life is threatened by the pregnancy itself, then the procedure would still be illegal. And it does not take into account the fact that doctors do not use other procedures because they pose greater risks than does this method of serious health consequences to the mother, including the loss of future fertility.

And of course the Senate amendment does not provide an exception to preserve the mother's health no matter how seriously or permanently it might be damaged.

For those reasons, Mr. Speaker, we feel strongly that a true life and health exception amendment should have been made in order.

It is bad enough, we feel, that we are being asked to vote on this irresponsible piece of legislation. To make matters worse, we are being required to consider it under an unfair rule, and it is one that should be defeated. Once again the majority has brought this most controversial of bills to the floor under a totally closed rule. That we would again be forced to consider a bill of this importance and of this complexity under these restrictions is offensive, to begin with.

Once again, Members are being denied a vote on an amendment that would allow an exception to protect a woman's life under all circumstances or to prevent serious adverse consequences to her health and future fertility.

The Committee on Rules heard very compelling testimony from the gentlewoman from New York [Mrs. LOWEY], the gentleman from Massachusetts [Mr. FRANK], and the gentlewoman from Colorado [Mrs. SCHROEDER] on their request to offer a true life and adverse health exception amendment to the Senate language.

We believe Members should have had the opportunity to vote on allowing those exceptions to the ban.

This is obviously a basic and fundamental concern to women and to their families. Without that exception, the bill will force a woman and her physician to resort to procedures that may be more dangerous to the woman's health and to her very life and that may be more threatening to her ability to bear other children than the method that we seek to ban. Making this amendment in order would have meant that Members could cast a vote that shows respect for the importance of a woman's life, health, and future fertility.

Mr. Speaker, the truth is we have absolutely no business considering this prohibition and criminalization of a constitutionally protected medical procedure. This is, we believe, a dangerous piece of legislation. We oppose it not only because it is the first time the Federal Government would ban a particular form of abortion, but also because it is part of an effort to make it virtually impossible for any abortion to be performed late in the pregnancy, no matter how endangered the mother's life or health might be.

What is at stake here is whether or not it will be compassionate enough to recognize that none of us in this legislative body has all the answers to every tragic situation which confronts a woman and her family. We are debating not merely whether to outlaw a procedure but under what terms.

If we must insist on passing legislation that is unprecedented and telling physicians which medical procedures they may use despite their own best judgment, then we must also, it seems to us, permit a life or adverse health exception. It is the only way we can ensure that the bill might possibly meet the requirements that have been handed down by the U.S. Supreme Court.

Mr. Speaker, this is a very personal matter to the people involved. I would hope that everyone can, but obviously not everyone has had the chance to, read the very moving testimony of one of my own constituents, Mrs. Coreen Costello of Agoura, CA, in opposition to this bill. Mrs. Costello described herself as a conservative pro-life Republican who always believed abortion was wrong until she was faced with the choice that she was in this case faced with.

She recounts in detail the events that have led to confronting the painful reality that her only real option was to terminate her pregnancy. The bill before us would ban the surgical procedure Mrs. Costello had about which she wrote, and I quote her:

''I had one of the safest, gentlest, most compassionate ways of ending a pregnancy that had no hope. Other women, other families, will receive devastating news and have to make decisions like mine. Congress has no place in our tragedies.''

Mr. Speaker, if I may add a personal note, in 1967, then-Governor Ronald Reagan signed California's Therapeutic Abortion Act, which I authored and which was one of the first laws in the Nation to protect the lives and the health of our women.

□ 1715

When the U.S. Supreme Court subsequently ruled in Roe versus Wade that the government cannot restrict abortion in cases where it is necessary to preserve a woman's life or health, I thought that we have come to at least accept the precept that every woman should have the right to choose with her family and her physician, but without government interference, and when her life and health are endangered, how to deal with this most personal and difficult decision.

I see now that obviously I was wrong, and that this Congress is willing even to criminalize for the first time a safe medical procedure that is used only rarely, and almost always to end the most tragic of pregnancies.

Mr. Speaker, as I said, we believe this legislation is unwise, it is unconstitutional, and it is bad public policy to return to the dangerous situation that existed about 30 years ago and more. This legislation is not a moderate measure, as its proponents argue. It is, instead, likely the first step in an ambitious strategy to overturn Roe versus Wade, and we believe it would be a tragedy for all women and their families.

Mr. Speaker, it should be emphasized that what we are talking about making a crime is a medical procedure that is used only in very rare cases, fewer than 500 per year. It is a procedure that is needed only as a last resort, in cases where pregnancies that were planned and are wanted have gone tragically wrong. Adoption of the bill would have these results.

In cases where it is determined that an abortion is necessary to save the life of the women, the Senate amendment would force her to choose a method that may leave her unable to bear children in the future. The language of the Senate amendment will not protect women whose lives are threatened by their pregnancies, and doctors will be forced to choose other procedures, even if they are more dangerous.

Mr. Speaker, choosing to have an abortion is always a terribly difficult and awful decision for a family to make, but we are dealing here with particularly wrenching decisions in particularly tragic circumstances. It seems to us that it would be fitting if we showed some restraint and compassion for women who are facing those devastating decisions.

Let me end, Mr. Speaker, by quoting again, if I may, from Mrs. Costello's testimony before the Senate Committee on the Judiciary, just a very brief amount:

> Due to the safety of this procedure, I am again pregnant now. Fortunately, most of you will never have to walk through the valley we have walked. It deeply saddens me that you are making a decision having never walked in our shoes. When families like ours are given this kind of tragic news, the last people we want to seek advice from are politicians. We talk to our doctors, lost of doctors. We talk to our families and other loved ones, and we ponder long and hard into the night with God.
>
> What happened to our family is heartbreaking and it is private, but we have chosen to share our story with you because we hope it will help you act with wisdom and compassion. I hope you can put aside your political differences, your positions on abortion, and your party affiliations and just try to remember us. We are the ones who know. We are the families that ache to hold our babies, to love them, to nurture them. We are the families who will forever have a hole in our hearts. We are the families that had to choose how our babies would die. Each one of you should be grateful that you and your families have not had to face such a choice. I pray that no one you love ever does. Please put a stop to this terrible bill. Families like mine are counting on you.

Mr. Speaker, we do, as I have said before, strongly oppose the rule before us and the bill that it makes in order. We urge defeat of the rule so we can sent it back to the Committee on Rules and at least ask for a rule that would allow us to vote on an amendment to preserve the life, under all circumstances, and the health of the mother.

Mr. Speaker, I reserve the balance of my time.

Mrs. WALDHOLTZ. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, before I yield to the next speaker, I think it is important that we recognize that the procedure

that we are talking about today is not a legitimate medical procedure recognized by experts of the American Medical Association. With all respect to my colleague on the Committee on Rules, for whom I have great respect and affection, there is no question but that the experience that his constituent had is one that none of us hope we have to share. But, Mr. Speaker, the American Medical Association's Council on Legislation, made up of 12 physicians, voted unanimously to recommend that the American Medical Association board of trustees endorse this partial birth abortion ban.

A member of the council, after they had discussed this procedure, said that they felt that this was not a recognized medical technique, and that the council members had agreed that the procedure was basically repulsive. We are not criminalizing an accepted medical technique, Mr. Speaker. It is unfortunate that we are having to debate what has become medicalized infanticide.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Speaker, I thank the gentlewoman for yielding time to me, and I commend her and the Committee on Rules for bringing forth this rule, and the members of the Committee on the Judiciary for originally introducing this legislation.

Mr. Speaker, I was sitting in my office at the time, still practicing medicine in 1993, when I got my copy of the American Medical News in which this procedure was first described where a baby is identified under ultrasound, the abortionist, using a forcep, reaches up into the birth canal and grabs the baby by the feet, dragging the baby out of the birth canal up to the level of its head, and then there, dangling outside the mother, typically with its arms and legs moving, a forcep is inserted into the back of the skull, an opening is created, the brains are sucked out, and the dead baby is then delivered.

I was amazed to read in this article that somebody could actually concoct a procedure this gruesome, and I was further shocked to read that the physicians who developed the procedure then went on to report that in 85 percent of the cases within which they do this procedure, there are no significant birth defects, and some of the defects that they cited, where they justified doing this procedure, included cleft lip and cleft palate.

Mr. Speaker, I was shocked, and frankly I was amazed that I could live in a country where a procedure as gruesome and awful as this could be legalized. Some would call this a safe medical procedure. I would contend that there was a party involved in this procedure where it was anything but safe. Indeed, it was lethal, and it was lethal in a most horrific way.

We in the United States, contrary to the contention of many people, have the most liberal left-wing abortion laws. In Europe, most of Europe that legalized abortion far before we did in this country, this type of procedure is not legal. They have restrictions on how you can do these procedures and when you can do them. Specifically, they are not legalized in late trimester, in late second trimester, and in the third trimester.

My colleague on the other side of the aisle I thought encapsulated the whole issue very well. There are some people who would like the mother to be able to choose how her baby will die. The majority of this body voted once before, and will vote again, that there is a place where the Government of the United States has to draw the line and say, ''This is beyond the pale.'' This is a total repudiation of the principles upon which our Nation was founded. I support the rule. I encourage all my colleagues to vote for the rule.

Mr. BEILENSON. Mr. Speaker, I yield 5 minutes to my good friend, the gentleman from Ohio [Mr. HALL], a fellow member of the Committee on Rules.

Mr. HALL of Ohio. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I rise in support of the Senate amendments to this legislation and was proud to be an original cosponsor of the House-passed bill.

While abortions, except to save the mother's life, are wrong for those of us who believe in life, this particular procedure is doubly wrong. It requires a partial delivery and involves pain to the baby.

Mr. Speaker, you will hear the medical details of these abortions from other witnesses, but I simply lend my support to the bill as one who tries to ascribe to a moral code and commonsense. A compassionate society should not promote a procedure that is gruesome and inflicts pain on the victim. We have humane methods of capital punishment. We have humane treatment of prisoners. We even have laws to protect animals. It seems to me we should have some standards for abortion as well.

Many years ago surgery was performed on newborns with the thought that they did not feel pain. Now we know they do feel pain. According to Dr. Paul Ranalli, a neurologist at the University of Toronto, at 20 weeks a human fetus is covered by pain receptors and has 1 billion nerve cells—more than us, since ours start dying off with adolescence. Regardless of the arguments surrounding the ethics of the procedure, it does seem that pain is inflicted.

Finally, Mr. Speaker, I do not want to discuss a bill relating to abortion without saying that we have a deep moral obligation to improving the quality of life for children after they are born. I am a Member of Congress who is opposed to abortion. But, I could not sit here and honestly debate this subject with a clear conscience if I did not spend a good portion of my time on hunger and trying to help children and their families achieve a just life once they are born.

We need to promote social policies that ensure the mother and child will receive adequate health care, training and other assistance that will, in turn, enable them to become productive members of society. We have not done a good job so far, and I am afraid to say, this House has been unraveling social programs all too easily. Until our Nation makes a commitment to offering pregnant women and their children a promising future, I am afraid the demand for abortion will not subside.

Enough is enough. If there's one thing this Congress ought to do this year is stop this very reprehensible and gruesome technique of abortion. We treat dogs better than this. Vote yes on this bill.

Mrs. WALDHOLTZ. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio [Mr. CHABOT].

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

Mr. CHABOT. Mr. Speaker, today we will again vote on whether or not it should be lawful for an abortionist to kill a baby that already has been partially delivered in circumstances where the mother's life is not at risk. Remember, the doctor must grasp two kicking, healthy legs to secure the baby so that he can insert into the child's skull a scissor-like device that causes the brain to collapse, and it kills the child. Even those who advocate this type of abortion shudder to describe it. Only the most extreme ideologue could favor such a gruesome procedure where the mother's life is not in jeopardy.

This whole debate is over whether thinking, feeling, healthy little babies who are within weeks or sometimes even days of natural delivery should be robbed of the opportunity to breathe the same air you and I share. These babies, only inches away from being fully born, are no different from mildly premature babies. They deserve to live.

I celebrate the fact that today we will take a step in representing those who cannot represent themselves by passing the partial birth abortion bill, and I strongly, strongly urge Members to vote for its passage.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. FARR].

Mr. FARR of California. Mr. Speaker, this is not a bill about life, this is a bill about politics. Think about it. The House passed this bill in its original version to ban partial birth abortions. The Senate changed it. The Senate said, ''You can make an exception to the ban in the case of the life of the mother.'' What is going on here? Congress is trying to be your doctor.

I though this was the era of getting Government off our backs, not the era of getting Government more into your personal issues.

□ 1730

Now it seems that we are imposing more Government regulations on a woman's personal life.

It is ironic that this Congress honors this month of March as Women's History Month. We celebrate women overcoming obstacles in their lives, women having liberties, and women having freedom of choice. Now here tonight, in a male-dominated Congress, they want to take away a woman's right to decide what is right for her and for her baby.

I have talked to constituents who have been forced to have this procedure to protect future fertility. I think we are foolish to think that we can handle this issue with our lawmaking process better than women can handle it in the medical arena.

Everyone knows that we cannot save life or make life by ordering it. Do not pass laws that may prevent healthy women from ever, ever becoming loving mothers. Support women. Support womanhood. Reject this rule. Reject this bill. Honor women. Honor medicine. Honor choice. Do not make bad law.

Mrs. WALDHOLTZ. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee [Mr. BRYANT].

(Mr. BRYANT of Tennessee asked and was given permission to revise and extend his remarks.)

Mr. BRYANT of Tennessee. Mr. Speaker, I rise in support of this rule which I think is a very good one. It allows the Senate amendments that were made to this bill to be accepted by this House, and I believe that the Senate amendments are reasonable and, as I said before, acceptable.

This rule continues to focus on the matter at hand, only the Senate amendments, and for that reason I do not think we need any extraneous amendments to this bill.

When this House considered the bill in the past, the recent past, it passed it by 288 people voting for it, which showed wide bipartisan support for this bill. Now, under the guise of protecting the mother's health, efforts are being made to change this rule or ask for amendments to allow this exception.

The Supreme Court has considered in the case of Roe versus Bolton that to protect the mother's health, that definition of health can encompass all factors, physical, emotional, psychological, familial, and the woman's age, all relevant to the patient's well-being. This type of exception, as we found in California, would open the door wide open to the humane device of this partial-birth abortion, and certainly would be unacceptable.

Even many of the people that voted in the House earlier for this bill which outlawed this particularly terrible procedure would call themselves prochoice.

I find it somewhat ironic, too, as we are taking up the Endangered Species Act on this Hill and we are talking about preservation of animals in particular, that we actually protect the American eagle and its preborn, the egg of that eagle, more than we protect the preborn of a human being. It is actually a fine of $500 to $5,000, up to 1 year in prison, for destroying an eagle egg, a preborn eagle.

But this issue here is not about the big issue of abortion, but simply outlawing a particularly egregious and terrible procedure that is used. As I argued on the floor before, were we to transfer this type of procedure over to a way of executing people who have committed murder, on death row, there would be many in this body that would be the first to stand up or encourage people to go to court to stop this type of procedure as in violation of the eighth amendment to our Constitution which prohibits cruel and unusual punishment. Were we to take someone, instead of electrocuting them or using the gas chamber or, as in Utah, using the firing squad, and take a screwdriver and crack their skull and suck out their brain, which is this procedure that is used in this particular type of abortion, again we would be in court very quickly to defend that particularly terrible procedure, and I would agree on that.

The example that we used in our earlier debate occurred in Washington State, where a man on death row actually went to court and was able to set aside temporarily his death row conviction or the execution of the death penalty because he was so heavy, over 400 pounds, that he would be decapitated were he hung as was the procedure in Washington.

We have precedent for this, and I would simply say that the American Medical Association Council on Legislation has voted unanimously to recommend that the AMA endorse this bill. I think their opinion would carry an awful lot of weight.

Mr. Speaker, I was very pleased when this body passed H.R. 1833, the Partial-Birth Abortion Ban Act, by an overwhelming 288-to-139 margin. Today we consider the Senate's amendments to the bill and the rule.

The Senate passed the Partial-Birth Abortion Ban Act with similar bipartisan support. And that body's amendments are reasonable and acceptable. Furthermore, the rule simply addresses the matter at hand—the Senate amendments. There is no reason to consider extraneous amendments.

Unfortunately, the President and proabortion extremists continue to oppose this modest, widely supported bill. The President has threatened to veto this bill because it doesn't have amendments that would allow this gruesome procedure for virtually any reason. Under the guise of protecting the mother's health, the radical abortionists want to add a health-of-the-mother exception. The bill already would allow the partial-birth abortion procedure if the abortion was necessary to save the woman's life, and this procedure was the only method of doing so.

However, to add ''health'' would be tantamount to writing in a loophole through which a Mack truck could be driven. While protecting a mother's health may sound reasonable on its face, the Supreme Court has defined ''health'' as anything that relates to one's well-being. Does that mean that being depressed or having a cold or allergies or a headache could qualify as jeopardizing health under such an open-ended definition? Certainly. In fact, the Court held in Doe versus Bolton that ''health'' encompasses ''all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient.'' Therefore, to add ''health'' to this legislation would gut the bill.

The fact is, according to the doctors who perform most of this type of abortion, 80 percent of partial-birth abortions are elective. That means they are for almost any reason.

Mr. Speaker, let's be completely clear about the procedure that this bill would ban. The opponents of this bill would direct the debate to side issues, and for good reason: If the American people know the facts, they'll want this horrible abortion procedure banned.

While all methods of abortion are repulsive, barbaric, and nauseating, this abortion method reaches depths of inhumanity that only a calloused conscience could approve of.

Remember that this abortion procedure takes place during the second trimester or later. That's after the baby's heart is beating, which occurs at about 3 weeks after conception. That's after the baby's brain waves can be measured, which happens at 6 weeks. That's after morning sickness has usually subsided, after 3 months.

First, the abortionist uses ultrasound—an amazing, high-technology medical tool that gives doctors and parents-to-be a look at the baby inside the womb—the abortionist uses this tool of life as a tool of death. He uses ultrasound to guide his forceps to grab the unborn baby's leg.

Second, the abortionist pulls the baby by his leg into the birth canal and proceeds to deliver the baby's entire body, except for the head.

Next, the abortionist jams scissors into the base of the baby's skull. That's the usual point when the baby dies. Let me interject here that the only thing that separates this act from murder is the fact that the baby's head is still in the birth canal.

Finally, the abortionist removes the scissors and inserts a suction catheter. The baby's brains are sucked out, collapsing the skull. The dead baby is then fully delivered. That's a partial-birth abortion.

Some of the so-called antichoice extremists who support this bill include the American Medical Association's Council on Legislation, which voted unanimously to recommend that the AMA endorse H.R. 1833. The council made that recommendation because its members concluded that partial-birth abortion is not a legitimate medical procedure. This statement begs the question, if partial-birth abortion isn't an acceptable medical procedure according to a professional body in the field of medicine, then what is this procedure? It certainly doesn't reflect the Hippocratic oath, which says doctors should first do no harm.

It is ironic that we wouldn't treat convicted capital offenders this way. The ACLU would be up in arms and in court and crying ''cruel and unusual punishment'' if a State tried to stab scissors in the base of the prisoner's skull and then suck out his brains with a vacuum cleaner.

In fact, a court in Washington State ruled that hanging convicted murderer Mitchell Rupe, who weighted 400 pounds, would be cruel and unusual punishment. Rupe had appealed his death penalty by arguing that because of his excessive body weight, the noose would decapitate him, and that would be cruel

and unusual punishment. The appellate judge agreed with this man, who had been convicted on two counts of first-degree murder.

Mr. Speaker, H.R. 1833 bans the performance of partial-birth abortions, the gruesome procedure that I have described.

As medical technology continues to develop to the point where surgery can be performed on unborn babies, where more and more premature babies survive, where doctors can perform increasingly sophisticated techniques that just 10 or 20 years ago we would have thought of as medical miracles, it's time to take a hard look at biological and medical facts.

H.R. 1833 bans a single abortion technique that even many people who call themselves pro-choice support the banning of. But what are the ethical and moral questions we as a society need to confront? Do the medical facts we have today support the ignorant bliss on which Roe versus Wade and Doe versus Bolton were decided? Is this country still a civilized society? What kind of a people would allow the partial birthing of a half-gestated baby, only to be stabbed with surgical scissors and his brains sucked out, knowing the biological facts we have in 1996?

It is also ironic that this Nation protects unborn eagles more vigorously than it protects unborn human beings. We punish people under three different acts—the Migratory Bird Treaty Act (16 U.S.C. 703), the Bald Eagle Protection Act (16 U.S.C. 668), and the Endangered Species Act (16 U.S.C. 1538 and 1540)—for destroying an eagle egg. The Migratory Bird Treaty Act provides for penalties up to $500 in fines and 6 months in prison for destroying an eagle egg. The penalty under the Bald Eagle Protection Act is a fine up to $5,000 and a year in prison. The Endangered Species Act provides for civil and criminal penalties; the criminal penalties for knowingly destroying an eagle egg, depending on the location where the egg is found, range to $50,000 in fines and 1 year in prison. Unborn eagles have that much protection under law. However, unborn human babies may be aborted at any time throughout the pregnancy. And in the case of partial-birth abortion, the baby can even be forcibly, partially delivered in order for the abortionist to destroy that baby's life.

Mr. Speaker, I have faith that the American people will make the right decision. Give the American people the facts, as has been done regarding partial-birth abortion, and they will arrive at the civilized, decent conclusion that this procedure should be outlawed. I believe the American people will remain true to our Nation's core values, that we are all endowed by our Creator with certain unalienable rights, foremost being the right to life.

I conclude with these verses from Psalm 139: ''For you created my inmost being; you knit me together in my mother's womb. * * * My frame was not hidden from you when I was made in the secret place. When I was woven together in the depths of the earth, your eyes saw my unformed body.''

Mr. Speaker, I urge that we accede to the Senate's amendments. I urge that we adopt this rule. And I urge the President to reconsider his veto threat.

Mr. BEILENSON. Mr. Speaker, I yield 5 minutes to the gentleman from Massachusetts [Mr. FRANK], who serves on the Committee on the Judiciary.

Mr. FRANK of Massachusetts. Mr. Speaker, we will get to debate the substance of the bill, although very briefly. The gentlewoman from Utah [Mrs. WALDHOLTZ] said that this rule provides adequate time to discuss the Senate amendments. This rule, in fact, provides quite deliberately the minimum time that it is legally possible to give a bill on the floor of the House.

The rule gives 1 hour. That is the minimum that is allowed under the basic rules, so this is part of an effort to suppress debate and discussion on this bill. We will get to the substance, but I want to talk here about the outrageous procedure. It is one more example of this majority running absolutely roughshod over the notion of open debate and democracy and fairness. This is, once again, a rule as we say in previous weeks where to achieve their political purpose, to make sure that their political message is unadulterated, the majority sacrifices the right of the American people to have free debate.

For example, the gentlewoman from Utah talked about the amendment that was adopted in the Senate. She said people felt that the life exception for the mother was not done right so the Senate straightened it out. Many of us raised that same point here in the House, and why did we not straighten it out here in the House? Because they had the same rules the last time. The rule did not allow that amendment. It is an amendment that we in the House were prevented from considering because of the close-fisted rule of the majority on this bill.

The Senate did adopt the amendment, so they are giving in and they say, ''OK, we will do it''. They are almost taking credit for the improvement the Senate made when they refused to allow us to vote on such an amendment here. Now we have another amendment that we want to offer, and I understand here that we cannot even offer a motion to recommit this.

It is a very cleverly crafted procedure they have. This is not a bill. It is a concurrence with the Senate amendment because, by making it that way, we cannot even recommit it and no amendments are in order. We can do nothing in the House to alter this. We can vote up or down. We have twice been asked by the majority, not asked, directed by the majority to vote on this very important issue with no amendment and with the minimum time for debate allowed under the rules of this House.

They want to do it. They want to do it quickly and have as little conversation as possible because it will not stand up, apparently, they believe, to greater scrutiny. They are afraid to allow an amendment.

We have an amendment that we offered, the gentlewoman from Colorado and I. It is an amendment that was offered in the Senate. The Senate adopted one amendment and then the Senate rejected another but it got 47 votes. We are hardly talking about some fringe position; 47 votes, including Republican votes, in the Senate, and we are not being allowed to offer it here.

We cannot do it on the motion to recommit because there is no committee to which it can be recommitted. This is simply a motion to concur in the Senate amendment, and what is the amendment that the majority is afraid to allow the House to vote on?

They cannot plead time. We are less busy than the guys in ''Marty,'' standing around on the corner. ''What do you want to do tonight?'' ''I don't know. What do you want to do tonight?''

Voting is not one of the things, because the majority cannot get itself organized. We have hardly overvoted ourselves this week, but the majority is afraid to allow the amendment.

The amendment says the doctor will not be considered a criminal and sent to prison if he performs this procedure to prevent damage to the health of the mother. If a doctor were to decide that this procedure was necessary to avoid damage to the mother's ability to give birth in the future, he would be committing a crime if he did it because the majority will not even let us vote on an amendment that would say to avoid damage to her ability in the future to bear children. We are talking about serious adverse health effects.

At the Committee on Rules, the majority allowed a debate in the Committee on Rules. They did not want to but they cannot shut us up. They are probably working on a way to do that in the Rules Committee.

The gentlewoman from Colorado said this is so broad. What do we mean by health? My answer is simple. I think serious adverse health is good enough, and I am prepared to put the doctor's opinion up.

But if you think that is too broad, then amend the amendment. My colleagues on the other side of the aisle are afraid of open debate. If you think serious adverse health is too broad, why do you not put very, very, really serious adverse health? Or if you are afraid of psychological, put physical health. I do not agree with that. I would vote against that, but if you want to avoid serious physical damage to the mother but do not want to let in depression, then allow us to vote on it.

But your preferred procedure which you are imposing successfully on this House, I am afraid, I reemphasize this, that procedure requires us to vote and will not allow an amendment that would say to a doctor if you perform this procedure, and by the way it is called a procedure by the American College of Obstetricians and Gynecologists. I will put their letter in opposition to this in the RECORD. You are saying that we cannot even offer an amendment that would say to avoid serious damage to the mother's physical health. Our amendment does not say that, but you could amend the amendment and make that in order.

I know that democracy seems complicated to people who have so little practice with it. You are instead going to demand that we vote to make it criminal even if a doctor wanted to prevent serious physical damange to the health of the mother.

Mr. Speaker, I include the following letter for the RECORD:

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, November 1, 1995.

STATEMENT ON H.R. 1833: THE PARTIAL-BIRTH ABORTION BAN ACT OF 1995

The American College of Obstetricians and Gynecologists is disappointed that the U.S. House of Representatives has attempted to regulate medical decision-making today by passing a bill on so-called ''partial-birth'' abortion.

The College finds very disturbing any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community—demonstrating why congressional opinion should never be substituted for professional medical judgment.

The College does not support H.R. 1833, or the companion Senate bill, S. 939.

Mrs. WALDHOLTZ. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to simply respond quickly. The gentleman from Massachusetts is an excellent student of the rules of the House, and as such an excellent student of the rules of the House the gentleman knows that the minority had an opportunity to offer a motion to recommit when the House originally considered this bill. At that time the gentleman could have offered his amendment. He chose not to. The minority chose to not offer a motion to recommit. This bill went over to the Senate. It is back now for our concurrence.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan [Mr. BARCIA].

Mr. BARCIA. Mr. Speaker, I rise today in support of House Resolution 1833, the Partial-Birth Abortion Ban Act, and I urge my colleagues to vote in favor of the rule and the final passage of this important legislation.

As a pro-life advocate I am committed to protecting the rights of unborn children. My primary concern is that abortion should not be treated like a routine medical procedure. Although some consider partial-birth abortions routine medical procedures, this could not be further from the truth. Partial-birth abortions are neither routine, legitimate or necessary.

Partial-birth abortions are most often performed in the second or third trimester. I am particularly troubled by the horrifying prospect of late term abortions. Even in Roe versus Wade, abortions are limited to the first trimester. Today we are considering continuing to allow abortions through the third trimester of fetal viability.

House Resolution 1833 not only bans the performance of this type of inhuman abortion but it imposes fines and a maximum of 2 years of imprisonment for any person who administered a partial-birth abortion. This gruesome and brutal procedure should not be permitted.

I strongly believe in the sanctity of life, and if 80 percent of the abortions are elective, we have to reconsider and reevaluate the value our society places on human life. This decision is not made in the case of rape or incest, not if the mother's life is in danger, and not if there are birth defects. In many cases this is a cold, calculated, and selfish decision.

This is not a choice issue. This is a life or death issue for an innocent child. Please join me in making this heinous procedure illegal.

Mr. BEILENSON. Mr. Speaker, I yield 3 minutes to the gentlewoman from New York [Ms. SLAUGHTER].

Mrs. SLAUGHTER. Mr. Speaker, in every way this debate today is a tragedy.

First, I want to make it very clear, as clear as I can to people who are interested in knowing the truth, that the third trimester abortions, and the partial-birth abortions are very rare and they are not done as elective surgery at all. They are done in the case of a severely deformed fetus, a dead fetus, or a mother who will not survive until the birth is completed.

It is not a case of grabbing hold of two kicking legs and delivering a child that will be able to grow and respond to life. It is not a case of that at all. Why do we add to the awful tragedy of the families that desperately want the children that they are carrying and lose? Why do we say that the Congress of the United States knows better than the parents do and better than their doctor does, and we are going to require that they continue this pregnancy.

I am scared about the precedent that this legislation sets. To say that the procedure, practice and procedure, should be left to the Congress of the United States and not to medical people is a dangerous idea. A physician cannot choose this procedure even if other procedures would have serious health consequences, and we have talked about that, the possibility of loss of fertility.

□ 1745

But the underlying thing that last bothered me ever since I have been in the Congress of the United States is there is another underlying piece here, and that is that women do not have the right to choose, maybe they are not smart enough, we cannot let them decide what is the best thing in the world for them to do. Some men have to sit around and decide what is best, usually deciding that in legislatures all over the country and this Congress what it is that we can say is appropriate for them.

It is not original with me, but if women were that dumb, how in the world does anybody here expect that they had had a mother who bore them and raised them to extraordinary lengths that they are today? Had a Member of the Congress of the United States. Just like any other patient, a woman deserves the best care based on the best circumstances and the knowledge that it fits her situation. It should not be tailored to fit the needs of Members of Congress or any ideas that they may have. Women should not be considered second-class citizens and that needs a big brother to tell her what is permissible and what is not.

Unfortunately, I think this is only a beginning. The bill's sponsors have consistently stated this is a first step and, if they have the votes, they will prevent all abortion. I think many of them would also prohibit birth control. They want Government intrusion into every doctor's office and eventually into every bedroom. We should not start down this road. We should not prohibit medical procedures by Government fiat. We should not prohibit physicians and patients from making informed decisions based on the individual facts of the particular case.

Mr. Speaker, I ask defeat of this rule, which prohibits this House from modifying the draconian antiwoman provisions of this bill. I then ask my colleagues to preserve the right of women to the most appropriate medical procedure based on the best medical advice by defeating this underlying bill.

Mrs. WALDHOLTZ. Mr. Speaker, I yield myself such time as I may consume.

I think it is important to point out the definition of elective and nonelective abortion regarding third-trimester abortions. In this particular situation, it depends on the definition of the person expressing it. One of the doctors who pioneered the partial-birth abortion procedure, as he called it, said the third trimester abortions he performed this way are nonelective, but he said that these abortions also are caused by factors such as maternal risk, rape, incest, psychiatric or pediatric indications. This doctor's definition of nonelective are extremely broad. He went on to tell the Subcommittee on the Constitution that he had performed more than 2,000 of these partial-birth abortions and that he attributed over 1,300 of them to what he called fetal indications or maternal indications.

Of those indications, the most common maternal indication was depression. Other maternal indications included what he called pediatric pelvis, their youth, spousal drug exposure, and substance abuse. Clearly, Mr. Speaker, what is elective or nonelective varies widely depending on the purpose of the person offering the definition.

Mr. Speaker, I yield 1 minute to the gentleman from Indiana [Mr. SOUDER].

Mr. SOUDER. Mr. Speaker, first I want to agree with the earlier speaker

that this amendment is actually not needed. We in the House had already protected life of the mother, but in the new language, ''necessary to save the life of the mother whose life is endangered by a physical disorder, illness, or injury, provided that no other medical procedure would suffice for that purpose,'' makes it clear this has nothing to do with life of the mother.

I would also like to address the question of whether we men are trying to regulate women. I think one of the tragedies of this country are men who beat their spouses, mothers and fathers who treat their children as though they are objects to abuse. The question here is whether it is human life. If it is human life, it has nothing to do with whether it is the right of the woman or the right of the man to kill this child.

If we disagree over life, that is one thing. But to act like we are trying to do anything other than protect an innocent life is unfair. In this case, the life is a life. If its head pops out a little bit further but if the legs are out and the heart is beating and the head is inside, then you jab it, it is not a human life. This is a debate over human life, not the rights of women and men.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from West Virginia [Mr. WISE].

Mr. WISE. Mr. Speaker, abortion is a tough debate under any circumstances, and an emotional one. But I think the reason I oppose this rule and oppose this measure is because in this one this debate is wrongly directed. This is not an issue about whether or not a woman should have a right to choose or what state a fetus is viable or when life begins. The tragic situation in this case is that overwhelmingly the women affected do not want an abortion. They wanted to have this child. But it is being performed in the last trimester because of medical necessities. There are less than 500 of these procedures performed a year. And, yes, what are some of the situations? This has been a pretty graphic debate. Some of the situations, such as brains that have developed outside the fetus's skull, a situation where the woman's health, the mother's health is significantly endangered, once again, this woman, this couple having their child, want to have this child in the overwhelming number of cases I have been able to find, yet they are not able to. They find this out in the last trimester. I have got problems with Congress, a lot of people have problems getting involved in different areas. A lot of people have problems with Congress making important medical decisions, particularly when a woman's life is possibly endangered.

Under this amendment, it is improved a little bit from leaving the House. The prosecution has to show beyond a reasonable doubt the doctor performed this procedure improperly except the only way you get to that point is you charge the doctor and bring that physician to trial. For exercising medical judgment, a physician goes to trial. He or she cannot perform this procedure even to safeguard the severe adverse health effects to the mother, only for the life of the mother.

I guess what concerns me the most is that in this legislation they would permit the doctor to be charged but the woman who requested that understood that something has to be done, requested something be done, she is not charged. This whole thing does not belong in the Congress, and Congress should not start down this road.

Mrs. WALDHOLTZ. Mr. Speaker, I yield 7 minutes to the gentleman from New Jersey [Mr. SMITH].

Mr. SMITH of New Jersey. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Mr. Speaker, for more than two decades the multimillion-dollar abortion industry has sanitized abortion methods by aggressively employing the most clever and most benign of euphemisms market research can buy. Until today they succeeded in a massive coverup about the sickening truth about abortion methods, including chemical poisoning of the child by highly concentrated salt water or some other potion, dismemberment of the baby's fragile body by a knife connected to a suction machine that is 20 to 30 times more powerful than the average vacuum cleaner, and now brain extraction, the method at issue today, as if the child's brain were a diseased tooth in need of extraction or a tumor to be excised. Make no mistake about it, Mr. Speaker, partial-birth abortion is child abuse. And those who do it today have an unfettered right to kill. We can revoke that license to kill, Mr. Speaker, and we must. If the President vetoes this legislation, then he alone will have empowered the abortionist to kill babies in this way. If he vetoes this bill, he renews this license to kill. He bears the responsibility for the thousands of kids who will die from this hideous method of abortion. Veto this bill, and there is no doubt whatsoever in my mind that Bill Clinton will go down in history as the abortion President.

Mr. Speaker, the abortion lobby lies to women and they lie to society at large, and they usually get away with it. But not this time. On this issue, they have said that partial-birth abortion is used primarily to save the life of the mother, an exception included in the bill, or for the deformity of the child. Leaving aside the inhumane notion that handicapped kids are throwaways or are to be construed as so much garbage, I thought we took care of that with passage of the Americans with Disabilities Act, which said that handicapped people have rights and they have inherent value, and we need to respect that.

Nevertheless, the fact of the matter is then, perhaps most of the partial-birth abortions procured in the United States are elective; in other words, they are abortions on demand. Dr. Martin Haskell, an abortionist who alone has performed over 1,000 partial-birth abortions, said in a tape recorded interview with the American Medical News that of the procedures he does, from 20 to 24 weeks, 80 percent are, ''purely elective.''

Mr. Speaker, the abortion lobby has also said that anesthesia kills the babies before they are removed from the womb. Even if that excuse were true, even if that rationalization were true, it would still mean that a baby dies. But again it is another lie. The American Society of Anesthesiologists, the ASA, has testified that such an assertion by the abortion lobby has, and I quote, ''absolutely no basis in scientific fact,'' and is, ''misleading and potentially dangerous to pregnant women.'' According to the ASA general anesthesia given to a pregnant woman does not kill nor does it injure an unborn baby or even provide the baby with protection from pain. And Dr. Haskell himself has said that local anesthesia he uses has no effect on the baby.

Mr. Speaker, to my left is a chart, one of a series of charts, medically correct, a diagram of what the actual procedure is all about. In a paper given by Dr. Haskell to the National Abortion Federation in 1992, entitled ''Second Trimester Abortion From Every Angle,'' in September Dr. Haskell describes the partial birth abortion this way. Remember, this man, one of the pioneers who is trying to promote the use of this despicable form of child abuse, and he says, and I quote,

> With the instrument, when the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws and firmly and reliably grasp a lower extremity of the child. The surgeon then applies firm traction to the instrument, causing a version of the fetus and pulls the extremity into the vagina.

He then goes on to say that,

> With a lower extremity in the vagina, the surgeon uses his fingers to deliver the lower extremity, then the torso, the shoulders, and then the upper extremities, the skull lodges in the internal cervical os. Usually there is not enough dilation for it to pass through. At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and hooks the shoulders of the fetus with the index and ring fingers palm down, while maintaining tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand. The surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances its tip curved down along the spine and under his middle finger until he feels it contact the base of the skull.

Mr. Speaker, according to Dr. Haskell, the surgeon then forces the scissors into the skull, right into the skull of that baby. And then he introduces a, suction catheter, holds it and excavates the skull contents.

Mr. Speaker, one nurse, a registered nurse by the name of Brenda Pratt Schaefer, witnessed several of these partial-birth abortions while working for Dr. Haskell. She said, in describing the process that,

> 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, inserted them into the back of the baby's head. Then he opened the scissors up. Then he stuck a high-powered suction tube into the hole and sucked the baby's brains out.

This is child abuse, Mr. Speaker, let us face reality. And we can stop it.

Finally, just let me say, Mr. Speaker, I want to commend the distinguished gentleman from Florida, Mr. CANADY, the chairman of the subcommittee, for his courage in bringing this very important human rights legislation to the floor. The other side hates him for it. The abortion, lobby certainly does. They hate many others who fight for unborn kids.

But just let me say, protecting children and protecting human rights is always difficult. I serve as the chairman of the Subcommittee on International Operations and Human Rights. For 16 years I have been promoting human rights abroad. This, I would say, and submit to my distinguished colleagues, is a human rights abuse. Children are being slaughtered, some say 500, as if 500 is a small number of executions. That is, I think, a very conservative estimate; it is very likely many, many more than that. And it is being promoted as a method of choice.

□ 1800

I would submit that we have the opportunity today to stop this kind of child abuse and to protect little children from this kind of killing. We ought to do it. Support the rule and support the bill.

Mr. BEILENSON. Mr. Speaker, I yield 1½ minutes to the gentlewoman from New York [Mrs. MALONEY].

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

Mrs. MALONEY. Mr. Speaker, I rise in strong opposition to this rule. The bill in question presents a direct challenge to Roe versus Wade. As one member of the majority boasted, ''We intend to ban a woman's right to choose, procedure by procedure.'' I take him at his word, because this legislation will do just that.

I would like to put a human face on this debate and talk about Coreen Costello, who is pictured here. Coreen Costello would have taken any child that God would have given her, regardless of any handicap. But this child, the child that she was expecting, was not a child that could live. The Dole amendment would not have allowed Coreen Costello to use the procedure that now allows her to have other children. She is currently expecting yet another child. The Committee on Rules denied an amendment that would keep Coreen Costello's doctor out of jail.

I urge Members to have a heart. Vote humanitarian, vote for children, vote for women, vote for families, vote against this rule.

Mr. BEILENSON. Mr. Speaker, I yield the balance of my time to the gentlewoman from Colorado [Mrs. SCHROEDER].

The SPEAKER pro tempore (Mr. ROGERS). The gentlewoman from Colorado is recognized for 4 minutes.

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

Mrs. SCHROEDER. Mr. Speaker, I thank the gentleman from California for yielding me time.

Mr. Speaker, I eagerly, eagerly ask Members to vote against this rule. This rule is one more gag rule put on doctors dealing with women and their families in the most difficult situations that any family would ever have to face. I think it is unbelievable that we are gagging Members of Congress from being able to deal with the severe and adverse health conditions a woman can have, and that is what is being done. We are not being allowed to present that amendment.

The reason we are doing this today is really all political. Let us be honest. We have a letter from the President pointing out he will veto this bill in this form because it violates Roe versus Wade. We now have a new decision, a 100-page decision in Ohio, where the same kind of procedure was tested and the court said no, that is violative of Roe versus Wade.

We have heard so many statements made here that were incorrect, that you do not even know what to say.

People get up and they obsess on this, they obsess on this procedure and they obsess on all this stuff. The real issue is, show me an obstetrician and gynecologist that is going to do something terrible and evil and awful. We try to make this into a witch trial. Show me parents that would want this.

These are crisis situations, where everything has gone wrong. We are only talking here about late, late abortions, where people were clinging to that child trying to go as far as possible. If we deny this kind of procedure, we are going to be denying to young parents their chance to have another shot at being a parent, which is probably one of the most driving desires anyone has.

Why do I say that? Because there are other procedures available. Sure, you could have a hysterectomy. There are other procedures available. But, guess what? You lose your reproductive organs. This procedure has been put together so that the reproductive system can remain whole and they get another shot at parenthood.

Should that not be okay? You hear people talk about how these are elective. Elective? These are not elective. Who in the world would sign up for a process like this, unless it was absolutely essential.

This bill does not do anything about early abortions in the first trimester. Remember what Roe versus Wade said? In the first trimester, you could do whatever. That is the elective part. We are talking about the late part, where Roe versus Wade said States can regulate this except in the case of life and severe health consequences to the mother.

Here is a mother that is happy we did not interfere in that, because she has gone on to be able to have another child, and she lived to see these two children grow to adulthood.

Is it the position of this Congress that other women in the future cannot have that opportunity? Are we going to move in and tell the doctors that would look at her health rather than this law, guess what, they go to prison for 2 years? Are we going to start criminalizing these medical procedures?

This is the first medical procedure we will ever have criminalized. Is that not interesting?

Mr. Speaker, I will put in the RECORD a letter from the American Nurses Association speaking clearly that they are opposed to this bill, and the American College of Gynecologists and Obstetricians, who are the ones that are the specialists who deal with this. They are opposed to this bill.

Mr. Speaker, we ought to be listening to the specialists and to the people who are talking about this. If we really think our medical profession is so badly trained in America, so against life that they are out doing these grizzly, terrible things, then we better look at the whole medical profession. But I do not think so. I hear this obsessing that you are hearing, which is wrong.

Vote ''no'' against this rule. Allow women to have their severe health consequences taken into consideration.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS DOES NOT SUPPORT H.R. 1833

DEAR COLLEAGUE: I thought you might be interested in the following statement released by the American College of Obstetricians and Gynecologists. Protect women's health by voting ''No'' on H.R. 1833.

PAT.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
November 1, 1995.

STATEMENT OF H.R. 1833—THE PARTIAL-BIRTH ABORTION BAN ACT OF 1995

The American College of Obstetricians and Gynecologists is disappointed that the U.S. House of Representatives has attempted to regulate medical decision-making today by passing a bill on so-called ''partial-birth'' abortion.

The College finds very disturbing any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community—demonstrating why congressional opinion should never be substituted for professional medical judgment.

The College does not support H.R. 1833, or the companion Senate bill, S. 939.

AMERICAN NURSES ASSOCIATION,
Washington, DC, November 8, 1995.

Hon. BARBARA BOXER,
U.S. Senate,
Washington, DC.

DEAR SENATOR BOXER: I am writing to express the opposition of the American Nurses Association to H.R. 1833, the ''Partial-Birth Abortion Ban Act of 1995'', which is scheduled to be considered by the Senate this

week. This legislation would impose Federal criminal penalties and provide for civil actions against health care providers who perform certain late-term abortions.

It is the view of the American Nurses Association that this proposal would involve an inappropriate intrusion of the federal government into a therapeutic decision that should be left in the hands of a pregnant woman and her health care provider. ANA has long supported freedom of choice and equitable access of all women to basic health services, including services related to reproductive health. This legislation would impose a significant barrier to those principles.

Furthermore, very few of those late-term abortions are performed each year they are usually necessary either to protect the life of the mother or because of severe fetal abnormalities. It is inappropriate for Congress to mandate a course of action for a woman who is already faced with an intensely personal and difficult decision. This procedure can mean the difference between life and death for a woman.

The American Nurses Association is the only full-service professional organization representing the nation's 2.2 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

The American Nurses Association respectfully urges you to vote against H.R. 1833 when it is brought before the Senate.

GERI MARULLO,
Executive Director.

Mr. BEILENSON. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Texas [Ms. JACKSON-LEE].

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to the rule and legislation of H.R. 1833, for the dastardly impact on the life and health of the mother and the fetus and the physicians.

Mr. Speaker, I rise in opposition to the rule for H.R. 1833. We must be allowed to offer amendments to H.R. 1833, specifically, those which would provide for a true exception to save a woman's life, or for serious, adverse health consequences to the woman, including her future fertility, or where there exists severe or potentially fatal fetal abnormalities.

In 1973, and more recently in 1992, the Supreme Court held that a woman has a constitutional right to choose whether or not to have an abortion. H.R. 1833 is a direct attack on the principles established in both Roe versus Wade and Planned Parenthood versus Casey.

H.R. 1833 is a dangerous piece of legislation which would ban a range of late term abortion procedures that are used when a woman's health or life is threatened or when a fetus is diagnosed with severe abnormalities incompatible with life.

Because H.R. 1833 does not use medical terminology, it fails to clearly identify which abortion procedures it seeks to prohibit, and as a result could prohibit physicians from using a range of abortion techniques, including those safest for the woman.

H.R. 1833 is a direct challenge to Roe versus Wade—1973. This legislation would make it a crime to perform a particular abortion method utilized primarily after the 20th week of pregnancy. This legislation represents an unprecedented and unconstitutional attempt to ban abortion and interfere with physicians' ability to provide the best medical care for their patients.

If enacted, such a law would have a devastating effect on women who learn late in their pregnancies that their lives or health are at risk or that the fetuses they are carrying have severe, often fatal, anomalies.

Women like Coreen Costello, a loyal Republican and former abortion protester whose baby had a lethal neurological disease; Mary-Dorothy Lines, a conservative Republican who discovered her baby had severe hydrocephalus; Claudia Ades, who terminated her pregnancy in the sixth month because her baby was riddled with fetal anomalies due to a fatal chromosomal disorder, Vicki Wilson, who discovered at 36 weeks that her baby's brain was growing outside his head; Tammy Watts, whose baby had no eyes, and intestines developing outside the body; and Vikki Stella, who discovered at 34 weeks that her baby had nine severe anomalies that would lead to certain death. All these children were wanted but could not survive. These are the women who would be hurt by H.R. 1833—women and their families who face a terrible tragedy—the loss of a wanted pregnancy.

In Roe, the Supreme Court established that after viability, abortion may be banned by States as long as an exception is provided in cases in which the woman's life or health is at risk. H.R. 1833 provides no true exceptions for cases in which a banned procedure would be necessary to preserve a women's life or health.

The Dole amendment does not cover all cases where a woman's life is in danger. This narrow life exception applies only when a woman's life is threatened by a physical disorder, illness or injury and when no other medical procedure would suffice. By limiting the life exception in this way, the bill would omit the most direct threat to a woman's life in cases involving severe fetal anomalies—the pregnancy itself.

In fact, none of the women who submitted testimony during the Senate and House hearings on this bill would have qualified for the procedure under the Dole life exception. Instead, this bill would require physicians to use an alternative life-saving procedure, even if the alternative renders the woman infertile, or increases her risk of infection, shock, or bleeding. Thus, the result of this provision is that women's lives would be jeopardized, not saved.

This bill unravels the fundamental constitutional rights that American women have to receive medical treatment that they and their doctors have determined are safest and medically best for them. By seeking to ban a safe and accepted medical technique, Members of Congress are intruding directly into the practice of medicine and interfering with the ability of physicians and patients to determine the best course of treatment. The creation of felony penalties and Federal tort claims for the performance of a specific medical procedure would mark a dramatic and unprecedented expansion of congressional regulation of health care.

This bill is bad medicine, bad law, and bad policy. Women facing late term abortions due to risks to their lives, health, or severe fetal abnormalities incompatible with life must be able to make this decision in consultation with their families, their physicians, and their god. Women do not need medical instruction from the government. To criminalize a physician for using a procedure which he or she deems to be safest for the mother is tantamount to legislating malpractice.

I urge my colleagues to vote against this rule so that we can offer amendments which would create true life and health exceptions to the bill. These amendments would allow doctors to continue to perform the procedure which they feel is safest for the mother without risk of prosecution.

True life and health amendments would ensure that mothers, and families, facing tragic circumstances would continue to receive the best possible, and safest medical care available.

Mr. BEILENSON. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. BECERRA]

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

Mr. BECERRA. Mr. Speaker, I rise in opposition to the rule and the bill. It is wrong-headed and should fail.

Mr. BEILENSON. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California [Ms. PELOSI].

(Ms. PELOSI asked and was given permission to revise and extend her remarks.)

Ms. PELOSI. Mr. Speaker, I rise in opposition to this legislation, which would prevent doctors from performing a lifesaving medical procedure. This is a direct threat to the health and lives of American women.

Mr. Speaker, we all hope that the number of abortions in this country can be decreased. But this debate is not about abortion. Restricting medical options that endangers the health of women is unconstitutional. The Supreme Court has stated that the Government may ban post-viability abortions, but it cannot restrict abortion when the procedure may be necessary to save the health and life of the mother.

The life exception included in this legislation is far too narrow to protect women's lives effectively. The exception would allow this procedure only as a last resort when a women's life is threatened by physical disorder, illness, and injury—when who other medical procedure would suffice. It does not consider that this may be the safest procedure to protect the health and life of the mother. This so-called life exception would have a women rendered sterile or face critical health risks rather than the use the safe and rare procedure that this legislation is attempting to outlaw.

Families faced with this difficult decision often go on to have successful pregnancies. Yet this legislation does nothing to protect health or future fertility of the mother—in fact, it puts a mother's future fertility at risk.

Mr. Speaker, the so-called partial-birth abortion ban is unconstitutional and inhumane. I urge my colleagues to vote against this legislation.

Mr. BEILENSON. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. FAZIO].

(Mr. FAZIO of California asked and was given permission to revise and extend his remarks.)

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to the rule and the underlying legislation.

Mrs. WALDHOLTZ. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore. The gentlewoman from Utah is recognized for 3½ minutes.

Mrs. WALDHOTZ. Mr. Speaker, let me address first the question that has been raised regarding this rule and the procedure by which this bill is brought to the floor.

We have heard complaints, Mr. Speaker, that there was not an opportunity to consider an amendment regarding the health consequences to the mother. But in fact, Mr. Speaker, as I pointed out earlier, the minority chose not to exercise its right to offer a motion to recommit when this bill first came to the floor. That was the opportunity, Mr. Speaker, that the minority had to offer whatever it felt was appropriate to change this bill. They decided not to do that. It is a bit disingenuous to complain about that now after the Senate has already taken up the bill, after the House had completed its debate.

In fact, Mr. Speaker, that particular amendment was offered in the Senate and it failed. We know what the definition of health of the mother is, because the Supreme Court provided us that definition in Doe versus Bolton, the companion case to Roe versus Wade, in which the Supreme Court defined health in the abortion context to include ''all factors, physical, emotional, psychological, familial and the woman's age relevant to the well-being of the patient.''

This is an extraordinary broadening of this bill. This bill was debated by the House, Mr. Speaker. It was debated by the Senate. We are back now to consider whether we should concur in the amendments that the other side has already stated improve the bill, a change that will allow doctors to exercise their best judgment in performing this procedure when it is necessary to save the life of the mother.

The gentlewoman from Colorado said though, Mr. Speaker, that we ought to look to the specialists, to the physicians, in determining whether this is an appropriate piece of legislation. So I wish to close, Mr. Speaker, by referring to the specialists.

First, Mr. Speaker, I would quote from Dr. Martin Haskell, a practitioner of the partial birth abortion method. When Dr. Haskell was asked about the advantages of this particular procedure he did not talk about the life of the mother. He did not talk about the sensation of the fetus. He did not talk about the health risk to the mother. He said this: ''Among its advantages are that it is a quick, surgical, outpatient method that can be performed on a scheduled basis under local anesthesia.'' Those are not emergency measures, Mr. Speaker.

When Dr. Haskell was asked in an interview with Cincinnati Medicine in the fall of 1993, Dr. Haskell said when asked about the impact to the fetus of this procedure, the question, ''Does the fetus feel pain?'' This is what Dr. Haskell said: ''I am not an expert, but my understanding is that fetal development is insufficient for consciousness.'' He continued, ''It is a lot like pets. We like to think they think like we do. We ascribe humanlike feelings to them, but they are not capable of the same level of awareness we are. It is the same with fetuses.''

Mr. Speaker, that is what one specialist, a practitioner of partial birth abortion, says about this procedure. But let us turn to another specialist, Dr. Pamela Smith, Director of Medical Education at the Department of ob-gyn at Mount Sinai Hospital in Chicago. Dr. Smith said, ''There is absolutely no obstetrical situations encountered in this country that would require this procedure.''

Mr. Speaker, I ask for support on this rule.

Mr. Speaker, I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mrs. WALDHOLTZ. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 269, nays 148, not voting 14, as follows:

[Roll No. 93]

YEAS—269

Allard
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bevill
Bilbray
Bilirakis
Bliley
Blute
Boehner
Bonilla
Bonior
Bono
Borski
Brewster
Browder
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Costello
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeLay
Diaz-Balart
Dickey
Dingell
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (NJ)
Frisa
Frost
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Goodlatte
Goodling
Gordon
Goss
Graham
Gunderson
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Hostettler
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson, Sam
Jones
Kanjorski
Kasich
Kelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
LoBiondo
Longley
Lucas
Manton
Manzullo
Martini
Mascara
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
McNulty
Metcalf
Mica
Miller (FL)
Molinari
Mollohan
Montgomery
Moorhead
Moran
Murtha
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Ortiz
Orton
Oxley
Packard
Parker
Paxon
Payne (VA)
Peterson (MN)
Petri
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Regula
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shuster
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thornberry
Thornton
Tiahrt
Upton
Volkmer
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff

NAYS—148

Abercrombie
Ackerman
Andrews
Baldacci
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bishop
Boehlert
Boucher
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Coyne
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dixon
Doggett
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Fields (LA)
Flake
Foglietta
Frank (MA)
Franks (CT)
Frelinghuysen
Furse
Gejdenson
Gephardt
Gilman
Gonzalez
Green
Greenwood
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Horn
Houghton
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnston
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Lantos
Levin
Lewis (GA)
Lincoln
Lofgren
Lowey
Luther
Maloney
Markey
Martinez
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Meyers
Miller (CA)
Minge
Mink
Moakley
Morella
Nadler
Neal
Obey
Olver
Owens
Pallone
Pastor
Payne (NJ)

Pelosi	Schumer	Velazquez
Peterson (FL)	Scott	Vento
Pickett	Serrano	Visclosky
Pomeroy	Shays	Ward
Rangel	Skaggs	Waters
Reed	Slaughter	Watt (NC)
Richardson	Spratt	Waxman
Rivers	Stark	Williams
Rose	Studds	Wilson
Roybal-Allard	Thompson	Wise
Rush	Thurman	Woolsey
Sabo	Torkildsen	Wynn
Sanders	Torres	Yates
Sawyer	Towns	Zimmer
Schroeder	Traficant	

NOT VOTING—14

Bryant (TX)	Ford	Stokes
Collins (IL)	Fowler	Thomas
Dooley	Gibbons	Torricelli
Dornan	Harman	Weldon (PA)
Filner	Smith (WA)	

□ 1832

The Clerk announced the following pairs:

On this vote:

Mr. Thomas for, with Ms. Harman against.
Mrs. Fowler for, with Mr. Stokes against.

Ms. FURSE and Mr. GILMAN changed their vote from ''yea'' to ''nay.''

Mrs. KELLY changed her vote from ''nay'' to ''yea.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. CANADY of Florida. Mr. Speaker, pursuant to House Resolution 389, I move to take from the Speaker's table the bill (H.R. 1833), to amend title 18, United States Code, to ban partial-birth abortions with the Senate amendments thereto, and concur in the Senate amendments.

The Clerk read the title of the bill.

The text of the Senate amendments is as follows:

Page 2, line 9, strike out [Whoever] and insert: *Any physician who*

Page 2, line 12, after ''both.'' insert: *This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury: Provided, That no other medical procedure would suffice for that purpose. This paragraph shall become effective one day after enactment.*

Page 2, line 13, strike out [As] and insert: *(1) As*

Page 2, after line 16, insert:

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

Page 2, line 17, strike out [(c)(1) The father,] and insert: *(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure,*

Page 3, strike out lines 12 through 20.

MOTION OFFERED BY MR. CANADY

Mr. CANADY of Florida. Mr. Speaker, I offer a motion.

The SPEAKER pro tempore (Mr. ROGERS). The Clerk will designate the motion.

The Clerk read the motion.

Mr. CANADY of Florida moves to concur in each of the six Senate amendments to H.R. 1833.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida [Mr. CANADY] and the gentlewoman from Colorado [Mrs. SCHROEDER] each will be recognized for 30 minutes.

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

GENERAL LEAVE

Mr. CANADY of Florida. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks on H.R. 1833.

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

There was no objection.

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

Mr. Speaker, I rise to express my support for the motion to concur in the Senate amendments to H.R. 1833, the Partial-Birth Abortion Ban Act. H.R. 1833 bans a particularly heinous late-term abortion procedure unless that procedure is necessary to save the life of the mother.

This is partial-birth abortion:

Guided by ultrasound, the abortionist grabs the live baby's leg with forceps.

Mr. Speaker, then the baby's leg is pulled out into the birth canal by the abortionist.

The abortionist delivers the living baby's entire body, except for the head, which is deliberately kept lodged just within the uterus.

Then the abortionist jams scissors into the baby's skull.

The scissors are then opened to enlarge the hold in the baby's skull.

The scissors are than removed, and a suction catheter is inserted.

The child's brains are sucked out, causing the skull to collapse so that the delivery of the child can be completed.

Clearly, the only difference between partial-birth abortion, the procedure which my colleagues have just seen described, and homicide is a mere 3 inches.

The supporters of partial-birth abortion seek to defend the indefensible, but today the hard truth cries out against them. Despite their relentless effort to misrepresent and confuse the issue, the opponents of this bill can no longer conceal the uncomfortable facts about this horrible procedure.

The ugly reality of partial birth abortion is revealed here in these drawings for all to see.

The Senate amendment to H.R. 1833 makes three acceptable changes to the House passed version of the bill:

First, the Senate amendment clarifies that H.R. 1833 allows a partial-birth abortion to be performed if it is necessary to save the life of the mother. Instead of a life exception in the form of an affirmative defense as passed by the House, the amendment inserts the life exception in the first paragraph of the bill. The effect of the amendment is to force the prosecution to prove beyond a reasonable doubt that the partial-birth abortion was performed to save the life of the mother or that another procedure would have saved her life.

Second, the Senate amendment restricts civil liability under the bill to physicians who perform partial-birth abortions or anyone who directly performs a partial-birth abortion. In other words, the amendment does not allow anyone who assists in a partial-birth abortion to be liable under H.R. 1833.

Third, the Senate amendment allows fathers to sue for damages only if the father was married to the mother at the time the partial-birth abortion was performed.

I believe that if H.R. 1833 is enacted into law with the Senate amendments, it will deter abortionists from partially delivering, and then killing, unborn children.

Unfortunately, Mr. Speaker, President Clinton has threatened to veto H.R. 1833 unless we make gutting changes to the bill. The President does not want to openly defend a procedure that 71 percent of the public says should be banned. Therefore, he is trying to deceive the American people by claiming he supports banning this, as he calls it, disturbing procedure while he has at the same time proposed an amendment that would gut H.R. 1833, making it totally meaningless.

Mr. Speaker, the President wants a bill that allows an abortionist to perform a partial-birth abortion whenever the abortionist says it is to prevent a serious adverse health consequence. The President wants to explicitly leave the definition of serious adverse health up to the abortionist. In Doe versus Bolton, the companion cause to Roe versus Wade, the Supreme Court defined health in the abortion context to include, and I quote, ''all factors: physical, emotional, psychological, familial, and the woman's age, relevant to the well-being of the patient.'' Partial-birth abortions are currently being performed for such health reasons as the mother's depression or young age.

While Dr. Martin Haskell, a prominent practitioner of partial-birth abortion, stated that 80 percent of the partial-birth abortions that he performed from 20 to 24 weeks are purely elective, Dr. James McMahon called the partial-birth abortions he performed in the third trimester non-elective or health related. In documents submitted to the House Subcommittee on the Constitution, Dr. McMahon asserted: after 26 weeks, that is, 6 months, those pregnancies that are not flawed are still non-elective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications. Dr. McMahon's definition of non-elective is extremely broad.

Accordingly, if President Clinton had his way, even third trimester partial-

birth abortions performed because of a mother's youth or depression would be justified to preserve the mother's health. This is simply unacceptable.

Furthermore, Dr. McMahon told the subcommittee that he had performed more than 2000 of what he called intact dilation and evacuation abortions. He attributed more than 1300 of these late-term abortions to fetal indications or maternal indications. The most common maternal indication was depression. Other maternal indications included pediatric pelvis, that is, youth, spousal drug exposure, and substance abuse.

□ 1845

It is never necessary to partially vaginally deliver a living infant at 20 weeks, that is, 4½ months or later, before killing the infant and completing the delivery in order to protect a mother's life or even her health.

During two extensive hearings in the Committee on the Judiciary on H.R. 1833, not one of the medical experts invited to testify by the bill's opponents could point to a single circumstance that would require the use an abortion technique in which the infant was partially delivered alive and then killed. On the contrary, several physicians, including one well-known abortionist, have stated that partial birth abortion poses risks to the health of the mother.

Dr. Pamela Smith, the director of medical education for the Department of Obstetrics and Gynecology at Mr. Sinai Hospital in Chicago, has written:

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

Dr. Martin Haskell, himself, said of a partial birth abortion, ''Among its advantages are that it is a quick surgical outpatient method that can be performed on a scheduled basis under local anesthesia.''

The President and other proponents of partial birth abortion know that adding an exception for health of the mother to H.R. 1833 is unnecessary and would gut the bill, allowing partial birth abortion on demand.

This is the question I would raise to the President and my colleagues who support abortion on demand: Is there ever an instance when abortion or a particular type of abortion is inappropriate? The vehement opposition of abortion rights supporters to H.R. 1833 makes their answer to my question clear. For them there is never an instance when abortion is inappropriate. For them the right to abortion is absolute, and the termination of an unborn child's life is acceptable at whatever time, for whatever reason, and in whatever way a woman or an abortionist so chooses.

To all my colleagues, I say this, Mr. Speaker: Look at this drawing. Open your eyes wide and see what is being done to innocent, defenseless babies. What we see here in this drawing is an offense to the conscience of humankind. Put an end to this detestable practice. Vote in favor of the motion to concur in the Senate amendments to H.R. 1833.

Mr. Speaker, I reserve the balance of my time.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan [Mr. CONYERS], the esteemed ranking member of the committee.

Mr. CONYERS. Mr. Speaker, I rise to make observations about two members of the Committee on the Judiciary, and I respect all of the members on the committee. First, I have asked the gentlewoman from Colorado, PATRICIA SCHROEDER, to manage this bill, because she will long be remembered for her sensitivity and dedication on a subject that is so difficult for all of us to deal with.

The other Member whose attention I would draw the membership to is the gentleman from Florida [Mr. CANADY], the author of this measure. Mr. CANADY is not a doctor, has never been to medical school, and has created a misnomer in the title of this bill. There is no medical term called ''partial birth abortion.'' It is not in the medical dictionary, the American College of Obstetricians and Gynecologists do not use the term and in fact, has come out very strongly against the bill.

Mr. Speaker, assuming that we are not doctors, let us just talk about the law that we have a responsibility to deal with. Since the measure of the Gentleman from Florida was introduced, a Federal court in Ohio has spoken on a very similar measure and the Ohio Federal court has said very, very clearly that this procedure, the dilation and extraction, or D and X procedure, which was banned by an Ohio statute, is unconstitutional. Similarly, this bill is unconstitutional.

I urge my colleagues to consider that Roe versus Wade, through the constitutional process, has protected a woman's right to choose, for over 20 years. This attempt to ban a class of medically appropriate abortions is not only very discouraging, it is unconstitutional.

Mr. CANADY of Florida. Mr. Speaker, I yield 3 minutes to the gentleman from Oklahoma [Mr. COBURN].

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

Mr. COBURN. Mr. Speaker, I think it is important that we talk about what this bill is and what it is not. The term abortion is used rather loosely around this body. Abortion, by definition, occurs before 20 weeks. This procedure is not used before 20 weeks. This procedure is used on viable infants, infants who are viable outside of the womb. So as we hear all the confusing dialogue tonight, it is important that everybody realize that infants, 22 weeks gestation, from the time of conception 22 weeks forward, which is actually less than 21 weeks, by normal count, those are viable infants by definition. Today if a baby is born at 22 weeks we do everything we can to save that baby.

So this bill is not about abortion, this bill is about eliminating the murdering of infants who are otherwise viable outside of the womb.

What is this bill? This bill eliminates a procedure that has been designed to be of benefit only to the abortionist. Every complicated pregnancy that might have an adverse outcome in terms of an indication under the present utilization of this procedure can in fact be delivered in a much more humane, much less traumatic, and much more beneficial way to both the infant and the mother. What this bill provides is the respect that a viable fetus deserves, an infant of 22 weeks.

Let us make no mistake about this, this procedure is utilized to terminate otherwise normal infants the vast majority of the time. We are going to hear otherwise on that, but if you think an infant with a cleft palate is someone who needs to be terminated, if you think adolescent females, because they are pregnant. should qualify under this bill, as the President would have us say, because of their adolescence or because of their age, should otherwise be an exception under this bill, then you do not in fact understand what this procedure is all about.

I would urge my colleagues to think about what this bill really is. This is not an abortion. This procedure is a convenient method for some practitioners to terminate the lives of otherwise viable infants.

Mrs. SCHROEDER. Mr. Speaker, I yield myself 2 minutes.

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

Mrs. SCHROEDER. Mr. Speaker, first of all, let me answer the gentleman who was just in the well. I think it is terribly important to say we were trying to offer the amendment that is the law of the land, which is severe adverse health consequences to the mother. I resent very much hearing that this is about cleft palates and these are designer things and so forth, because this is not, and there is no one in this body trying to make it that way.

Now let me tell you why I hate this debate. I hate this debate because this debate reminds me of my 30th birthday, and let me bring you to my 30th birthday. My 30th birthday was spent in intensive care, an intensive care in which I had been given last rites. I had a 15-day-old baby girl I had not seen and a 4-year-old boy that I was terrified I would not see again. I want to tell the Members, that is scrambling, man. We had doctors, we had everybody running around figuring out what in the world can happen.

I just want to say to people in this Chamber, if you really think families in that situation want you, the U.S. Congress, to come in and tell them

which procedures their doctors may use and which ones they may not use, I think you are wrong. I think doctors think this is a zone of privacy and families think this is a zone of privacy, and that we should trust our doctors, although I understand there are some Members here who trust Hamas more than they trust the Government. But I happen to trust my doctor in that instance a whole lot more than I trust you Members of Congress. I want you to know it.

I want you to know I also looked at your drawings. You know what it said on the bottom? It said, ''Drawing commissioned by the National Conference of Catholic Bishops.'' Maybe they deliver babies, and maybe they practice medicine, but I go with the American College of Gynecologists and Obstetricians, because those are the ones I know that deliver babies. I am tired of the playing politics on this. I think America's families are tired of playing politics on this, and I really think that that is all this is about.

I wish there were some way to bring some sanity to this. My time has expired. I have thousands more I could say, but I only want to tell you, my 30th birthday was hell, and because of people like you, I could be dead, and I resent that very much.

Mr. Speaker, I rise to urge my colleagues to oppose the motion that would send to the President an abortion ban that does not have an exception for the life or health of the woman.

When the House first voted on this bill, we fought hard, but unsuccessfully, for an opportunity to debate and vote on an amendment that would provide an exception to the ban in cases where the woman's life or health is at risk. Since the original House vote on this bill, two noteworthy events have occurred.

First, an Ohio court has issued a 100-page opinion setting forth, with great detail and care, the unconstitutionality of a similar provision passed by the Ohio legislature. Central to the court's analysis is the fact that under Roe versus Wade and later cases, the government cannot ban abortions that are necessary to preserve the life or health of the woman.

Second, on February 28, President Clinton sent a letter to the chairman of the Judiciary Committee clearly stating that he will veto the legislation unless it contains a true exception for the life and health of the woman, as required by Roe versus Wade.

Because H.R. 1833, both in its original form and as amended by the Senate, fail to include any exception for the health of the woman, and because the life exception is too narrowly framed to constitute a true life exception, the bill before us today is unconstitutional. It clearly violates Roe versus Wade, and most importantly, it sends an unacceptable message to American women that their lives and health are not worthy of full protection.

In the course of our committee's hearings on this bill, we heard heart-rending stories from four women whose families benefited from the procedure this bill would ban, all in cases where terrible tragedies occurred late in the woman's pregnancy. As I listened to these women's stories, it became obvious to me that, in many respects, this bill is not about abortion at all. These pregnancies were wanted pregnancies, and the women told us that their families loved and cherished the babies that God was giving to them, no matter what disabilities those babies might have.

Unfortunately, these families had to confront the terrible tragedy that life was not to be for these babies, and they had to make decisions about how to manage the medical crises that confronted them in the way that best safeguarded the woman's life, health, and her ability to have another chance at motherhood. They chose this procedure based on advice from multiple medical specialists, knowing that it posed the least risk to them and their future fertility. Some of these women told us that they were pro-life before they had this procedure, and they remain pro-life today. But they oppose this bill because it bans a medical procedure that preserved their health and their future fertility. Several of these women are pregnant again today, thanks to this procedure that safeguarded their reproductive capacity.

So, in truth, the bill before us today is as much about safe motherhood as it is about abortion. In 1920, 800 women died for every 100,000 live births. In 1990, 10 women died for every 100,000 births. While the maternal mortality ratio in the United States has decreased dramatically, pregnancy-related complications and deaths remain an important public health concern.

We cannot get complacent about safe motherhood. And an adjunct of safe motherhood is that when something goes terribly wrong with a pregnancy, the woman, her family, and her doctor have every right to do everything possible to preserve her future reproductive capacity, so that she can have another chance at motherhood.

So many times when we say the words ''life and health of the woman'' people react as if it's some kind of tricky legal technicality. That women don't die anymore because of pregnancy or childbirth. As a woman who almost died after childbirth, let me assure you, it can happen. And the CDC statistics I am citing are a reminder that the life and the health of the woman can indeed be placed in jeopardy during pregnancies today. The leading causes of pregnancy-related death are hemorrhage, embolism, and hypertensive disorders. Combined, they account for over 70 percent of pregnancy-related deaths. That's why options that reduce the risk of excess bleeding, such as the procedure we are considering today, can in many cases save the life or health of the woman.

You would think that Congress would have the sense to leave the practice of medicine to doctors. You would think that Congress would respect the privacy of the families who confront these terrible tragedies, and their intelligence in deciding how best to manage the life and health risks these tragedies bring with them. Instead, this bill tells these families that Congress would put the doctors who preserved the woman's life, her health, and her future fertility in prison for 2 years.

Look Coreen Costello in the eye, and tell her that the second chance at safe motherhood that this procedure afforded her is something that Congress is taking away. Sit down with her children and explain to them that Congress would subordinate their mother's health to a political agenda, so that supporters of this bill can run sensational 30-second ads to advance their political ambitions.

If this committee were serious about passing a bill that would pass constitutional muster, we would be voting on amendments to cure the constitutional problems that are so carefully detailed in the Ohio court decision and the President's letter. The President's letter makes it clear that he would quickly sign a bill that contained an exception for procedures necessary for the life of the woman or to avert serious adverse health consequences to the woman.

Without altering the bill to cure the vagueness problem, the undue burden on previability abortions, and to add a true life or health exception, everyone in this Chamber knows that this bill would be enjoined immediately by the courts. That being the case, what can the purpose be in forcing this bill to the President's desk without a life or health exception? I am afraid I cannot see one other than political gamesmanship, and it is distressing in the extreme to see that game being played at the expense of the lives and health of very real women in this country, women like Coreen Costello and Mary-Dorothy Line.

Don't play a political game with the lives and health of the women of this country. Don't vote to send this bill to the President without a health exception and without a true life exception.

Mr. Speaker, I include for the RECORD the following:

THE ISSUE IS NOT ABORTION

(By Mary-Dorothy Line)

My husband and I are extremely offended by the ad sponsored by the National Conference of Catholic Bishops that appeared in the March 26, 1996 edition of the Washington Post. A bill pending before the House (H.R. 1833) would ban intact dilation and evacuation (intact D&E) procedures used in some late-term abortions; late term abortions which are provided to protect the mother's life or health when there is no hope for the baby. This legislation is wrong, and it would hurt a lot of American families. We know. We are one of those families.

I am a registered Republican and we are practicing Catholics. Last April, we found out I was pregnant with our first child and were extremely happy. 19 weeks into my pregnancy, an ultrasound indicated that there was something wrong with our baby. The doctor noticed that his head was too large and contained excessive fluid. This problem is called hydrocephalus. Every person's head contains fluid to protect and cushion the brain, but if there is too much fluid, the brain cannot develop.

As practicing Catholics, when we have problems and worries, we turn to prayer. So, our whole family prayed. We were scared, but we are strong people and believe that God would not give us a problem if we couldn't handle it. This was our baby; everything would be fine. We never thought about abortion.

A few weeks later we had two more ultrasounds. We consulted with five specialists, who all told us the same thing. Our little baby had an advanced, textbook case of hydrocephaly. We asked what we could do. They all told us there was no hope and recommended that we terminate the pregnancy. We asked about in utero operations and shunts to remove the fluid, but were again told there was nothing we could do. We were devastated. I can't express the pain we still feel—this was our precious little baby, and he was being taken from us before we even had him.

My doctors, some of the best in the country, recommended the intact D&E procedure.

No scissors were used and no one sucked out our baby's brain as is depicted in the inflammatory ads supporting H.R. 1833. A simple needle was used to remove the fluid—the same fluid that killed our son—to allow his head to pass through the birth canal undamaged. This was not our choice—this was God's will.

My doctor knew that we would want to have children in the future, even though it was the furthest thing from my mind at the time. They recommended the best procedure for me and our baby. Because the trauma to my body was minimized by this procedure, I was able to become pregnant again. We are expecting another baby in September.

I pray every day that this will never happen to anyone again, but it will, and those of us unfortunate enough to have to live this nightmare need a procedure which will give us hope for the future.

Congress needs to hear the truth. The truth does make a difference—when people listen. Last week, I testified at a hearing held in the Maryland legislature. A committee there was considering a bill similar to the one Congress in prepared to pass this week. In Maryland, they listened. And in Maryland, several conservative legislators joined in the 15–6 committee vote to reject this bill.

After seeing the callous way our tragedies are regarded by the proponents of H.R. 1833, I know the only hope to protect families lies with the President of the United States. I am told he is a good man. I am told he listens to people. I hope he listens to us, to the truth, and not to the political propaganda. I pray he shows love and compassion for women like me and families like mine. I pray he vetoes this bill.

Many people do not understand the real issue—it is women's health; not abortion and certainly not choice. We must leave decisions about the type of medical procedure to employ with the experts in the medical community and with the families they affect. It is not the place for government.

Mr. CANADY of Florida. Mr. Speaker, I yield 3½ minutes to the gentlewoman from California [Mrs. SEASTRAND].

Mrs. SEASTRAND. Mr. Speaker, I thank the gentleman from Florida for yielding time to me.

Mr. Speaker, I rise this evening in support of the amended version of H.R. 1833. The practice of partial-birth abortions should spark outrage in all of us. We, of this Congress, have a duty, a duty to protect children who might otherwise fall victim to this procedure. I believe we also have a duty to protect women from the scandalous falsehoods perpetrated by the opponents of this bill.

Those desperate to obscure the true nature of partial-birth abortions claim that the anesthesia given to the mother prior to the procedure results in the death of the child in utero. Based upon this myth they argue that it is misleading to call the procedure a partial-birth abortion, and any concerns that the child experiences pain are misplaced. Extreme abortion advocates have trumpeted this mistaken notion with the complicity of the unquestioning media.

Mr. Speaker, I rely upon the authority of Dr. Norig Ellison, president of the American Society of Anesthesiologists, who says this claim has ''absolutely no basis in scientific fact.''

Dr. David Birnbach, the president-elect of the Society for Obstetric Anesthesia and Perinatology, says it is crazy. The American Medical News reported in a January 1 article that ''Medical experts contend the claim is scientifically unsound and irresponsible, unnecessarily worrying pregnant women who need anesthesia.''

During the House and Senate debates over this measure, we heard several of the opponents piously express concern for the health of women. Yet, they willingly propagate the mistaken rhetoric of the extreme pro-abortionists, and undoubtedly frighten pregnant women in need of anesthesia for other medical reasons.

In Dr. Ellison's words:

> I am deeply concerned that the widespread publicity may cause pregnant women to delay necessary and perhaps life-saving medical procedures totally unrelated to the birthing process, due to misinformation regarding the effects of anesthetics on the fetus.

Mr. Speaker, the Senate amendments to the bill clearly make an exception should the life of the mother depend on the employment of this procedure. I am satisfied that no woman will be harmed as a result of this legislation, and many children will be spared a particularly gruesome fate. To oppose this bill is to display the extremism in the defense of abortion rights that is beyond reason and without compassion.

In the immortal words of Abraham Lincoln:

> Fellow Citizens, we cannot escape history . . . The fiery trial through which we will pass will light us down, in honor or dishonor, to the latest generation.

Let it be recorded by history that this Congress took a stand, not only against cruel medical practice, but for the life and death of women.

□ 1900

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York [Mrs. LOWEY], the distinguished cochair of the Caucus on Women's Issues.

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

Mrs. LOWEY. Mr. Speaker, I rise in opposition to H.R. 1833.

Mr. Speaker, we are here today debating this extreme bill because the Republican leadership is absolutely committed to eliminating the right to choose. The pro-life majority in this House has restricted abortion rights throughout the last year—and this bill is yet another step on the road to the back alley. This legislation will criminalize abortion, harass doctors, and prevent women from getting the medical care they need.

Families facing a late-term abortion are families that want to have a child. These couples have chosen to become parents, and only face terminating the pregnancy due to tragic circumstances. Terminating a wanted pregnancy at this stage is agonizing and deeply personal.

This procedure is not about choice, It is about necessity.

Let me tell you about Claudia Ades, who lives in Sanata Monica, CA. She heard about this bill, and called to ask me if there was anything she could do to defeat it. As Claudia said so passionately, ''This procedure saved my life and my family.''

Three years ago, Claudia was pregnant and happier than she had ever been. However, 6 months into her pregnancy she discovered that the child she was carrying had severe fetal anomalies that made its survival impossible, and placed Claudia's own life at risk.

After speaking to a number of doctors, Claudia and her husband finally concluded that there was no way to save the pregnancy. ''This was a desperately wanted pregnancy,'' Claudia said, ''But my child was not meant to be in this world.''

Those of us with healthy children can only imagine the horror that Claudia felt when she received the news about her condition. It is the news that all mothers pray every day they will never hear.

But, in those tragic cases where families do hear this horrible news, who should decide? The one thing that I know for sure is that the decision should not be made by Congress. At that horrible, tragic moment, the Government has no place.

Now, the Republican leadership could have made this a better bill by including real life and health exceptions. Not the sham life exception that's included in this bill—written by the Republican presidential candidate from Kansas who never met an abortion restriction that he didn't support. President Clinton even indicated that he would sign the bill if it contained real exceptions. But the Republican leadership doesn't want the President to sign this bill—they want him to veto it. This entire debate is a pay-off to the Christian Coalition and an exercise in election year political theatre.

Mr. Speaker, President Clinton's veto pen is the only thing protecting American women from the back alley. H.R. 1833 is an extreme bill that will put the lives of American women at risk. I urge its defeat.

Mr. CANADY of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from Virginia [Mr. GOODLATTE], a member of the Committee on the Judiciary.

Mr. GOODLATTE. Mr. Speaker, I thank the chairman for his fine work.

Mr. Speaker, today I rise in support of an eminently reasonable bill to ban a heinous procedure to partially deliver fully formed babies, and then kill them. Again, I repeat, this is a very reasonable bill which the majority of Americans wholeheartedly support. Those who oppose this bill are the excessive ones.

Already, 288 of the Members of this House have voted to ban partial birth abortions. The bill before us today is identical except for three minor changes—all of which I support:

It still allows an exception to the ban in order to save the life of the mother, and now provides in those cases that the prosecution must prove that there was no other alternative available to save the mother's life, rather than placing the burden on the physician.

It clarifies that only the physician who performs the abortion may incur civil liability under the bill.

It allows fathers to sue a physician for damages only if the father and mother of the child were married when the abortion was performed.

We must put an end to this barbaric procedure where the difference between abortion and murder is literally a few inches. This is effective legislation to ban an unbelievably gruesome act. I urge my colleagues to support it.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts [Mr. FRANK], the ranking member of the subcommittee.

Mr. FRANK of Massachusetts. Mr. Speaker, I salute the courage of the gentlewoman from Colorado [Mrs. SCHROEDER] and her willingness to take this issue on.

Mr. Speaker, we are clearly here dealing with a political issue. We heard one of the previous speakers say the purpose of it is to give the President something to veto. The President has said, amend this bill and he will sign it. Amend it to say that if the particular procedure is deemed necessary by a doctor to avoid serious adverse health consequences, he can do it.

Understand that this bill would say to a doctor, if in his judgment performing the abortion in this way is necessary to prevent severe physical damage to the mother, as long it is not life-threatening, he cannot do it. He can do it if it will save her life, but if it will destroy forever her chances of having a child, if it will cause her serious, long-lasting physical pain and disability, this bill says it is a crime to do it.

Mrs. SCHROEDER. Mr. Speaker, will the gentleman yield?

Mr. FRANK of Massachusetts. I yield to the gentlewoman from Colorado.

Mrs. SCHROEDER. Mr. Speaker, I think the gentleman is absolutely correct. They are saying that there is a life exception, but it is very cosmetic because the way I read the bill, it is that the doctor would have to prove there was no other medical procedure that would suffice, and maybe there is another medical procedure but it would not be as good for her outcome.

Mr. FRANK of Massachusetts. Mr. Speaker, reclaiming my time, and of course that is only life. It does not deal with health. The majority refused to allow an amendment. Be very clear about it. We have twice asked them let us vote, as the Senate did, and the amendment in the Senate got 46 votes and lost narrowly.

Members have said, ''Your health exception is too broad.'' My colleagues on the other side of the aisle can narrow it if they want to. But they cannot, however, object that we have one that is too broad when they have none at all; when they are asking the House to vote for a bill that will make it a crime for a doctor to perform this procedure even if he believes that performing it is necessary to prevent serious physical, long-lasting, permanent damage to the mother. That is not a reason for going forward under this outrageous bill.

Mrs. SCHROEDER. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New York [Mr. SCHUMER].

Mr. SCHUMER. Mr. Speaker, I salute the gentlewoman from Colorado for her leadership, and I want to reiterate some of the points that have been made before.

Mr. Speaker, it all boils down to this: A doctor is in an operating room, an obstetrician-gynecologist. There is a serious problem that evolves and the doctor has to make a judgment. Does it make any sense for this body, or for any body, to impose the threat of a crime, a criminal penalty and a jail sentence, on that doctor while he or she is making the decision about what is best for health or for life?

Then let us say that we even go with the narrow amendment of life. What is the doctor going to do? Is a doctor not supposed to worry that maybe his or her judgment is different than what a jury might determine 2 years later, not under the glare of the operating room lights?

This amendment is regrettable. It is unfortunate. I have some sympathy with those that disagree with my view on the issue of choice, about the idea that it should not be easy and it should not be a quick decision, and abortion should not be a method of birth control. We are not talking about that here because in these cases the mother, the parents, wanted to have the baby but something happened and an emergency may occur. We, again without a bit of knowledge of what is actually the best medical procedure, are imposing something here, and that is simply wrong.

I would say to my colleagues, resist this amendment. It is not going to be an issue in political campaigns, believe me. It is too arcane and too gruesome. Do the right thing. Rise to the occasion and vote down this awful amendment.

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

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

Mr. ROEMER. Mr. Speaker, we hear now today from some of our colleagues that this is an issue of privacy and the U.S. Congress should not vote on it. We vote on issues of speech, and that is very private. We vote on issues of prayer, and that is very private. We vote on issues of guns, and that is everywhere private. Certainly we should vote to ban this kind of procedure that takes the life of a partially delivered baby.

I hear some of my colleagues on this side of the aisle even say that this is a regrettable procedure, an unfortunate procedure. This is a gruesome and brutal procedure, and as we spend billions of dollars every single year on medicine and technology, certainly there is no room in our society for this kind of procedure to continue to take place in 1996, no matter what your view is as a pro-life or a pro-choice Member of Congress.

What are we voting on? A partial birth abortion is defined as a procedure in which a doctor partially delivers a living fetus before killing the fetus and completing the delivery. That is what we are voting on.

What have we added to this in chapter 74, section 1531? ''This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, illness or injury.''

Finally, let me conclude by saying this issue should not divide pro-choice and pro-life. It should not divide women and men. It should not divide Democrats and Republicans. It is a brutal and inhumane procedure that should be banned, and I urge my colleagues to support this bill.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentlewoman from California [Mrs. LOFGREN], a distinguished Member of the Committee on the Judiciary.

Ms. LOFGREN. Mr. Speaker, politicians in Congress have issues. We have wedge issues, we have issues we put in direct mail and we have rhetoric. I have heard a lot of partial discussions, selected comments that are meant to inflame, meant to persuade, and I think in some cases meant to mislead. But the people who will be hurt by this bill do not have issues. They have tragedies, and they do not need this bill to pass.

Mr. Speaker, I want to talk about people I really know, my friend Suzie Wilson's son and daughter-in-law, Bill and Vicki Wilson, and their wonderful children, Jon and Kaitlyn, because 2 years ago this April 8th they lost Abigail.

They were very much looking forward to Abigail. They had had two baby showers. The nursery was full of pink ribbons waiting for Abigail, and in the eighth month they found out that all of Abigail's brains had formed outside of her cranium and that there was no way that this child could survive. It was a tragedy.

They took their case to the doctor, who was able to save Vicki's life and to save her fertility. The question that faced them was not whether Abigail could live, but how would Abigail die and whether Vicki's uterus would burst while Abigail was dying.

I am glad that Vicki and Bill had the chance they did to keep their family intact. I know because we had a lot of tears, we friends of the family. They did not need the Congress of the United States to help them at that moment. They needed a doctor. They needed the

love of their friends and their family. They needed the guidance of God.

Mr. Speaker, I have talked to Members in this body who have told me privately that if it were their wife, they would want this procedure, and then gone ahead and voted for this bill. I would ask all of you, do your politics with some other issues. Hurt someone else. Search your conscience and look at my friends, the Wilson family. Think of them and put politics aside.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Georgia [Ms. MCKINNEY].

Ms. MCKINNEY. Mr. Speaker, on Friday this House voted to repeal the assault weapons ban as a payoff to the NRA. Today we are voting to ban a rare but sometimes medically necessary procedure as a payoff to certain right-wing elements within the Republican party.

Mr. Speaker, we need to be honest with each other. Anti-choice forces see this ban as the first step toward ending a woman's right to choose in America. As far as the anti-choice forces are concerned, there is no difference between the procedure we are debating today and abortions in the cases of rape and incest.

□ 1915

Yet these same radicals believe that properly manipulated, this late-term procedure can be the wedge issue to divide the overwhelmingly pro-choice American public. Today, it is this procedure. Tomorrow, it is family planning.

Mr. Speaker, no one in this body likes this procedure. And, yes, it is unpleasant. But this rarely used medical procedure remains necessary to ensure that women who must have an abortion are still able to bear children afterwards.

Mr. CANADY of Florida. Mr. Speaker, I yield 2 minutes to the gentlewoman from Idaho [Mrs. CHENOWETH].

Mrs. CHENOWETH. Mr. Speaker, I rise today in absolute support of H.R. 1833.

As I walked to the floor this evening, it struck me how ridiculous and sad it is that in this great Chamber in this great Nation, we should even be debating this issue.

What we are talking about today is not the issue of abortion per se.

That is a discussion for another time, and that time will come.

What we are talking about is a procedure that is positively medieval.

The issue of abortion is very emotional and I try to avoid using inflammatory rhetoric on the issue, because I have felt it didn't further the debate.

But in this case murder is not too strong a term.

Partial birth abortion is murder, cold, grisly, and premeditated.

Partial birth is used on babies who are up to 9 months in the womb.

The ninth and final month.

At 9 months, what is the difference between a baby in the womb or a baby in the crib? One is just as helpless as the other.

And yet this procedure exists and is used at will.

We have seen statements from abortionists that not only have they frequently performed this procedure, but they have often performed it in purely elective circumstances.

Can anyone argue that this chilling act is medically necessary?

The American Medical Association's Council on Legislation voted unanimously to recommend that the AMA board of trustees endorse H.R. 1833.

Many council members agreed that, ''the procedure is basically repulsive.''

To condone the practice of partial birth abortion is to discard and disgrace every shred of morality that we as human beings should embrace.

Mr. Speaker, I strongly urge my colleagues to take a stand against this evil procedure known as partial birth abortion and vote for H.R. 1833.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Kansas [Mrs. MEYERS].

Mrs. MEYERS of Kansas. Mr. Speaker, we know that after the 24th week, only .01 percent of all abortions are performed, .01 percent. There are two or three procedures that are used, meaning that this particular procedure is used in only a portion of that .01 percent. Of these procedures, all are more terrifying and unpleasant than this one. But if a woman is carrying a fetus which has a severe abnormality or if the woman has a severe health condition which threatens her health if she continues to carry the fetus, one of these procedures must be used. The bill itself states that there are circumstances in which no other procedure will suffice.

The Senate amendments improved the bill only marginally, and I must still vote ''no'' because, one, I believe strongly that we should not remove a medical option that might preserve the health of a woman or preserve the ability of a woman to have future children. Second, I believe strongly that we should not decide medical procedures on the floor of this House and am deeply concerned about where this might lead. And, third, I believe strongly that we should not criminalize a medical procedure. For these three reasons, I must vote ''no.''

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentlewoman from California [Ms. WOOLSEY].

Ms. WOOLSEY. Mr. Speaker, I rise in opposition to H.R. 1833 and criminalizing late-term abortions.

First of all, this conference report is a cruel, a very cruel attempt to make a political point. Make no mistake about it, ladies and gentleman, this conference report, with all of the emotional rhetoric and the exaggerated testimony, is a frontal attack on Roe versus Wade by the Gingrich majority, plain and simple. With the Gingrich majority, what they want is to do away with Roe. The radical rights wants to do away with Roe, and H.R. 183 is a good first step as far as they are concerned. So let us be honest about what this debate is really about.

This legislation seeks to prohibit the wide array of medical techniques which are rarely used but are sometimes required in the late stages of pregnancy, like with the Wilson family, in extreme and tragic cases when the life of the mother is in danger, or the fetus is so malformed that it has absolutely no chance of survival; for example, when the fetus has no brain, or the fetus is missing organs or the fetus's spine has grown outside of its body, when the fetus has zero chance of life, when women are forced to carry these malformed fetuses to term, they are in danger of chronic hemorrhaging, permanent infertility, or death.

Woman and their doctors need to make these decisions, not the Congress. Like the Wilsons, the family needs to make this decision with their doctors, not the Congress.

I urge my colleagues to oppose the conference report on H.R. 1833.

Mr. CANADY of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey [Mr. SMITH].

Mr. SMITH of New Jersey. Mr. Speaker, children, however dependent, are not property and no child is ever a throw-away. A pregnancy is not a disease. Yet partial-birth abortions treat a partially delivered child as a tumor, as a wart, as a disease to be destroyed.

Even if you have a doubt, I say to my colleagues concerning the humanity of an unborn child, can you not resolve that doubt in the baby's favor when the infant is half delivered?

Mr. Speaker, for the first time ever, Democrats and Republicans will send to the President a bill that says ''no'' to the horrific procedure that literally sucks the brains out of a baby's head. This poster to my left is not some kind of fiction. It is the reality of this horrendous child abuse.

A registered nurse, Brenda Pratt Shafer, said after seeing some of these partial-birth abortions, and I quote, ''The baby's body was moving, his little fingers were clasping together, he was kicking his feet. All the while, his little head was stuck inside.'' Dr. Haskell took a pair of scissors and inserted them into the back of the baby's head. Then he opened up the scissors. Then he stuck a high-powered suction tube into the hole and sucked the baby's brains out.

Mr. Speaker, for the first time ever, despite the extraordinary ability of the pro-abortion lobby to obfuscate and confuse, the reality of abortion is finally getting the scrutiny it deserves. By addressing this particular kind of abortion, this legislation compels us to face the dark secret, the cold fact that an unborn baby dies in every abortion.

I am astonished that Members can support this kind of abortion. Two decades of cover up are over. I would say to colleagues that the brutal methods,

whether it be chemical poisoning or suction, dismemberment of a baby, in this case a partially delivered baby killed with brain suction, this must be brought to the forefront so the people know exactly what is going on.

I hope the President says to the bill that he will sign it. I hope he signs it. It is not likely. He will have earned the legacy of being the abortion President. What a tragic, what a pathetic legacy to be the abortion President, especially a man who once in his past used to be pro-life.

Mrs. SCHROEDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am sorry the gentleman would not yield. I wanted to point out it does say it was the Conference of Catholic Bishops that created that poster.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Hawaii [Mrs. MINK].

(Mrs. MINK of Hawaii asked and was given permission to revise and extend her remarks.)

Mrs. MINK of Hawaii. Mr. Speaker, it is really tragic, tragic that the personal problems and the anxieties of women who face these very, very difficult decisions that must be made with respect to their health and their safety and the integrity of their family and to have those tragic circumstances of a person's life be used under these circumstances to advance this political goal of trying to do away with abortion.

But I think that the debate clearly points out that what is being attempted here is a denunciation of the rights of women that have been created by the U.S. Supreme Court. That is what is at stake here.

It is not this procedure that is used so few times out of necessity, but it is the principle of interfering with the doctor and the women that require this procedure, taking away that right of a woman to make this difficult decision, taking away the right of a woman to consult with her physician about what needs to be done, allowing the Congress of the United States to make these decisions. I think that is the most reprehensible thing we could even think of.

We talk about getting big government off of the backs of people. Well, let us concentrate about what we are trying to do today. We are trying to take away the rights of reproductive freedom that the Supreme Court has established, which the courts have said we must not interfere, and this is what is before us today, and that is why this Congress must oppose it. That is why this bill must never become law. It is trying to dictate to the doctors how to practice and criminalize their profession. I think it is outrageous.

Mrs. SCHROEDER. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas [Ms. JACKSON-LEE], a distinguished member of the Committee on the Judiciary.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentlewoman for yielding this time to me.

I am not a criminal, Mr. Speaker. And I am ashamed that what we are doing today may, in fact, makes innocent women, women who love children, criminals. Coreen Costello, Mary-Dorothy Lines, Claudia Ades, Viki Wilson, Tammy Watts, and Vikki Stella, all women who offered their most personal stories about wanting to conceive and to have a loving child and yet coming upon a physical and debilitating need to have a medical procedure.

Today we have legislation that will not cover all cases where a woman's life is in danger. The bill will not provide a health exception. H.R. 1833 creates obstacles to medical research, and tragically the life exception will not protect women. Criminals, we are making. Women, their families, their physicians. This is not the way to go.

In order to suggest that those of us who rise to support the rights of women do not have a love of a higher authority, how shameful. This is a bad bill. It does not help this country. It does not help women, and it certainly does not help the love we have for our children.

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

Mr. Speaker, I want to respond to a point that was made a few moments ago about this bill criminalizing the activities of women and making criminals of women. That is simply not true.

I would suggest that before Members come to the floor to speak about the bill, they might want to read the bill. The bill says clearly a woman upon whom a partial-birth abortion is performed may not be prosecuted under this section.

Mr. Speaker, I reserve the balance of my time.

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Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from New York [Mrs. MALONEY].

Mrs. MALONEY. Mr. Speaker, I rise in opposition to H.R. 1833. In yet another attempt to roll back a woman's right to choose, to roll back Roe versus Wade, and make all abortions illegal, choice opponents are putting forward legislation which could endanger a woman's life and her ability to have children in the future.

How odd that the majority party would describe itself as family friendly. Plain and simple, the supporters of this bill feel it is more important to save a doomed fetus than the life of a mother and her ability to have children in the future.

Coreen Costello is the mother of two. The Dole amendment would not have allowed her to use this procedure. Coreen Costello said in front of the Senate in her testimony that she would have taken any child that God gave her, regardless of any handicap. But her child was a child that could not live. Fortunately for Coreen and her family, her doctor was able to save her life and her fertility. She is now expecting her next child.

But what about the women who come after Coreen? What will happen to them, their health, their lives, their families, if this life-saving procedure is outlawed? Congress has no place in their decisions and no place in their tragedies.

Mrs. SCHROEDER. Mr. Speaker, I yield 3 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON].

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentlewoman from Colorado for yielding me time.

If your daughter and son-in-law were faced with the extraordinary tragedy of discovering extreme fetal deformity late in pregnancy or a life threatening development with abortion being the only alternative, would you, would you, each individual Member of this body, want her to have available to her the procedure that was the least threatening to her life and the most protective of her future reproductive capability and the most respectful of the need for the parents to be and their living children to mourn their tragic loss?

Consider the experience of Coreen Costello. Mrs. Costello and her husband hold strong pro-life views, but were suddenly faced with the terrible and painful truth of the problems with her pregnancy. Specialists had determined that the baby had a lethal neurological disorder. Doctors at Cedars-Sinai told the Costellos that their daughter would not live, and due to the amniotic fluid pooling in Mrs. Costello's uterus, as well as the baby's position, there was a serious risk of a ruptured uterus. Natural birth or an induced labor were impossible. Coreen Costello then considered a caesarean section, but the doctors at her hospital were adamant that the risk to her health and life were simply too great.

She and her husband chose not to risk leaving their other children motherless by opting for a D&E procedure. Because of the safety of the procedure, Coreen is now pregnant again.

What right have we here in Congress on this floor to say to this family that you should have risked mom's life and ignored your doctor's advice? By what authority do we tell these women that we know more in each of their cases than their own physicians?

It is ironic that some of you here are advocating legislation that would assure that managed care plans guaranteed physicians the right to tell women all the medical possibilities for treatment, and yet you will legislate here tonight the denial to women of America who face terribly tragic, painful, personal circumstances of the right to have the medical procedure that in truth is safest for them and most protective of their reproductive capability, assures them to the maximum extent possible that they will have more children in their future.

Men of the House of Representatives, women who are Members of Congress,

if it were your daughter, would you not want her life and reproductive hopes and dreams protected? Of course you would. Do not do this shortsighted, mean-spirited, terrible thing to women in our Nation.

Mr. CANADY of Florida. Mr. Speaker, I yield 1 minute to the gentlewoman from North Carolina [Mrs. MYRICK].

Mrs. MYRICK. Mr. Speaker, I honestly believe that a lot of the problems we have today in society stem from the fact that we have no regard for human life. You can call me old-fashioned, but I believe every individual born into this world is special, needed and important.

You know, our forefathers shared this philosophy when they wrote in our Declaration of Independence that we are endowed by our Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness.

I ask that we consider the difference. A doctor performs a painful, cruel, partial abortion one day, and it is accepted. And then the next day, if that same mother gave birth to the same age child and then she killed her child, she would be charged with murder. Only a few hours separates these two acts, but one is considered justified and accepted, even promoted, and the other is considered unjust. There is something wrong with our society today if we continue to justify such an unjust procedure.

Mrs. SCHROEDER. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Vermont [Mr. SANDERS].

Mr. SANDERS. Mr. Speaker, I know that there are some Members of Congress who believe they know everything about everything, but maybe once in awhile Members of this body might want to show a little humility. We are discussing a procedure which, as I understand it, is used in .01 of 1 percent of abortions, a situation which occurs only under the most tragic circumstances.

Day after day we hear from our conservative friends about how the big, bad Government should leave people alone and get off of the backs of people. I would urge our conservative friends to heed that advice on this occasion.

This is a tragic circumstance. Let the woman, let her family, let the physician make that decision, not the politicians in Congress.

Mr. CANADY of Florida. Mr. Speaker, I yield 1 minute to the gentleman from Missouri [Mr. VOLKMER].

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

Mr. VOLKMER. Mr. Speaker, I rise today in strong support of H.R. 1833, the Partial Birth Abortion Ban Act. Today's battle for the rights of the unborn differ from previous prolife and proabortion debates. Yes, this debate today will not stop all abortions. It will only stop one procedure, the partial birth abortion. It brings to light the fact that when a woman and her unborn child have this type of procedure, that only the woman leaves the operating room.

Mr. Speaker, I think we are all forgetting one thing: A third trimester baby has a very good chance of living, if it was allowed to be born without interference. I urge my colleagues who might otherwise not support a prolife piece of legislation to support this legislation, which simply and narrowly protects against partial birth abortions.

This debate is not about a woman's right to choose, because there are other options. This debate today is about putting an end to a procedure that kills a child just a few inches from full birth.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. BECERRA] a distinguished member of the Committee on the Judiciary and also the spouse of a distinguished physician.

Mr. BECERRA. Mr. Speaker, I thank the gentlewoman for yielding me time.

Mr. Speaker, I am confused. The debate I am hearing from that side has nothing to do with the medical procedure that it seems we are trying to ban. I continue to hear people talk about how we are conducting abortions on babies that otherwise would be able to survive; if the pregnancy were to go to term, we would have a living baby. When in fact, as my wife who happens to be a high-risk obstetrician-gynecologist who deals specifically with women who have difficult pregnancies, has said, this is not a procedure where you are talking about a fetus that will go to term and where you will have a healthy baby born. This is a procedure that is used when it is fairly clear that the baby has no chance to live, and to allow the pregnancy to go to term would jeopardize the health and perhaps the life of the woman. So it seems like the debate is not really on point.

Now, let me read something that came from the American College of Obstetricians and Gynecologists, those doctors that are asked to perform these types of procedures and to protect the women involved.

They state:

> The college finds very disturbing any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community, demonstrating why congressional opinion should never be substituted for professional medical judgment.

Mr. Speaker, I think that states it best. We have people here who are trying to impose their opinion on a medical profession where technical, highly sophisticated, highly trained individuals are being asked to perform lifesaving procedures.

It does not make sense. We should stay out of this. We should let a woman make that very difficult choice of what type of procedure she would need to preserve her health and her life, and perhaps have a chance to have a pregnancy that will be able to go to term.

Mr. Speaker, I would urge Members to seriously consider voting strongly against this particular bill, because it does not do what the proponents say.

Mrs. SCHROEDER. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore (Mr. ROGERS). The gentlewoman from Colorado is recognized for 2½ minutes.

Mrs. SCHROEDER. Mr. Speaker, as a woman, when I am with my doctor, I want that doctor focused on my health, and not on their criminal liability. What this bill does is it will focus any doctor on steering away from what they think might be best for the patient, because they could serve 2 years in prison or they could have a criminal record, or on and on and on.

Mr. Speaker, I think every citizen thinks that that is a zone of privacy. This Congress has never interfered in that zone of privacy between a family and their physician. Today, for the first time, if this bill becomes law, we will be moving to make an act criminal by a doctor. I much more trust my doctor than I do Members of this body, I am sorry to say, so I get very angry when I hear some of the things that have been said here.

I have heard people talk about ''inhumane, brutal, gruesome, terrible.'' We have seen the drawings. The drawings were not done by the American College of Gynecologists and Obstetricians. They do not support this bill. They were done, as they say rightfully, by the Catholic Conference of Bishops. Now, they have the right to make their case here, but, please, again, I think most Americans trust their doctors to make those difficult decisions.

We have heard about pain, we have heard about everything. I sat through those hearings. The anesthesiologists who testified said that there is pain in everything. There is pain in birth. So if we are just going to outlaw anything that is painful, we are going to be a very busy Congress. What they were saying is what happened, some of the advocates were misstating anesthesiology procedures. That is possible, because people here are not doctors.

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But they were not supporting the bill. They were just trying to set the record straight. Bottom line, as the gentlewoman from Kansas said, these are in very tragic circumstances. Only .01 percent of all abortions would be affected by this. These are basically a handful of doctors, and thank goodness a handful of families. But I must say as one who has been there, one who almost lost her life, I would be terribly resentful of this happening, and I never thought it could happen to me, so I say to people, please, please, I know this is a difficult issue.

Anything you cannot explain, anything that is difficult to explain, people hesitate to vote against. But please

be willing to make this explanation. It is much too important for America's families.

Mr. CANADY of Florida. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Nevada [Mrs. VUCANOVICH].

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

Mrs. VUCANOVICH. Mr. Speaker, I strongly urge my colleagues to support H.R. 1833 with the Senate amendments which would ban this brutal procedure know as partial-birth abortion.

Mr. Speaker, as many of you know, I have 15 grandchildren. Two of my grandchildren, the miracle twins as I call them, were born prematurely at 7 months. They were so tiny that they could fit in your hands but they were perfectly formed little human beings and they are now 14 years old.

It makes me shudder to think that somewhere, perhaps even today, in this country that there are other little preborn human beings 7 months old in their mothers womb that are going to be subject to this brutal, horrible procedure known as a partial birth abortion.

I am not the only one who finds this procedure horrifying. The American Medical Association's Legislative Council unanimously decided that this procedure was not ''a recognized medical technique'' and that ''this procedure is basically repulsive.'' This is especially true when you realize that 80 percent of these types of abortion are done as a purely elective procedure. It is important to note that this bill does make exception for this type of abortion if it is necessary to save the life of the mother, however, this is an exception that will have to be used rarely.

I think we can all agree that it is inhuman to begin the birthing process and nearly complete the delivery of the baby, only to suck the life out of the child.

I strongly urge my colleagues to support H.R. 1833, with the Senate amendments, which would ban this brutal procedure known as partial birth abortion.

Mr. CANADY of Florida. Mr. Speaker, I yield the balance of my time to the gentleman from Illinois [Mr. HYDE], chairman of the Committee on the Judiciary.

The SPEAKER pro tempore (Mr. ROGERS). The gentleman from Illinois is recognized for 5 minutes.

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

Mr. HYDE. Mr. Speaker, I listened with great intensity to the debate this evening. It is an important debate. I heard the gentleman from Vermont talk about humility, and he is absolutely right. You do not deal with people's lives in a sense of arrogance at all. But at the same time, if you believe you are right, if you are convinced that you possess the truth and you remain silent, you become the accomplice of liars and forgers. I just ascribe the failure to consider the unborn, and I listened to all of the impassioned remarks of my friends on the other side, they never talk about the unborn. It is the woman, it is her family, it is her doctor, but the little tiny infant in the shadows, the absent person, the invisible person is the unborn, and that is a failure of imagination. That is a compassion deficit.

Mr. Speaker, I guess you have to be healthy to be born. I guess our Declaration of Independence, when it talked about the right to life being inalienable should have said if you are healthy, if you are healthy. God help you if you are handicapped before you are born. But if you make it through the birth canal, we will give you a preferred parking place. That is the way we deal with those situations. No, the partial birth abortion, which is just what it is. It is not an exercise of reproductive rights, and it is not a fetus. It is an abortion. It is not a termination of a pregnancy. It is an extermination of a defenseless little life whose little arms and little legs are wiggling until that scissors gets shoved in his neck and then they stiffen. We heard that testimony. Some of you heard that testimony. There is a coursening of our national conscience when you tolerate this form of torture.

Catholic bishops. Thank God somebody cares about this grotesquery. Thank God, I do not think that invalidates those charts. A political goal? If defending human dignity is political, then I plead guilty. But somebody has to speak up for that little defenseless child almost born, three-quarters born, just the little head left, and they brutally kill that little child, and you do it in the name of compassion. I am sorry, I think that is a coursening, a desensitizing of our conscience.

This bill outlaws a uniquely barbaric method of abortion. Even to describe it is painful, but it is not as painful as the pain that little unborn child feels. If steel traps are too brutal for wild animals, what is too brutal for a tiny member of the human family, an almost-born infant? Have you heard of PETA, People for the Ethical Treatment of Animals? We need a PETA for humans, people for the ethical treatment of tiny, defenseless, cannot rise up in the streets, cannot vote, cannot escape members of the human family. You would not treat a coyote like you treat this little almost-born baby.

Members keep insisting the Government should not intervene. Well, I know some Members are for Government intervention in everything but abortion. I understand that. But who will speak for the baby if the Government does not? What is the purpose of law to protect the weak from the strong? What is weaker than a little child almost born and you destroy that child in a barbaric way? No, I am glad the Government is there. I am not that libertarian that I do not think that Government should not protect the weak from the strong.

The only thing Members consider is the autonomy of the woman, the woman. Well, God bless the woman, and she needs help and care and love and nurturing. But what about the little baby? Why do you leave that out of your equation, our of your calculus?

We had four anesthesiologists tell us those little babies feel pain. That is why they get anesthesia. One of the head of the anesthesiology department at Emory University says the pre-term baby feels pain more that when it is born. That validates the title ''silent scream.'' What about the pain felt by the little baby? Not a word, not a word.

Is there anything, is there anything we say no to? Is everything permitted? God help us if that is true. Let us draw the line here. This should not be tolerated.

Mr. DICKEY. Mr. Speaker, I submit the following material for enclosure in the RECORD:

DILATION AND EXTRACTION FOR LATE SECOND TRIMESTER ABORTION—PRESENTED AT THE NATIONAL ABORTION FEDERATION RISK MANAGEMENT SEMINAR, SEPTEMBER 13, 1992

(By Martin Haskell, M.D.)

INTRODUCTION

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term Dilation and Extraction or D&X to distinguish it from dismemberment-type D&E's.

This procedure can be performed in a properly equipped physician's office under local anesthesia. It can be used successfully in patients 20–26 weeks in pregnancy.

The author has performed over 700 of these procedures with a low rate of complications.

BACKGROUND

D&E evolved as an alternative to induction or instillation methods for second trimester abortion in the mid 1970's. This happened in part because of lack of hospital facilities allowing second trimester abortions in some geographic areas, in part because surgeons needed a ''right now'' solution to complete suction abortions inadvertently started in the second trimester and in part to provide a means of early second trimester abortion to avoid necessary delays for instillation methods.[1] The North Carolina Conference in 1978 established D&E as the preferred method for early second trimester abortions in the U.S.[2,3,4]

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.[5]

However, most surgeons find dismemberment at twenty weeks and beyond to be difficult due to the toughness of fetal tissues at this stage of development. Consequently, most late second trimester abortions are performed by an induction method.[6,7,8]

Two techniques of late second trimester D&E's have been described at previous NAF meetings. The first relies on sterile urea intra-amniotic infusion to cause fetal demise and lysis (or softening) of fetal tissues prior to surgery.[9]

The second technique is to rupture the membranes 24 hours prior to surgery and cut the umbilical cord. Fetal death and ensuing autolysis soften the tissues. There are attendant risks of infection with this method.

In summary, approaches to late second trimester D&E's rely upon some means to induce early fetal demise to soften the fetal tissues making dismemberment easier.

PATIENT SELECTION

The author routinely performs this procedure on all patients 20 through 24 weeks LMP

Footnotes at end of article.

with certain exceptions. The author performs the procedure on selected patients 25 through 26 weeks LMP.

The author refers for induction patients falling into the following categories: previous C-section over 22 weeks; obese patients (more than 20 pounds over large frame ideal weight); twin pregnancy over 21 weeks; patients 26 weeks and over.

DESCRIPTION OF DILATION AND EXTRACTION METHOD

Dilation and extraction takes over three days. In a nutshell, D&X can be described as follows: dilation; more dilation; real-time ultrasound visualization; version (as needed); intact extraction; fetal skull decompression; removal; clean-up; recovery.

Day 1—Dilation

The patient is evaluated with an ultrasound, hemoglobin and Rh. Hadlock scales are used to interpret all ultrasound measurements.

In the operating room, the cervix is prepped, anesthetized and dilated to 9–11 mm. Five, six or seven large Dilapan hydroscopic dilators are placed in the cervix. The patient goes home or to a motel overnight.

Day 2—Dilation

The patient returns to the operating room where the previous day's Dilapan are removed. The cervix is scrubbed and anesthetized. Between 15 and 25 Dilapan are placed in the cervical canal. The patient returns home or to a motel overnight.

Day 3—The Operation

The patient returns to the operating room where the previous day's Dilapan are removed. The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized and grasped with a tenaculum. The membranes are ruptured, if they are not already.

The surgical assistant places an ultrasound probe on the patient's abdomen and scans the fetus, locating the lower extremities. This scan provides the surgeon information about the orientation of the fetus and approximate location of the lower extremities. The transducer is then held in position over the lower extremities.

The surgeon introduces a large grasping forcep, such as a Bierer or Hern, through the vaginal and cervical canals into the corpus of the uterus. Based upon his knowledge of fetal orientation, he moves the tip of the instrument carefully towards the fetal lower extremities. When the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws to firmly and reliably grasp a lower extremity. The surgeon then applies firm traction to the instrument causing a version of the fetus (if necessary) and pulls the extremity into the vagina.

By observing the movement of the lower extremity and version of the fetus on the ultrasound screen, the surgeon is assured that his instrument has not inappropriately grasped a maternal structure.

With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.

The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.

At this point, the right-handed surgeon slides the fingers of the left had along the back of the fetus and ''hooks'' the shoulders of the fetus with the index and ring fingers (palm down). Next he slides the tip of the middle finger along the spine towards the skull while applying traction to the shoulders and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

Reassessing proper placement of the closed scissors tip and safe elevation of the cervix, the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

The surgeon finally removes the placenta with forceps and scrapes the uterine walls with a large Evans and a 14 mm suction curette. The procedure ends.

Recovery

Patients are observed a minimum of 2 hours following surgery. A pad check and vital signs are performed every 30 minutes. Patients with minimal bleeding after 30 minutes are encouraged to walk about the building or outside between checks.

Intravenous fluids, pitocin and antibiotics are available for the exceptional times they are needed.

ANESTHESIA

Lidocaine 1% with epinephrine administered intra-cervically is the standard anesthesia. Nitrous-oxide/oxygen analgesic is administered nasally as an adjunct. For the Dilapan insert and Dilapan change, 12cc's is used in 3 equidistant locations around the cervix. For the surgery, 24cc's is used at 6 equidistant spots.

Carbocaine 1% is substituted for lidocaine for patients who expressed lidocaine sensitivity.

MEDICATIONS

All patients not allergic to tetracycline analogues receive doxycycline 200 mgm by mouth daily for 3 days beginning Day 1.

Patients with any history of gonorrhea, chlamydia or pelvic inflammatory disease receive additional doxycycline, 100 mgm by mouth twice daily for six additional days.

Patients allergic to tetracyclines are not given prophylactic antibiotics.

Ergotrate 0.2 mgm by mouth four times daily for three days is dispensed to each patient.

Pitocin 10 IU intramuscularly is administered upon removal of the Dilapan on Day 3.

Rhogam intramuscularly is provided to all Rh negative patients on Day 3.

Ibuprofen orally is provided liberally at a rate of 100 mgm per hour from Day 1 onward.

Patients with severe cramps with Dilapan dilation are provided Phenergan 25 mgm suppositories rectally every 4 hours as needed.

Rare patients require Synalogos DC in order to sleep during Dilapan dilation.

Patients with a hemoglobin less than 10 g/dl prior to surgery receive packed red blood cell transfusions.

FOLLOW-UP

All patients are given a 24 hour physician's number to call in case of a problem or concern.

At least three attempts to contact each patient by phone one week after surgery are made by the office staff.

All patients are asked to return for check-up three weeks following their surgery.

THIRD TRIMESTER

The author is aware of one other surgeon who uses a conceptually similar technique. He adds additional changes of Dilapan and/or lamineria in the 48 hour dilation period. Coupled with other refinements and a slower operating time, he performs these procedures up to 32 weeks or more.[10]

SUMMARY

In conclusion, Dilation and Extraction is an alternative method for achieving late second trimester abortions to 26 weeks. It can be used in the third trimester.

Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia

Among its disadvantages are that it requires a high degree of surgical skill, and may not be appropriate for a few patients.

FOOTNOTES

[1] Cates, W. Jr., Schulz, K.F., Grimes D.A., et al: The Effects of Delay and Method of Choice on the Risk of Abortion Morbidity, Family Planning Perspectives, 9:266, 1977.

[2] Borell, U., Emberey, M.P., Bygdeman, M., et al: Midtrimester Abortion by Dilation and Evacuation (Letter), American Journal of Obstetrics and Gynecology, 131:232, 1978.

[3] Centers for Disease Control: Abortion Surveillance 1978, p. 30, November, 1980.

[4] Grimes, D.A., Cates, W. Jr. (Berger, G.S., et al, ed): Dilation and Evacuation, Second Trimester Abortion—Perspectives After a Decade of Experience, Boston, John Wright—PSG, 1981, p. 132.

[5] Ibid, p. 121–128.

[6] Ibid, p. 121.

[7] Kerenyi, T.D. (Bergen, G.S., et al, ed): Hypertonic Saline Instillation, Second Trimester Abortion—Perspectives After a Decade of Experience, Boston, John Wright—PSG, 1981, p. 79.

[8] Hanson, M.S. (Zatuchni, G. I., et al, ed): Midtrimester Abortion: Dilation and Extraction Preceded by Laminaria, Pregnancy Termination Procedures, Safety and New Developments, Hagerstown, Harper and Row, 1979, p. 192.

[9] Hern, W.M., Abortion Practice, Philadelphia, J.B. Lippincott, 1990, p. 127, 144–6.

Mr. TIAHRT. Mr. Speaker, I believe my colleagues will be interested in Dr. Birnbach's testimony related to partial birth abortions.

Mr. Chairman, members of the subcommittee, my name is David Birnbach, M.D., and I am presently the director of obstetric anesthesiology at St. Luke's-Roosevelt Hospital Center, a teaching hospital of Columbia University College of Physicians and Surgeons in New York City. I am also president-elect of the Society for Obstetric Anesthesia and Perinatology, the society which represents my subspecialty.

I am here today to take issue with the previous testimony before committees of the Congress that suggests that anesthesia causes fetal demise. I believe that I am qualified to address this issue because I am a practicing obstetric anesthesiologist. Since completing my anesthesiology and obstetric anesthesiology training at Harvard University, I have administered analgesia to more than 5,000 women in labor and anesthesia to over 1,000 women undergoing caesarean section. Although the majority of these cases were at full term gestation, I have provided anesthesia to approximately 200 patients who were carrying fetuses of less than 30 weeks gestation and who needed emergency nonobstetric surgery during pregnancy. These operations have included appendectomies, gall bladder surgeries, numerous orthopedic procedures such as fractured ankles, uterine and ovarian procedures, including malignant tumor removal, breast surgery, neurosurgery, and cardiac surgery.

The anesthetics which I have administered have included general, epidural, spinal, and local. The patients have included healthy as well as very sick pregnant patients. Although

I often use spinal and epidural anesthesia in pregnant patients, I also administer general anesthesia to these patients and, on occasion, have needed to administer huge doses of general anesthesia in order to allow surgeons to perform cardiac surgery or neurosurgery.

In addition, I believe that I am also especially qualified to discuss the effect of maternally administered anesthesia on the fetus, because I am one of only a handful of anesthesiologists who has administered anesthesia to a pregnant patient undergoing in-utero fetal surgery, thus allowing me to watch the fetus as I administered general anesthesia to the mother. A review of the experiences that my associates and I had while administering general anesthesia to a mother while a surgeon operated on her unborn fetus was published in the Journal of Clinical Anesthesia vol. 1, 1989, pp. 363–367. In this paper, we suggested that general anesthesia provides several advantages to the fetus who will undergo surgery and then be replaced in the womb to continue to grow until mature enough to be delivered. Safe doses of anesthesia to the mother most certainly did not cause fetal demise when used for these operations.

Despite my extensive experience with providing anesthesia to the pregnant patient, I have never witnessed a case of fetal demise that could be attributed to an anesthetic. Although some drugs which we administer to the mother may cross the placenta and affect the fetus, in my medical judgment fetal demise is definitely not a consequence of a properly administered anesthetic. In order to cause fetal demise it would be necessary to give the mother dangerous and life-threatening doses of anesthetics. This is not the way we practice anesthesiology in the United States.

Mr. Chairman, I am deeply concerned that the previous congressional testimony and the widespread publicity that has been given this issue will cause unnecessary fear and anxiety in pregnant patients and may cause some to unnecessarily delay emergency surgery. As an example, several newspapers across the United States have stated that anesthesia causes fetal demise. Because this issue has been allowed to become a ''controversy'' several of my patients have recently expressed concerns about anesthesia, having seen newspaper or heard radio or television coverage of this issue. Evidence that patients are still receiving misinformation regarding the fetal effects of maternally administered anesthesia can be seen by review of an article that a pregnant patient recently brought with her to the labor and delivery floor. In last month's edition of Marie Claire, a magazine which many of my pregnant patients read, an article about partial birth abortion states: ''The mother is put under general anesthetic, which reaches the fetus through her bloodstream. By the time the cervix is sufficiently dilated, the fetus has overdosed on the anesthetic and is brain-dead.'' These incorrect statements continue to find their way into newspapers and magazines around the country. Despite the previous testimony of Dr. Ellison, I have yet to see an article that states, in no uncertain terms, that anesthesia when used property does not harm the fetus. This supposed controversy regarding the effects of anesthesia on the fetus must be finally and definitively put to rest.

In order to address this complex issue, I believe that it is necessary to comment on three of the statements which have recently been made to the Congress.

First, Dr. James McMahon, now deceased, testified that anesthesia causes neurologic fetal demise.

Second, Dr. Lewis Koplick supported Dr. McMahon and stated: ''I am certain that anyone who would call Dr. McMahon a liar is speaking from ignorance of abortions in later pregnancy and of Dr. McMahon's technique and integrity.''

Third, Dr. Mary Campbell of Planned Parenthood has addressed this issue by writing the following: ''Though these does are high, the incremental administration of the drugs minimizes the probability of negative outcomes for the mother. In the fetus these dosage levels may lead to fetal demise—death—in a fetus weakened by its own developmental anomalies.''

My responses to these statements are as follows:

One, there is absolutely no scientific or clinical evidence that a properly administered maternal anesthetic causes fetal demise. To the contrary, there are hundreds of scientific articles which demonstrate the fetal safety of currently used anesthetics.

Two, Dr. Koplick has stated that the ''massive'' doses used by Dr. McMahon are responsible for fetal demise. This again, is incorrect and there is not scientific or clinical data to support this allegation. I have personally administered ''massive'' doses of narcotics to intubated critically ill pregnant patients who are being treated in an intensive care unit. I am pleased to say that the fetuses were born alive and did well.

Three, Dr. Campbell has described the narcotic protocol which Dr. McMahon had used during his D&X procedures: it includes the administration of Midazolam (10–40 mg) and Fetanyl (900–2,500 µg). Although there is no evidence that this dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death. These doses are far in excess of any anesthetic that would be used by an anesthesiologist and even if they are incrementally given over a 2 to 3 hour period these doses would in all probability cause enough respiratory depression of the mother, to necessitate intubation and/or assisted respiration. Since Dr. McMahon cannot be questioned regarding his ''heavy handed'' anesthetic practice. I am unable to explain why we would willingly administer such huge amounts of drugs if he did indeed administer 2,500 µg of fentanyl and 40 mg of midazolam to a patient in a clinic, without an anesthesiologist present, he has definitely placing the mother's life at great risk.

In conclusion, I would like to say that I believe that I have a responsibility as a practicing obstetric anesthesiologist to refute any and all testimony that suggests that maternally administered anesthesia causes fetal demise. It is my opinion that in order to achieve that goal one would need to administer such huge doses of anesthetic to the mother as to place her life at jeopardy. Pregnant women must get the message that should they need anesthesia for surgery or analgesia for labor, they may do so without worrying about the effects on their unborn child.

Thank you for your attention. I am happy to respond to your questions.

Mr. VOLKMER. Mr. Speaker, I submit the following material for inclusion in the RECORD:

[From the American Medical News, Nov. 20, 1995]

OUTLAWING ABORTION METHOD: VETO-PROOF MAJORITY IN HOUSE VOTES TO PROHIBIT LATE-TERM PROCEDURE

(By Diane M. Gianelli)

Washington.—His strategy was simple: Find an abortion procedure that almost anyone would describe as ''gruesome,'' and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about ''partial birth'' abortions, he was set.

He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming—and veto-proof—margin: 288–139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a ''pro-life'' infusion in both the House and Senate, massive crossover voting occurred, with a significant number of ''pro-choice'' representatives voting to pass the measure.

The controversial procedure, done in second- and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, ''partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

''Partial birth'' abortions, also called ''intact D&E'' (for dilation and evacuation), or ''D&X'' (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton Ohio, and, until his recent death, James T. McMahon, MD of the Los Angeles area. Dr. McMahon said in a 1993 AM/News interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere, but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure, after considering a number of other options. An Ohio law passed earlier this year, for instance, bans ''brain suction'' abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

MIXED FEELINGS IN MEDICINE

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

''I have very serious reservations about this procedure,'' said Colorado physician Warren Hern. MD. The author of ''Abortion Practice,'' the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a

series of legislative attempts to chip away at abortion rights. But of the procedure in question he says. ''You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it.''

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

Turning the fetus to a breech position is ''potentially dangerous,'' he added. ''You have to be concerned about causing amniotic fluid embolism or placental abruption if you do that.''

Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

''There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother.'' Dr. Smith wrote in letter to Canady.

The procedure also has its defenders. The procedure is a ''well-recognize and safe technique by those who provide abortion care,'' Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the Congressional Record.

''The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown,'' Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were ''many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?''

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R, N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of ''a woman's right to choose,'' and focus on the reality of abortion. And, he said, to expose those who support ''abortion on demand'' as ''the real extremists.''

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D, Calif.) said, ''Despite the other side's spin doctors—real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the woman, and, if possible, preserve her ability to have children.''

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

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with AMNews, Dr. Haskell conceded that 80 percent of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, ''depression'' was listed most often as the reason for late-term nonelective abortions with maternal indications. ''Cleft lip'' was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted ''out of context.'' AMNews Editor Barbara Bolsen defended the article, saying AMNews ''had full documentation of the interviews, including tape recordings and transcripts.''

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

''No, it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress—intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken.

''So in my case, I would say probably about a third of those are definitely dead before I actually start to remove the fetus. And probably the other two-thirds are not,'' said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce ''a medical coma'' in the fetus, and ''there is neurological fetal demise.''

But Watson Bowes, MD, a maternal-fetus specialist at the University of North Carolina, Chapel Hill, said in a letter to Canady that Dr. McMahon's statement ''suggests a lack of understanding of maternal-fetal pharmacology. * * * Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthesized for the procedures, and the fetuses did not die.''

NEXT MOVE IN THE SENATE

At AMNews press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word ''veto.'' But he said he ''cannot support'' a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D, Colo.) says that's not sufficient. ''This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way,'' she said during the House debate.

Canady disagrees. ''No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother.''

ORGANIZED MEDICINE POSITIONS VARY

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as ''an unwarranted intrusion into the physician-patient relationship.'' The American College of Obstetricians and Gynecologists also opposes it on grounds it would ''supersede the medical judgment of trained physicians and * * * would criminalize medical procedures that may be necessary to save the life of a woman,'' said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

Rep. Nita Lowey (D, N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were ''attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions,'' Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse. Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it ''the most horrifying experience of my life.

''The baby's body was moving. His little fingers were clasping together. He was kicking his feet.'' Afterwards, she said, ''he threw the baby in a pan.'' She said she saw the baby move. ''I still have nightmares about what I saw.''

Dr. Hern says if the bill becomes law, he expects it to have ''virtually no significance'' clinically. But on a political level, ''it is very, very significant.''

''This bill's about politics,'' he said, ''it's not about medicine.''

Mrs. VUCANOVICH. Mr. Speaker, I submit the following material for inclusion in the RECORD:

[From Cincinnati Medicine, Fall 1993]

2ND TRIMESTER ABORTION

(An interview with W. Martin Haskell, MD)

Last summer, American Medical News ran a story on abortion specialists. Included was W. Martin Haskell, MD, a Cincinnati physician who introduced the D&X procedure for second trimester abortions. The Academy received several calls requesting information about D&X. The following interview provides an overview.

Q: What motivated you to become an abortion specialist?

A: I stumbled into it by accident. I did an internship in anesthesia. I worked for a year in general practice in Alabama. I did two years in general surgery, then switched into family practice to get board certified. My intentions at that time were to go into emergency medicine. I enjoyed surgery, but I realized there was an abundance of really good surgeons here in Cincinnati. I didn't feel I'd

make much of a contribution. I'd be just another good surgeon. While I was in family practice, I got a part-time job in the Women's Center. Over the course of several months, I recognized things there could be run a lot better, with a much more professional level of service—not necessarily in terms of medical care—in terms of counseling, the physical facility, patient flow, and in the quality of people who provided support services. The typical abortion patient spends less than ten minutes with the physician who performs the surgery. Yet, that patient might be in the facility for three hours. When I talked to other physicians whose patients were referred here, I saw problems that could be easily corrected. I realized there was an opportunity to improve overall quality of care, and make a contribution. I own the center now.

Q: Back in 1979 when you were making these decisions, did you consider yourself prochoice?

A: I've never been an activist. I've always felt that no matter what the issue, you prove your convictions by your hard work—not by yelling and screaming.

Q: Have there been threats against you?

A: Not directly. Pro-life activist Randall Terry recently said to me that he was going to do everything within his power to have me tried like a Nazi war criminal.

Q: A recent American Medical News article stated that the medical community hadn't really established a point of fetal viability. Why not?

A: Probably because it can't be established with uniform certainty. Biological systems are highly variable. The generally accepted point of fetal viability is around 24–26 weeks. But you can't take a given point in fetal development and apply that 100 percent of the time. It just doesn't happen that way. If you look at premature deliveries and survival percentages at different weeks of gestation, you'll get 24-week fetuses with some survival rate. The fact that you get some survivors demonstrates the difficulty in defining a point.

Q: Most women who get abortions end pregnancies during the first trimester. Who is the typical second-trimester patient?

A: I don't know that there is a typical second-trimester abortion. But if you look at the spectrum of abortions (most women are between the ages of 19 and 29) they tend to be younger. Some are older. The typical thing that happens with older women is that they never realized they were pregnant because they were continuing to bleed during the pregnancy. The other thing we see with older women is fetal malformations or Down's Syndrome. These are being diagnosed much earlier now than they used to be. We're seeing a lot of genetic diagnoses with ultrasound and amniocentesis at 17–18 weeks instead of 22–24 weeks. With the teenagers, anybody who has ever worked with or had teenagers can appreciate how unpredictable they can be at times. They have adult bodies, but a lot of time they don't have adult minds. So their reaction to problems tends to be much more emotional than an adult's might be. It's a question of maturity. So even though they may have been educated about all kinds of issues in reproductive health, when a teenager becomes pregnant, depending upon her relationship with her family, the amount of peer support she has—every one is a highly-individual case—sometimes they delay until they can no longer contain their problem and it finally comes out. Sometimes it's money: It takes them a while to get the money. Sometimes it's just denial.

Q: Do you think more information on abstinence and contraceptives would decrease the number of teenage pregnancies?

A: I grew up in the sixties and nobody talked about contraception with teenagers in the sixties. But today, though it may be controversial in some areas, there's a lot being taught about reproductive health in the high school curricula. I think a lot more is being done, but the bottom line is we're all still just human—with human emotions, and particularly with teenagers, a sense of invulnerability; it can't happen to me. So education helps a lot, but it's not going to eliminate the problem. You can teach a person the skills, but you can't make them use them.

Q: Does it bother you that a second trimester fetus so closely resembles a baby?

A: I really don't think about it. I don't have a problem with believing the fetus is a fertilized egg. Sure it becomes more physically developed but it lacks emotional development. It doesn't have the mental capacity for self-awareness. It's never been an ethical dilemma for me. For people for whom that is an ethical dilemma, this certainly wouldn't be a field they'd want to go into. Many of our patients have ethical dilemmas about abortion. I don't feel it's my role as a physician to tell her she should not have an abortion because of her ethical feelings. As individuals grow and mature, learn more, feel more, experience more, their perspective about themselves and life, morality and ethics change. Facing the situation of abortion is a part of that passage through life for some women—how they resolve that is their decision. I can be their advisor much as a lawyer can be; he can tell you your options, but he can't make you file a suit or tell you not to file a suit. My role is to provide a service and, to a limited degree, help women understand themselves when they make their decision. I'm not to tell them what's right or wrong.

Q: Do your patients ever reconsider?

A: Between our two centers, that happens maybe once a week. There's a patient who changes her mind or becomes truly ambivalent and goes home to reconsider, then might come back a week or two later. I feel that's one of the strengths of how we approach things here. We try not to create pressure to have an abortion. Our view has always been that there are enough women who want abortions that we don't have to coerce anyone to have one. We've always been strongly against pressure on our patients to go ahead with an abortion.

Q: How expensive is a second trimester abortion?

A: Fees range from $1,200–1,600 depending on length of pregnancy. More insurance companies cover abortion than don't cover it. About 15 percent of our patients won't use insurance because they want to maintain privacy. About 10–20 percent use insurance. The rest pay out of pocket.

Q: What led you to develop D&X?

A: D & E's, the procedure typically used for later abortions, have always been somewhat problematic because of the toughness and development of the fetal tissues. Most physicians do terminations after 20 weeks by saline infusion or prosteglandin induction, which terminates the fetus and allows tissue to soften. Here in Cincinnati, I never really explored it, but I didn't think I had that option. There certainly weren't hospitals willing to allow inductions past 18 weeks—even Jewish, when they did abortions, their limit was 18 weeks. I don't know about University. What I saw here in my practice, because we did D & Es, was that we had patients who needed terminations at a later date. So we learned the skills. The later we did them, the more we saw patients who needed them still later. But I just kept doing D & Es because that was what I was comfortable with, up until 24 weeks. But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D & Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot length presentation, you'd reach in and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. At first, I would reach around trying to identify a lower extremity blindly with the tip of my instrument. I'd get it right about 30–50 percent of the time. Then I said, ''Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it. I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Q: Does the fetus feel pain?

A: Neurological pain and perception of pain are not the same. Abortion stimulates fibers, but the perception of pain, the memory of pain that we fear and dread are not there. I'm not an expert, but my understanding is that fetal development is insufficient for consciousness. It's a lot like pets. We like to think they think like we do. We ascribe human-like feelings to them, but they are not capable of the same self-awareness we are. It's the same with fetuses. It's natural to project what we feel for babies to a 24-week old fetus.

[From the American Medical News, Jan. 1, 1996]

ANESTHESIOLOGISTS QUESTION CLAIMS IN ABORTION DEBATE

(By Diane M. Gianelli)

WASHINGTON.—When he saw an article in the St. Louis Post-Dispatch that claimed anesthesia caused fetal death in some late-term abortion procedures. David Birnbach, MD, was ''shocked.''

''I thought, 'This is crazy,'" said Dr. Birnbach, who is director of obstetric anesthesiology at New York's St. Luke's-Roosevelt Hospital Center, and vice president of the Society for Obstetric Anesthesia and Perinatology.

''Everyday we have pregnant patients who get anesthesia—women who break their ankles, need knee surgery, have appendectomies, gallbladder removals, breast biopsies, and so on. Anesthetics done safely by an anesthesiologist do not do harm to either the mother or the baby,'' he said.

The anesthesia-causes-fetal-death claim was made by one of the two U.S. physicians who specialized in a particular type of late-term abortion that opponents call ''partial birth'' abortions. The contention has been repeated by other proponents of the procedure, who refer to it as ''intact D&E'' (for dilation and evacuation) or ''D&X'' (dilation and extraction).

Medical experts contend the claim is scientifically unsound and irresponsible, unnecessarily worrying pregnant women who need anesthesia. But while some are now qualifying their assertion that anesthesia induces fetal death, they are not backing away from it.

When Rep. Charles T. Canady (R, Fla.) introduced a bill to ban the procedure, James T. McMahon, MD, a Los Angeles area family physician who specialized in this procedure before his recent death, responded. Dr. McMahon wrote that the anesthesia given to the mother before the abortion causes ''neurological fetal demise.''

The bill to ban the procedure, passed late last year by both the House and the Senate, defines it as one in which the provider ''partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

The procedure was recently banned in Ohio, where its other main practitioner, Martin Haskell, MD, lives. But a federal

judge declared the law there unconstitutional in a preliminary injunction last month.

On the federal level, the bill faces a presidential veto threat, and while the measure passed the House by a 2-to-1 ratio, proponents do not have enough Senate votes to override a veto.

The claim about anesthesia causing fetal death has been repeated by many of the bill's opponents, including the National Abortion Federation, the National Abortion and Reproductive Rights Action League, and members of Congress. A recent Planned Parenthood ''fact sheet'' on these late-term abortions claims that ''the fetus dies from an overdose of anesthesia given to the mother intravenously.''

The distinction of when fetal death occurs is critical, because the bill would ban only procedures in which the fetus was killed after being partially delivered alive through the birth canal. If it could be proved that the fetuses died inside the womb—from anesthesia or any other cause—the abortion would not fall under the proposed law.

After reading the anesthesia-kills-fetuses claim in the St. Louis paper, the American Society of Anesthesiologists issued a press release denouncing it. And in testimony before the Senate, Norig Ellison, MD, president of the society—which did not take a position on the bill—called Dr. McMahon's statements ''entirely inaccurate.''

He added that he was ''deeply concerned'' that the widespread publicity given to Dr. McMahon's claims ''may cause pregnant women to delay necessary and perhaps even life-saving medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus.''

In fact, cases of maternal concern have already surfaced. Dr. Birnbach said he has already had patents raise questions. And Rep. Tom Coburn, MD, an Oklahoma Republican who still delivers babies when he goes home on weekends, said he just had a patient refuse epidural anesthesia during childbirth after hearing those claims. Dr. Coburn is a co-sponsor of the bill.

Dr. Ellison, vice chair of the Dept. of Anesthesiology at the University of Pennsylvania School of Medicine in Philadelphia, testified that very little of the anesthetic given the mother ever reaches, the fetus. He added that ''in my medical judgment, it would be necessary—in order to achieve 'neurological demise' of a fetus in a 'partial birth' abortion—to anesthetize the mother to such a degree as to place her own health in serious jeopardy.''

Planned Parenthood's Mary Campbell, MD, who wrote the fact sheet claiming anesthesia cases fetal death, was grilled during the Senate Judiciary Committee hearing Nov. 17, 1995, by Sen. Spence Abraham (R, Mich.).

When prodded, she conceded ''I do not know what causes the fetus to die.'' When asked why her fact sheet attributes the cause to anesthesia, she replied, ''I simplified that for Congress.''

Afer the hearing, Dr. Campbell wrote to Sen. Barbara Boxer, (D, Calif.), who led the movement against the bill in the Senate. In her letter, Dr. Campbell repeated that anesthesia caused fetal death, but added some caveats. She said it ''may lead to fetal demise (death) in a fetus weakened by its own developmental anomalies.''

''In other cases,'' she wrote, ''these drugs prevent the perception of pain by the fetus; they cause depression of fetal respiration before the extraction procedure and preclude fetal respiration afterward.''

Dr. Birnbach disputes her contention. Even in the very high-end doses she mentioned, he said—10 mg to 40 mg of Versed, given in 1 mg to 2 mg increments, and 900 ug to 2,500 ug of fentanyl, given in 100 ug to 150 ug increments—''anesthesia does not kill an infant if you don't kill the mother.''

He added that when patients receive the high-end dosage range specified by Dr. Campbell, the mother was in fact at risk for depressed breathing. ''You can't give those high doses without harming the mother unless the mother is assisted in her breathing,'' he said.

Dr. Birnbach said that, on occasion, he has given even larger doses than the high-end ones cited by Dr. Campbell and has never caused any harm to either the mother or the fetus.

He also said that Dr. Campbell's claims that the medications depress fetal respiration before the abortion takes place were ''immaterial'' because fetuses don't breathe in the womb.

Dr. Birnbach added, however, that an infant born alive with depressed respiration can still survive normally. ''The narcotics are not a problem. We can reverse the narcotics and we can breathe for the baby.''

Another recurring theme at both the hearings and during the ensuing debate about the procedure centers around fetal pain. Specialists in this procedure claim the fetus feels no pain for a variety of reasons, but usually because they say fetuses lack the neural development necessary to perceive pain, or if they are capable of feeling pain, anesthesia given to the mother prevents the preception of pain in the fetus.

Robert J. White, MD, PhD, professor of neurosurgery at Case Western University in Cleveland, testified on the topic before Congress last summer. ''There are published scientific studies that demonstrate that by the 20th week, many of the neuronal pathways that sense pain have already started to develop,'' he said. ''By the 24th week, the connections of the cortex and the thalamus are well under way. . . . There is no way to argue with impunity that pain reception is not possible.''

Michael J. Murray, MD, an anesthesiologist at the Mayo Clinic in Rochester, Minn., and president of the Minnesota Medical Assn., agrees.

In fact, he said, physicians doing fetal surgery inject narcotic fentanyl and muscle relaxants into the umbilical cord to provide pain relief, even though the mother is already anesthetized, ''because what they get from the mom is not enough.'' He added that studies on neonates getting surgery right after birth indicate that those who were given opioids had much better outcomes than those who were just given muscle relaxants.

The bottom line for many anesthesiologists, regardless of their position on abortion: Women should not be concerned about questionable claims thrown out in the heat of the debate.

''Women who need anesthesia for emergency surgery during pregnancy or who request analgesia for labor should take heart that both they and their babies will do just fine,'' Dr. Birnbach said.

Mr. CANADY of Florida. Mr. Speaker, I submit the following material for inclusion in the RECORD.

March 27, 1996.

THE SMITH-DOLE SENATE AMENDMENT PROTECTS THE LIFE OF THE MOTHER

DEAR COLLEAGUE: This is in response to a March 26 ''Dear Colleague'' from Reps. Nita Lowey and Nancy Johnson, which ran under the very misleading headline, ''The Dole Amendment Endangers Women's Lives.''

As initially passed by the House on Nov. 1, 1995—with 288 votes—HR 1833 contained an ''affirmative defense'' provision that protected a doctor if he showed that he ''reasonable believed'' that a partial-birth abortion procedure was necessary to save a mother's life. These sorts of ''affirmative defense'' exceptions are found in literally dozens of federal criminal statutes. However, opponents of HR 1833 distorted the legal effect of the ''affirmative defense'' mechanism. Therefore, the prime sponsor of the Senate bill, Sen. Bob Smith (who for some curious reason is not mentioned in the Lowey-Johnson letter) and Sen. Dole offered an amendment that says the ban ''shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury: Provided, That no other medical procedure would suffice for that purpose.''

Senator Barbara Boxer—the leading Senate opponent of HR 1833—immediately endorsed the Smith-Dole Amendment, which was adopted 98–0. Here is what Senator Boxer said on the floor of the Senate: ''And now here we have it. Here we have it, an exception now for life of the mother. I think that is progress. I think that is progress, because when we started, there was no exception. It was an affirmative defense.'' [Congressional Record, Dec. 5, 1995, p. S 18005]

Moreover, in a Jan. 31 letter to Cardinal Anthony Bevilacqua of Philadelphia, President Clinton himself recognized that the Senate had added a life-of-mother exception (but the President continues to demand the addition of the gutting ''health exception'' endorsed by the National Abortion and Reproductive Rights Action League.)

Reps. Lowey and Johnson write, ''It is unclear whether pregnancy would legally constitute a physical disorder.'' A normal pregnancy does not constitute a life-threatening condition—but in those rare cases in which a ''physical disorder, illness, or injury'' causes the pregnancy to threaten a mother's life, the Senate exception obviously applies. With respect, our colleagues' reading of the Senate language is absurdly convoluted, and violates standard principles of statutory construction.

As to our colleagues' other objections: let's keep in mind that a partial-birth abortion involves the almost complete delivery of a living baby, who is then killed. Now, if the entire baby has been delivered alive, except for the head, supposedly without jeopardy to the mother, why can't the doctor simply deliver the head as well, without killing the baby?

When the American Medical News put essentially that very question to Dr. Martin Haskell (who has done over 1,000 partial-birth abortions) in a tape-recorded interview, Dr. Haskell's answer was both candid and chilling: ''The point here is you're attempting to do an abortion . . . not to see how do I manipulate the situation so that I get a live birth instead,'' he said.

(There are rare cases in which a baby suffers from such severe hydrocephaly—head enlargement caused by excess fluid in the skull—so that without intervention, both vaginal delivery and a Caesarian could pose risks to the mother. In those cases, according to Prof. Watson Bowes, a nationally eminent authority on fetal and maternal medicine who is co-editor of the Obstetrical and Gynecological Survey, the standard treatment is cephalocentesis—removal of excess fluid through a needle. ''Fluid is then withdrawn which results in reduction of the size in the head so that delivery can occur,'' wrote Prof. Bowes. ''This procedure is not intended to kill the fetus, and, in fact, is usually associated with the birth of a live infant.'')

Attempts by HR 1833 opponents to ''revive'' the life-of-mother issue are merely another reflection of their refusal to come to grips

with the uncomfortable fact—which is amply documented in the writings and validated statements of partial-birth abortion practitioners—that the overwhelming majority of partial-birth abortions have nothing whatever to do with life-threatening complications of pregnancy, but are (in the words of Dr. Martin Haskell) ''purely elective.''

Sincerely,

HENRY J. HYDE,
Chairman.

''FETAL DEATH'' OR DANGEROUS DECEPTION? THE EFFECTS OF ANESTHESIA DURING A PARTIAL-BIRTH ABORTION

The claim that anesthesia given to a pregnant woman kills her fetus/baby before a partial-birth abortion is performed has ''absolutely no basis in scientific fact,'' according to Dr. Norig Ellison, the president of the American Society of Anesthesiologists. It is ''crazy,'' says Dr. David Birnbach, the president-elect of the Society for Obstetric Anesthesia and Perinatology.

Despite such authoritative statements, this medical misinformation is still being disseminated. Here are a few examples:

ABORTION ADVOCATES

KATE MICHELMAN OF THE NATIONAL ABORTION RIGHTS ACTION LEAGUE (NARAL)

One of the leading proponents of the ''anesthesia myth'' is Kate Michelman, president of the National Abortion Rights Action League (NARAL). For example, in an interview on ''Newsmakers,'' KMOX–AM in St. Louis on Nov. 2, 1995, Ms. Michelman said: The other side grossly distorted the procedure. There is no such thing as a ''partial-birth.'' That's, that's a term made up by people like these anti-choice folks that you had on the radio. The fetus—I mean, it is a termination of the fetal life, there's no question about that. And the fetus, is, before the procedure begins, the anesthesia that they give the woman already causes the demise of the fetus. That is, it is not true that they're born partially. That is a gross distortion, and it's really a disservice to the public to say this.

DR. MARY CAMPBELL OF PLANNED PARENTHOOD

Prior to the November 1, 1995, House vote on the bill, Planned Parenthood circulated to lawmakers a ''fact sheet'' titled, ''H.R. 1833, Medical Questions and Answers,'' which includes this statement:

''Q: When does the fetus die?

''A: The fetus dies of an overdose of anesthesia given to the mother intravenously. A dose is calculated for the mother's weight which is 50 to 100 times the weight of the fetus. The mother gets the anesthesia for each insertion of the dilators, twice a day. This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb.''

THE NEW YORK DAILY NEWS

The fetus is partially removed from the womb, its head collapsed and brain suctioned out so it will fit through the birth canal. The anesthesia given to the woman kills the fetus before the full procedure takes place. But you won't hear that from the anti-abortion extreme. It would have everybody believe the fetus is dragged alive from the womb of a woman just weeks away from birth. Not true. (Editorial, Dec. 15, 1995)

USA TODAY

''The fetus dies from an overdose of anesthesia given to its mother.'' (Editorial, Nov. 3, 1995)

THE ST. LOUIS POST-DISPATCH

''The fetus usually dies from the anesthesia administered to the mother before the procedure begins.'' (News story, Nov. 3, 1995)

SYNDICATED COLUMNIST ELLEN GOODMAN

Syndicated columnist Ellen Goodman wrote in mid-November that, if one relied on statements by supporters of the bill, ''You wouldn't even know that anesthesia ends the life of such a fetus before it comes down the birth canal.''

THE TRUTH

''Medical experts contend the claim is scientifically unsound and irresponsible, unnecessarily worrying pregnant women who need anesthesia.'' (American Medical News, January 1, 1996)

''[A]nesthesia does not kill an infant if you don't kill the mother.'' (Dr. David Birnbach quoted in American Medical News, January 1, 1996)

''I am deeply concerned, moreover, that widespread publicity . . . may cause pregnant women to delay necessary and perhaps life-saving medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus.'' (Dr. Norig Ellison, Nov. 17, 1995, testimony before Senate Judiciary Committee)

''Drugs administered to the mother, either local anesthesia administered in the paracervical area or sedatives/analgesics administered intramuscularly or intravenously, will provide no-to-little analgesia [relief from pain] to the fetus.'' (Dr. Norig Ellison, November 22, 1995, letter to Senate Judiciary Committee)

Mr. SALMON. Mr. Speaker, I submit the following material for inclusion in the RECORD:

AMERICAN MEDICAL NEWS,
PUBLISHED BY THE AMA,
Chicago, IL, July 11, 1995.

Hon. CHARLES T. CANADY,
Chairman, Subcommittee on the Constitution, Committee on the Judiciary, U.S. House of Representatives, Rayburn House Office Bldg., 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 questions.

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

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

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

Respectfully yours,

BARBARA BOLSEN,
Editor.

Attachment.

AMERICAN MEDICAL NEWS TRANSCRIPT

Relevant portions of recorded interview with Martin Haskell, M.D.

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

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

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

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

AMN. I mean, you couldn't dilate further? Or is that riskier?

HASKELL. Well, you could dilate further over a period of days.

AMN. would that just make it . . . would it go from a 3-day procedure to a 4- or a 5-?

HASKELL. Exactly. The point here is to effect a safe legal abortion. I mean, you could say the same thing about the D&E procedure. You know, why do you do the D&E procedure? Why do you crush the fetus up inside the womb? To kill it before you take it out?

Well, that happens, yes. But that's not why you do it. YOu do it to get it out. I could do the same thing with a D&E procedure. I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

AMN, wrapping up the interview. I wanted to make sure I have both you and (Dr.) McMahon saying 'No' then. That this is misinformation, these letters to the editor saying it's only done when the baby's already dead, in case of fetal demise and you have to do an autopsy. But some of them are saying they're getting that information from NAF. Have you talked to Barbara Radford or anyone over there? I called Barbara and she called back, but I haven't gotten back to her.

HASKELL. Well, I had heard that they were giving that information, somebody over there might be giving information like that out. The people that staff the NAF office are not medical people. And many of them when I gave my paper, many of them came in, I learned later, to watch my paper because many of them have never seen an abortion performed of any kind.

AMN. Did you also show a video when you did that?

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 Diana 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 your sensibilities as much.''

BROCHURE CITES N.Y. CASE

The four-page anti-abortion brochures also include a graphic depiction of the D&X procedure. But the cover features a photograph of 16-month-old Ana Rosa 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 maternal health.

But Douglas Johnson of the National Right to Life Committee called that suggestion ''blatantly false.''

''The abortion practitioners themselves will admit the majority of their late-term abortions are elective,'' he said. ''People like Dr. Haskell are just trying to teach others how to do it more efficiently.''

NUMBERS GAME

Accurate figures on second- and third-trimester abortions are elusive because a number of states don't require doctors to report abortion statistics. For example, one-third of all abortions are said to occur in California, but the state has no reporting requirements. The Guttmacher Institute estimates there were nearly 168,000 second- and third-trimester abortions in 1988, the last year for which figures are available.

About 60,000 of those occurred in the 16- to 20-week period, with 10,660 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 after 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.'

''On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother.''

Dr. McMahon says he doesn't want to ''hold patients hostage to my technical skill. I can say, 'No, I won't do that,' and then they're stuck with either some criminal solution or some other desperate maneuver.''

Dr. Haskell, however, says whatever qualms he has about third-trimester abortions are ''only for technical reasons, not for emotional reasons of fetal development.''

''I think it's important to distinguish the two,'' he says, adding that his cutoff 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.

Mr. SMITH of New Jersey. Mr. Speaker, I submit the following material for inclusion in the RECORD:

PARTIAL-BIRTH ABORTIONS: BEHIND THE MISINFORMATION

(By Douglas Johnson, NRLC Federal Legislative Director)

NOTE: The Partial-Birth Abortion Ban Act (HR 1833) has been approved in slightly different versions by the U.S. House of Representatives (Nov. 1, 1995, on a vote of 288–139) and by the U.S. Senate (Dec. 7, 1995, on a vote of 54–44). It is expected that the House will approve the Senate-passed bill on March 27 and send it to President Clinton soon thereafter. President Clinton will veto the bill because ''the President shares the view of many that it would represent an erosion of a woman's right to choose,'' White House Press Secretary Mike McCurry said on December 20, 1995.

Opponents of the bill have disseminated an extraordinary amount of misinformation regarding the partial-birth abortion procedure and the legislation—much of it starkly contradicted by the past writings and recorded statements of doctors who have performed thousands of partial-birth abortions. Some of this misinformation has been adopted and widely disseminated by some journalists, columnists, editorialists, and lawmakers. This factsheet addresses some of these issues.

WHAT IS THE PARTIAL-BIRTH ABORTION BAN ACT (HR 1833)?

The Partial-Birth Abortion Ban Act (HR 1833) would place a national ban on use of the partial-birth abortion procedure, except in cases (if there are any) in which the procedure is necessary to save the life of a mother.

The bill specifically defines a ''partial-birth abortion'' as ''an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.'' [emphasis added] Abortionists who violate the law would be subject to both criminal and civil penalties, but no penalty could be applied to the woman who obtained such an abortion.

The bill is aimed at a procedure that has often been utilized by Dr. Martin Haskell of Dayton, Ohio; by the late Dr. James McMahon of Los Angeles; and by others. This procedure is generally used beginning at 20 weeks (4½ months) into the pregnancy, is ''routinely'' used to 5½ months, and has often been used even during the final three months of pregnancy.

The Los Angeles Times accurately and succinctly described this abortion method in a June 16, 1995 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 (''Dilation and Extraction for Late Second Trimester Abortion'') that described in detail, step-by-step, how to perform the procedure. Anyone who is seriously seeking the truth behind the conflicting claims regarding partial-birth abortions would do well to start by reading Dr. Haskell's paper, and the transcripts of the explanatory interviews that Dr. Haskell gave in 1993 to the publications American Medical News (the official AMA newspaper) and Cincinnati Medicine.

Regarding the procedure, Dr. Haskell wrote, ''Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.'' (p. 33). Dr. Haskell also wrote that he ''routinely performs this procedure on all patients 20 through 24 weeks LMP [i.e., from last menstrual period] with certain exceptions'' [i.e., from 4½ to 5½ months], these ''exceptions'' involving complicating factors such as being more than 20 pounds overweight.

Dr. Haskell also wrote that he used the procedure through 26 weeks [six months] ''on selected patients.'' [p.28]

Dr. James McMahon used essentially the same procedure to a much later point—even into the ninth month. (Dr. McMahon died of cancer on Oct. 28, 1995.)

In a letter to Congressman Charles Canady dated March 19, 1996, Dr. William Rashbaum of New York City wrote that he has performed the procedure ''routinely since 1979. This procedure is performed only in cases of later gestational age.''

DOES THE BILL CONTAIN AN EXCEPTION FOR LIFE-OF-THE-MOTHER CASES?

As originally passed by the House on November 1, 1995, HR 1833 contained an ''affirmative defense'' provision, which would have shielded an abortionist from civil and criminal liability if he showed that he had ''reasonably believed'' that utilization of the partial-birth abortion procedure was necessary to save the life of a mother.

Similar ''affirmative defense'' exceptions are found in literally dozens of federal criminal laws. Nevertheless, after bill opponents distorted this provision, NRLC endorsed and the Senate unanimously adopted the Smith-Dole Amendment, which provides that the ban ''shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury.''

Senator Barbara Boxer (D–Ca.), the lead Senate opponent of the HR 1833, immediately endorsed the Smith-Dole Amendment, saying:

And now here we have it. Here we have it, an exception now for life of the mother. I think that is progress, because when we started there was no exception. It was an affirmative defense. [Congressional Record, Dec. 5, 1995, p. S 18005]

Under the Smith-Dole Amendment, an abortionist could not be convicted of a violation of the law unless the government proved, beyond a reasonable doubt, that the abortion was not covered by this exception. (In addition, of course, the government would have to prove, beyond a reasonable doubt, all of the other elements of the offense—that the abortionist ''knowingly'' partly removed a baby from the womb, that the baby was still alive, and that the abortionist then killed the baby.)

In a Jan. 31 letter to Cardinal Anthony Bevilacqua of Philadelphia, President Clinton acknowledged that the Senate had added a life-of-mother exception.

WHAT FURTHER CHANGES DOES PRESIDENT CLINTON DEMAND IN THE BILL?

In a February 28, 1996 letter to certain Members of Congress, the President insisted that abortionists must be permitted to use the procedure, not only to save a mother's life, but also whenever they assert that the procedure is necessary to prevent unspecified ''serious health consequences.''

The President's letter proposed precisely the language of an amendment offered on the Senate floor by Sen. Barbara Boxer (D–Ca.), which was endorsed by the National Abortion and Reproductive Rights Action League (NARAL) as a ''pro-choice vote.''

NARAL and other pro-abortion advocacy groups clearly recognized that the Boxer Amendment amounted to a re-statement of the status quo. After the Boxer Amendment was defeated by only a two-vote margin (51 to 47), a spokeswoman for the pro-abortion Alan Guttmacher Institute said, ''We were almost able to kill the bill.'' (Congressional Quarterly Weekly Report, Dec. 9, 1995, page 3738)

President Clinton—a Yale Law School graduate who once taught constitutional law—understands very well that with respect to abortion, ''health'' is a legal term of art. In Doe v. Bolton (the companion case to Roe v. Wade), the Supreme Court defined ''health'' (in the abortion context) to include ''all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient.''

Thus, the Boxer Amendment (demanded by President Clinton) would allow abortionists to continue to perform partial-birth abortions, even during the seventh, eighth, and ninth months, for reasons such as ''depression.'' This is not a far-fetched hypothetical, as discussed below under ''For What Reasons Are Partial-Birth Abortions Usually Performed?''

Senator Boxer has added the word ''serious'' before ''health,'' for optical effect, but adding the word does not legally narrow the scope of ''health,'' since the amendment confers on the abortionist himself the unlimited power to define whether the ''depression'' or other ''health'' concern is ''serious.'' No partial-birth abortion would ever be blocked by the law, because the Boxer Amendment confers on the abortionist absolute authority to decide what the law means (''in the medical judgment of the attending physician'').

Thus, a ''life'' exception and a ''health'' exception are two vastly different things. For example: Prior to enactment of the Hyde Amendment in 1976, the federal Medicaid program paid for 300,000 ''health'' or ''medically necessary'' abortions a year; the term was construed to cover any physician-performed abortion. The Hyde Amendment limited reimbursement to ''life'' cases, which have been on the order of 100 to 200 annually. In other words, the ratio of ''health'' cases to ''life'' cases, under Medicaid, was more than 1,000 to 1.

HOW MANY PARTIAL-BIRTH ABORTIONS ARE PERFORMED?

Nobody knows. Pro-abortion groups have claimed that ''only'' 450 such procedures are performed every year. But the combined practices of Dr. Martin Haskell and the late Dr. James McMahon alone would have approximated that figure.

In a letter to Congressman Canady dated March 19, 1996, New York doctor William K. Rashbaum wrote that he has performed the procedure that would be banned by HR 1833 ''routinely since 1979. This procedure is performed only in cases of later gestational age.'' Moreover, The New York Times reported in a Nov. 6, 1995 news story about the bill:

''Of course I use it, and I've taught it for the last 10 years,'' said a gynecologist at a New York teaching hospital, who spoke on the condition of anonymity. ''So do doctors in other cities.''

It is impossible to know how many other abortionists have adopted the procedure, without choosing to write articles or grant interviews on the subject. Both Haskell and McMahon spent years trying to convince other abortionists of the merits of the procedure. That is why Haskell wrote his 1992 instructional paper. For years, Mr. McMahon was director of abortion instruction at the Cedar Sinai Medical Center in Los Angeles.

There are at least 164,000 abortions a year after the first three months of pregnancy, and 13,000 abortions annually after 4½ months, according to the Alan Guttmacher Institute (New York Times, July 5 and November 6, 1995), which is an arm of Planned Parenthood. These numbers should be regarded as minimums, since they are based on voluntary reporting to the AGI.

FOR WHAT REASONS ARE PARTIAL-BIRTH ABORTIONS TYPICALLY PERFORMED?

Some opponents of HR 1833, such as NARAL and the Planned Parenthood Federation of America (PPFA), have persistently disseminated claimed that the procedure is employed only in cases involving extraordinary threats to the mother of grave fetal disorders. Regrettably, more than a few reporters, commentators, and members of Congress have uncritically embraced such claims and disseminated them as ''facts.''

For example, PPFA said in a press release that the procedure is ''done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality.'' (Nov. 1, 1995) But (as PPFA well knows), this claim is inconsistent with the writings and recorded statements of doctors who have performed thousands of these procedures, or with documents gathered by the House and Senate judiciary committees.

Dayton abortionist Dr. Martin Haskell, who wrote a paper describing step-by-step how to perform the procedure (he's done over 1,000), described it as ''a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.''

Dr. Haskell wrote that he ''routinely performs this procedure on all patients 20 through 24 weeks'' (4½ to 5½ months) pregnant [emphasis added], except on women who are more than 20 pounds overweight, have twins, or have certain other complicating factors.

In 1993, 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 concerning this specific abortion method, in which he said:

And I'll be quite frank: most of my abortions are elective in that 20–24 week range * * * In my particular case, probably 20% [of this procedure] are for genetic reasons. And the other 80% are purely elective.

In testimony in a lawsuit in 1995, Dr. Haskell testified that women come to him for partial-birth abortions with ''a variety of conditions. Some medical, some not so medical'' Among the ''medical'' examples he cited was ''agoraphobia'' (fear of open places).

Moreover, in testimony presented to the Senate Judiciary Committee on November 17, 1995, ob/gyn Dr. Nancy Romer of Dayton (the city in which Dr. Haskell operates one of his abortion clinics) testified that three of her own patients had gone to Haskell's clinic for abortions ''well beyond'' 4½ months into pregnancy, and that ''none of these women had any medical illness, and all three had normal fetuses.''

Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified that one little boy had Down Syndrome, while the other two babies were completely normal and their mothers were healthy. [Nurse Shafer's testimony before the House Judiciary subcommittee, with associated documentation, is available on request to NRLC.]

Dr. James McMahon voluntarily submitted to the House Judiciary Constitution subcommittee a breakdown of a self-selected sample of 175 partial-birth abortions that he performed for what he called ''maternal indications.'' Of these,the largest single category of ''maternal indication''—39 cases, or 22% of the total sample—were for ''depression.'' (Other ''maternal indications'' included ''spousal drug exposure'' and ''substance abuse.'') Dr. McMahon's self-selected sample of ''fetal indications'' cases showed he had performed nine of these procedures for ''cleft plate.'' Even though this data is cited in the official report of the committee, when NARAL President Kate Michelman was asked at a November 7, 1995 press conference about ''arguments . . . that these procedures . . . are given for depression or cleft palate,'' Ms. Michelman responded, ''That is . . . not only a myth, it's a lie.''

Dr. McMahon also wrote: After 26 weeks [six months], those pregnancies that are not flawed are still nonelective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications. [Emphasis added.] [''Pediatric indications'' was Dr. McMahon's terminology for young teenagers.]

Dr. Pamela E. Smith, director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Chicago, gave the Senate Judiciary Committee her analysis of Dr. McMahon's sample of 175 cases in which he said he had used the procedure because of maternal health indications. Of this sample, 39 cases (22%) were for maternal ''depression,'' while another 16% were ''for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, small pelvis),'' Dr. Smith noted. She added that in one-third of the cases, the conditions listed as ''maternal indications'' by Dr. McMahon really indicated that the procedure itself would be seriously risky.

Reporter Karen Tumulty wrote an article about late-term abortions, based in large part on extensive interviews with Dr. McMahon and on direct observation of his practice, which appeared in the Los Angeles Times Magazine (January 7, 1990). She concluded: 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.

Dr. George Tiller of Wichita, Kansas, specializes in late-term abortions, including third-trimester abortions. Dr. Tiller's spokeswoman, Peggy Jarman, told the Kansas City Star: About three-fourths of Tiller's late-term patients, Jarman said, are teenagers who have denied to themselves or their families they were pregnant until it was too late to hide it.

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.''

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 barriers.''

It is true, of course, that some partial-birth abortions involve babies who have grave 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.

IS A PARTIAL-BIRTH ABORTION EVER THE ONLY WAY TO PRESERVE A MOTHER'S PHYSICAL HEALTH?

Dr. Pamela E. 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.''

Dr. Harlan R. Giles, a professor of ''high-risk'' obstetrics and perinatology at the Medical College of Pennsylvania, performs abortions by a variety of procedures up until ''viability.'' 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 Caesarean 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]

Opponents of H.R. 1833 have publicized the cases of several women whose babies suffered from severe hydrocephalus (enlargement of the head). 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 Gynecological 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 cerebrospinal 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.

IS THE BABY ALIVE WHEN SHE IS PULLED FEET-FIRST FROM THE WOMB?

Yes, in most cases the baby is alive until the end of the procedure. 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.'' On July 11, 1995, American Medical News submitted the transcript of the tape-recorded interview with Haskell to the House Judiciary Committee. 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 an 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.

DOES ANESTHESIA GIVEN TO THE MOTHER KILL THE BABY? DOES THE BABY FEEL PAIN DURING THE PROCEDURE?

In Dr. Haskell's 1992 instructional paper, he lists among the ''advantages'' of the procedure that ''it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.'' [emphasis added] According to Prof. David H. Chestnut, editor of Obstetric Anesthesia: Principles and Practice, ''Rational use of local anesthetic drugs does not affect the fetus.'' (Testimony to House Judiciary Constitution Subcommittee, March 21, 1996).

Dr. James McMahon utilized general anesthesia, at least in some cases, but anesthesiologists say that these drugs do not harm the fetus/baby unless given in amounts that would kill the mother or place her in grave danger. (See below.)

Nevertheless, many critics of the bill have insisted that the unborn babies are killed by anesthesia given to the mother, prior to being ''extracted'' from the womb. For example, syndicated columnist Ellen Goodman wrote in November that, based on her review of statements by supporters of the bill, ''You wouldn't even know that anesthesia ends the life of such a fetus before it comes down the birth canal.''

The Planned Parenthood Federation of America (PPFA) has been among the most persistent purveyors of this mythology. Another leading proponent of the ''anesthesia myth'' has been Kate Michelman, president of the National Abortion and Reproductive Rights Act League (NARAL). For example, in an interview on ''Newsmakers,'' KMOX–AM in St. Louis on Nov. 2, 1995, Ms. Michelman explained that she thinks it is wrong to call the procedure a ''partial birth'' because (she claimed) the baby is already dead. Kate Michelman's verbatim statement follows:

The other side grossly distorted the procedure. There is no such thing as a 'partial birth'. That's, that's a term made up by people like these anti-choice folks that you had on the radio. The fetus— I mean, it is a termination of the fetal life, there's no question about that. And the fetus, is, before, the procedure begins, the anesthesia that they give the woman already causes the demise of the fetus. That is, it is not true that they're born partially. That is a gross distortion, and it's really a disservice to the public to say this.

However, the claim that anesthesia can kill an unborn fetus has been emphatically refuted in congressional testimony by the heads of the leading professional societies of anesthesiologists. These exports have criticized both pro-abortion leaders and certain journalists and commentators, for disseminating these bogus claims, while failing to publicize the authoritative statements of experts that these claims are entirely bogus.

In testimony before the Senate Judiciary Committee on November 17, 1995, Dr. Norig Ellison, president of the 34,000-member American Society of Anesthesiologists (ASA), said that such claims have ''absolutely no basis in scientific fact.'' On behalf of the ASA, Dr. Ellison testified that regional anesthesia (used in many partial-birth abortions and most normal deliveries) has virtually no effect on the fetus. General anesthesia has some sedating effect on the fetus, but much less than on the mother; even pain relief for the fetus is doubtful, and certainly anesthesia would not kill the baby, Dr. Ellison testified. (In March 1996, Dr. Ellison said that his testimony had been reported in the medical press and that not one anesthesiologist had contacted ASA to express any disagreement.)

In testimony before the House Judiciary Constitution Subcommittee on March 21, 1996, Dr. David J. Birnbach, president-elect of the Society for Obstetric Anesthesia and Perinatology, testified, ''I have never witnessed a case of fetal demise that could be attributed to an anesthetic. . . . In order to cause fetal demise, it would be necessary to give the mother dangerous and life-threatening doses of anesthesia.''

Recently, the Planned Parenthood Federation of America (PPFA) and NARAL have tried to ''explain'' that they were really just referring to the practice of the late Dr. James McMahon—who, they claimed, used massive doses of narcotic anesthesia. But Dr. Birnbach said, ''Although there is no evidence that this massive dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death.''

Brenda Pratt Shafer, a registered nurse from Dayton, Ohio, stood at Haskell's side while he performed three partial-birth abortions in 1993. In testimony before the Senate Judiciary Committee (Nov. 17), Shafer described in detail the first of the three procedures—which involved, she said, a baby boy at 26½ weeks (over 6 months). According to Mrs. Shafer, the abortionist delivered the baby's body and the arms—everything but the head. The doctor kept the baby's head just inside the uterus. The baby's little fingers were 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. The doctor opened up the scissors, stuck a high-powered suction tube into the opening and sucked the baby's brains out. Now the baby was completely limp.

Since the baby is usually not dead before being removed from the womb, does the baby experience pain? Yes, according to experts such as Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, who testified before the House Judiciary Constitution Subcommittee: ''The fetus within this time frame of gestation, 20 weeks and beyond, is fully capable of experiencing pain.'' After analyzing the partial-birth procedure step-by-step for the subcommittee, Prof. White concluded: ''Without question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure.''

Similar testimony was presented to the subcommittee on March 21, 1996, by Dr. Jean A. Wright, associate professor of pediatrics and anesthesia at the Emory University School of Medicine in Atlanta. Recent research shows that by the stage of development that a fetus could be a ''candidate'' for a partial-birth abortion (20 weeks), the fetus ''is more sensitive to pain than a full-term infant would be if subjected to the same procedures,'' Prof. Wright testified. These fetuses have ''the anatomical and functional processes responsible for the perception of pain,'' and have ''a much higher density of Opioid (pain) receptors'' than older humans, she said.

IS THERE A MORE ''OBJECTIVE'' TERM FOR THE PROCEDURE THAN ''PARTIAL-BIRTH ABORTION''?

Congressman Charles Canady (R-FL), the author of H.R. 1833 and the chairman of the subcommittee that conducted hearings on the bill, said on March 23, ''It it time for some in the media to stop editing or denigrating the legal terminology that has been adopted by the U.S. House and the U.S. Senate, which is partial-birth abortion.''

(When Congress defined certain firefarms as ''assault weapons,'' that terminology was readily accepted by most journalists and editors—even though manufacturers of such devices utilize other terms.)

Some opponents of the Partial-Birth Abortion Ban Act (H.R. 1833) insist that anyone writing about the bill should say that it bans a procedure ''known medically as intact dilation and evacuation.'' But when journalists comply with this demand, they do so at the expense of accuracy. The bill itself makes no reference whatever to ''intact dilation and evacuation'' abortions. More importantly, the term ''intact dilation and evacuation'' is not equivalent to the class of procedures banned by the bill.

The bill would make it a criminal offense (except to save a woman's life) to perform a ''partial-birth abortion,'' which the bill would define—as a matter of law—as ''an abortion in which the person performing the abortion partially vaginally delivers a *living* fetus before killing the fetus and completing the delivery.'' [emphasis added]

In contrast, the term ''intact dilation and evacuation'' was invented by the late Dr. James McMahon, and until recently, was idiosyncratic to him. It appears in no standard medical textbook or database, nor does it appear anywhere in the standard textbook on abortion methods, Abortion Practice by Dr. Warren Hern.

Because ''intact dilation and evacuation'' is not a standard, clearly defined medical term, the House Judiciary Constitution Subcommittee staff (which drafted the bill under Congressman Canady's supervision) rejected it as useless for purposes of defining a criminal offense. Indeed, it is worse than useless—a criminal statute that relied on such a term would be stricken by the federal courts as ''void for vagueness.''

Although there is no clear definition of the term, we know enough to say that it is inaccurate to equate ''intact dilation and evacuation'' abortions with the procedures banned by HR 1833, since in his writings Dr. McMahon clearly used the term so broadly as to cover certain procedures which would not be affected at all by HR 1833 (e.g., removal of babies who are killed entirely in utero, and removal of babies who have died entirely natural deaths in utero). Indeed, some of the specific women highlighted by opponents of HR 1833 had various types of ''intact D&E'' abortion procedures that were not covered by HR 1833's definition of ''partial-birth abortion.''

The term chosen by Congress is in no sense misleading. In sworn testimony in an Ohio lawsuit on Nov. 8, 1995, Dr. Martin Haskell—who has done over 1,000 partial-birth abortions, and who authored the instructional paper that touched off the controversy over the procedure—explained that he first learned of the method when a colleague described very briefly over the phone to me a technique that I later learned came from Dr. McMahon where they internally grab the fetus and rotate it and accomplish—be somewhat equivalent to a breach type of delivery.

In short, it is a misguided notion of objectivity for the any journalist to denigrate the term for a criminal offense that has been adopted and explicitly defined by the U.S. House and the U.S. Senate, in favor of a undefined term recently manufactured by the very special-interest that would be ''regulated'' by the legislation.

[In his 1992 instructional paper, Dr. Haskell referred to the method as ''dilation and extraction'' or ''D&X''—noting that he ''coined the term.'' The term ''dilation and extraction'' does not appear in medical dictionaries or databases.]

ARE THE FIVE LINE DRAWINGS OF THE PROCEDURE CIRCULATED BY NRLC ACCURATE, OR ARE THEY MISLEADING?

American Medical News (July 5, 1993) interviewed Dr. Martin Haskell and 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.''

Moreover, at a June 15, 1995, public hearing before the House Judiciary Subcommittee on the Constitution, Dr. J. Courtland Robinson, a self-described ''abortionist'' who testified on behalf of the National Abortion Federation, was questioned about the drawings by Congressman Charles Canady (R–Fl.). Mr. Canady directed Dr. Robinson's attention to the drawings, which were displayed in poster size next to the witness table, and asked Dr. Robinson if they were ''technically correct.'' Dr. Robinson responded:

That is exactly probably what is occurring in the hands of the two physicians involved. [Hearing record, page 89.]

Professor Watson Bowes of the University of North Carolina at Chapel Hill, co-editor of the Obstetrical and Gynecological Survey, 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. . . . 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.

On Nov. 1, 1995, Congresswoman Patricia Schroeder and her allies actually tried to prevent Congressman Canady from displaying the line drawings during the debate on HR 1833 on the floor of the House of Representatives. But the House voted by nearly a 4-to-1 margin (332 to 86) to permit the drawings to be used.

DOES THE BILL CONTRADICT U.S. SUPREME COURT DECISIONS?

The Supreme Court has never said that there is a constitutional right to kill human beings who are mostly born.

In its official report on HR 1833, the House Judiciary Committee makes the very plausible argument that HR 1833 could be upheld by the Supreme Court without disturbing Roe. In Roe, the Supreme Court said that ''the word 'person,' as used in the Fourteenth Amendment, does not include the unborn.'' Thus, under the Supreme Court's doctrine, a human being becomes a legal ''person'' upon emerging from the uterus.

But a partial-birth abortion does not involve an ''unborn fetus.'' A partial-birth abortion, by the very definition in the bill, kills a human being who is partly born. Indeed, a partial-birth abortion kills a human being who is four-fifths across the 'line-of-personhood' established by the Supreme Court.

Moreover, in Roe v. Wade itself, the Supreme Court took note of a Texas law that made it a felony to kill a baby ''in a state of being born and before actual birth,'' and the Court did not disturb that law.

Thus, the Supreme Court could very well decide that the killing of a mostly born baby, even if done by a physician, is not protected by Roe v. Wade.

SHOULD CONGRESS EVER BAN SPECIFIC ''SURGICAL PROCEDURES''?

Some prominent congressional opponents of the bill to ban partial-birth abortions, including Rep. Schroeder (D-Co.), argue that Congress should not attempt to ban a specific surgical procedure. But Rep. Schroeder is the prime sponsor of HR 941, the ''Federal Prohibition of Female Genital Mutilation Act.'' (The Senate companion bill is S. 1030.) This bill generally would ban anyone (including a licensed physician) from performing the procedure known medically as ''infibulation,'' or ''female circumcision.'' (Some physicians perform the procedure in response to requests from immigrants from certain countries, based on the rationale that those involved otherwise will probably obtain the procedure from persons without medical training.) The bill provides a penalty of up to five years in federal prison. Supporters of this bill argue, persuasively, that subjecting a little girl to infibulation is a form of child abuse. But then, so too is subjecting a baby to the partial-birth abortion procedure.

Mr. WELDON of Florida. Mr. Speaker, I submit the following material for inclusion in the RECORD:

MOUNT SINAI HOSPITAL
MEDICAL CENTER
Chicago, IL, October 28, 1995.

Hon. CHARLES CANADY,
Chairman, Subcommittee on the Constitution, House Committee on the Judiciary, Longworth House Office Building, Washington, DC

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

1. Since the procedures entails 3 days of forceful dilatation of the cervix the mother could develop cervical incompetence in subsequent pregnancies resulting in spontaneous second trimester pregnancy losses and necessitating the placement of a cerclage (stitch around the cervix) to enable her to carry a fetus to term.

2. Uterine rupture is a well known complication associated with this procedure. In fact, partial birth abortion is a ''variant'' of internal podalic version . . . a technique sometimes used by obstetricians in this country with the intent of delivering a live child. However, internal podalic version, in this country, has been gradually replaced by Cesarean section in the interest of maternal as well as fetal well being (see excerpts from the standard text Williams Obstetrics pages 520, 521, 865 and 866).

Furthermore, obstetrical emergencies (such as entrapment of the head of a hydrocephalic fetus or of a footling breech that has partially delivered on its own) are never handled by employing this abortion technique. Cephalocentesis, (drainage of fluid from the head of a hydrocephalic fetus) frequently results in the birth of a living child. Relaxing the uterus with anesthesia, cutting the cervix (Duhrssen's incision) and Cesarean section are the standard of care for a normal, head entrapped breech fetus.

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

Sincerely,

PAMELA E. SMITH, MD,
Director of Medical Education, Department of Obstetrics and Gynecology.

THE UNIVERSITY
NORTH CAROLINA,
Chapel Hill, July 11, 1995.

Hon. CHARLES CANADY,
Chairman, Subcommittee on the Constitution, House Committee on the Judiciary, Washington, DC.

DEAR CONGRESSMAN CANADY: I have reviewed the Partial-Birth Abortion Ban Act (HR 1833, S. 939) and the related materials that you submitted to me.

Your bill would ban the use of the ''partial-birth abortion'' method, which you define as ''an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

As regards the use of the term ''partial-birth abortion'' to describe the procedure: 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.[1] Dr. Haskell himself refers to that procedure as dilation and extraction,'' but that is only a term, as he wrote, he ''coined.'' Another practitioner, Dr. James McMahon, who uses a similar technique, uses the term ''intact dilation and evacuation.''[2]

There is no standard medical term for this period. The method, as described by Dr. Haskell in his paper, involves dilatation 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 (brain aspiration) which allows completion of the birth.

As regards when fetal death occurs during this procedure: Although I have never witnessed this procedure, it seems likely from the description of the procedure by Dr. Haskell that many if not all of the fetuses involved in this procedure are alive until the scissors and the suction catheter are used to remove brain tissue.[1] Dr. Haskell, explicitly contrasts his procedure with two other late abortion methods that do induce fetal death prior to removal of the fetus (these alternative methods being intra-amniotic infusion of urea, and rupture of the membranes and severing of the umbilical cord).[1] Also, Doctor Haskell, in an interview with Diane Gianelli of American Medical News that the majority of the fetuses aborted this way are alive until the end of the procedure.''[2] This is consistent with the observations of Brenda Shafer, R.N. who, in a letter to Congressman Tony Hall, described partial-birth abortions performed by Dr. Haskell which she observed.[3]

Footnotes follow at end of Article.

Moreover, in a document entitled ''Testimony Before the House Subcommittee on the Constitution'', June 23, 1995, 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.''[4] 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.

Dr. Dru Carlson, a maternal/fetal medicine specialist from Cedars-Sinai Medical Center in Los Angeles, writes that she has personally observed Dr. McMahon perform this procedure. In a letter to Congressman Henry Hyde she described the procedure and wrote that after the fetal body is delivered, it is removal of cerebrospinal fluid from the brain that causes instant brain herniation and death.[5] This statement clearly suggests that the fetus is alive until the suction device is inserted into the brain.

As regards whether the fetus experiences pain during this procedure: Dr. McMahon states that the fetus feels no pain through the entire series of procedures.[4] Although it is true that analgesic medications given to the mother will reach in 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. Further evidence that the fetus is capable of feeling fetal pain is the response of extremely preterm infants to painful stimuli.

As regards the accuracy of the illustrations of this procedure which have been distributed by the National Right to Life Committee: I have read the letters dated June 12, 1995 and June 27, 1995 sent to members of Congress by the National Abortion Federation, which state that the drawings of the partial-birth abortion procedure that have been distributed by you and by the National Right to Life Committee are ''highly imaginative . . . with little relationship to the truth'' and ''misleading.''[7]

Having read Dr. Haskell's paper[1], 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.''[2] First hand 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 nonmedical person who is trying to understand how the procedure is performed.

As regards the impact of the banning of the procedure on other indicated standard medical procedures: 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 cerebrospinal fluid).

Fluid is then withdrawn which results in reduction in the size of 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. This is an important distinction between a needle cephalocentesis which is intended to facilitate the birth of a living fetus as contrasted with the procedure described by Doctors Haskell and McMahon, which is intended to kill a living fetus which has been partially delivered.

The technique of the partial-birth abortion could be used to remove the 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.

As regards viability of preterm infants in the second trimester of pregnancy: I have reviewed a ''fact sheet'' distributed by the National Abortion and Reproductive Rights Action League (NARAL) in opposition to your legislation.[8] This document states, ''Very few premature infants born at 24 weeks' gestation actually survive. The chance for survival at 25 weeks' gestation is 10–15%; one week later—at 26 weeks—the chances of survival double to 24–45%. A survival rate of 50% is achieved only in live births at 27 or more weeks gestation.'' These figures are outdated and misleading. In a recent study from the National Institute of Child Health and Human Development Neonatal Network, survival was documented in a large number of premature infants born at the seven participating institutions.[9] At 23 weeks gestation the neonatal survival was 23 percent and at 24 weeks' gestation survival was 34 percent. As you can see in Figure 3 in the enclosed article by Maureen Hack et al., there are wide inter-institutional variations in neonatal survival at east gestational age. For example, at 24 weeks' gestation neonatal survival varied from a low of 10 percent to a high of 57 percent. This data applies to infants born without major congenital defects.

I trust this information will be helpful.

Respectfully,

WATSON A. BOWES, Jr., M.D.
Professor.

FOOTNOTES

[1] Haskell M. Dilation and extraction for late second trimester abortion. Presented at the National Abortion Federation Risk Management Seminar, Dallas, Texas, September 13, 1992.

[2] Gianelli D.M. Shock-tactic ads target late-term abortion procedures. American Medical News, July 5, 1993, p 3 ff.

[3] Shafer B. Letter written to Congressman Tony Hall, July 9, 1995.

[4] McMahon JT. Written submission to the House Subcommittee on the Constitution, Washington, D.C., June 23, 1995.

[5] Carlson DE. Letter to the Honorable Henry Hyde, Chairman, House Judiciary Committee, June 27, 1995.

[6] Saporta V, Prohaska G. Letter to Members of Congress, U.S. House of Representatives, June 12, 1995.

[7] Saporta V. Letter to Members of Congress, U.S. House of Representatives, June 27, 1995.

[8] National Abortion and Reproductive Rights Action League. Third-Trimester Abortion: The Myth of ''Abortion on Demand''. (Date not listed)

[9] Hack M, Hobar JD, Malloy MH, et al. Very low birth weight outcomes of the National Institute of Child Health and Human Development Neonatal Network. Pediatrics. 1991; 87:587–597.

Mr. ABERCROMBIE. Mr. Speaker, today I rise to discuss H.R. 1833, the Partial-Birth Abortion Ban Act. During the course of the debate, gory and graphic descriptions are going to be used to exaggerate and manipulate emotions to obscure the real issues. In fact, the title itself is misleading. This is not about abortion on demand, the issue is about women and their families facing a tragic situation. Women who chose to have a dilation and extraction or a dilatation and evacuation preformed late in their pregnancy, do so only as a last resort. These surgical procedures are rarely ever utilized. Fewer than 500 a year are performed. These procedures are used in the case of desired pregnancies gone tragically wrong due to severe fetal anomaly or severe risk to the health or life of the mother.

I have read the personal testimony of Coreen Costello and Mary-Dorothy Line.These women and others like them wanted their child and were willing to have a child with disabilities. However, once they realized that the baby could not survive outside of the womb, they had to make a soul searching decision. This was a very difficult decision made by the women and their husbands, but because they chose to have a late term abortion procedure they saved their lives and preserved their ability to have more children. Without the surgical procedures H.R. 1833 outlaws, neither of these women would be pregnant today or even healthy.

Under H.R. 1833, Congress would intrude into the lives of Coreen Costello, Mary-Dorothy Line and other women by denying them surgical procedures which ensure their ability to conceive more children. H.R. 1833 says to American women: your health and fertility mean nothing to us.This bill flagrantly violates women's rights and demotes them to second class citizenry.

The Supreme Court ruled in the cases of *Roe* v. *Wade,* and *Planned Parenthood* v. *Casey* that if a woman's life or health is endangered, late term abortions can not be banned. Yet even as amended by the Senate, H.R. 1833 does not have a genuine life exception. Pregnancy does not qualify as a physical disorder, illness or injury. In addition, H.R. 1833 also does not provide an exception for when the mother's health is at serious risk. The language in H.R. 1833, under legal scrutiny, clearly violates the Supreme Court's rulings since it does not provide life or health exemptions. This bill prevents women from receiving the safest possible medical care in the rare instances when such care is called for in the most trying of personal circumstances and anguish.

The bill is an example of the impossibility of writing a law of general application for situations which clearly demand individualized professional judgement in consultation with the parties personnely effected. To interfere in such conditions is an affront to moral sensibility and it disregards the profound consequences both physicians and their patients must resolve.

Mr. POSHARD. Mr. Speaker, I rise today in strong support of the ban on partial birth abortions, and urge my colleagues to follow suit in passing this important legislation.

I sincerely believe this late-term abortion procedure goes beyond the usual scope of debate we in the House have heard on the issue of abortion. This ban is not only about respecting life, it's about using humane and ethical medical practices. In fact, a number of historically pro-choice Members of this body joined in supporting this ban when it first was conducted by the House because of the nature of the procedure.

As amended by the Senate, this bill continues to allow for such a procedure should the life of the mother be endangered by a physical disorder, illness, or injury. So let us not argue today about the health and well-being of our prospective mothers, because this bill protects

those very rights. To include an exception for the health of a mother versus her life, does nothing more than allow this procedure to continue to be used as an elective form of abortion.

For this reason, the Partial Birth Abortion Ban Act deserves the support of every Member of Congress, regardless of your stance on the issue of abortion.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to H.R. 1833. In 1973, and more recently in 1992, the Supreme Court held that a woman has a constitutional right to choose whether or not to have an abortion. H.R. 1833 is a direct attack on the principles established in both Roe versus Wade and Planned Parenthood versus Casey.

H.R. 1833 is a dangerous piece of legislation which would ban a range of late-term abortion procedures that are used when a woman's health or life is threatened or when a fetus is diagnosed with severe abnormalities incompatible with life. Because H.R. 1833 does not use medical terminology, it fails to clearly identify which abortion procedures it seeks to prohibit, and as a result could prohibit physicians from using a range of abortion techniques, including those safest for the woman.

H.R. 1833 is a direct challenge to Roe versus Wade (1973). This legislation would make it a crime to perform a particular abortion method utilized primarily after the 20 week of pregnancy. This legislation represents an unprecedented and unconstitutional attempt to ban abortion and interfere with physicians' ability to provide the best medical care for their patients.

If enacted, such a law would have a devastating effect on women who learn late in their pregnancies that they are carrying have severe, often fatal, anomalies.

Woman like Coreen Castello, a loyal Republican and former abortion protester whose baby had a lethal neurological disease; Mary-Dorothy Lines, a conservative Republican who discovered her baby had severe hydrocephalus; Claudia Ades, who had to terminate her pregnancy in the sixth month because her baby was riddled with fetal anomalies due to a fatal chromosomal disorder; Vicki Wison, who discovered at 36 weeks that her baby's brain was growing outside his head; Tammy Watts, whose baby had no eyes, and intestines developing outside the body; and Vikki Stella, who discovered at 34 weeks that her baby had nine severe anomalies that would lead to certain death. These are not elective procedures. These are the women who would be hurt by H.R. 1833—women and their families who face a terrible tragedy—the loss of a wanted pregnancy.

In Roe, the Supreme Court established that after viability, abortion may be banned by States as long as an exception is provided in cases in which the woman's life or health is at risk. H.R. 1833 provides no true exceptions for cases in which a banned procedure would be necessary to preserve a women's life or health.

The Dole amendment does not cover all cases where a woman's life is in danger. This narrow life exception applies only when a woman's life is threatened by a physical disorder, illness or injury and when no other medical procedure would suffice. By limiting the life exception in this way, the bill would omit the most direct threat to a woman's life in cases involving severe fetal anomalies—the pregnancy itself.

In fact, none of the women who submitted testimony during the Senate and House hearings on this bill would have qualified for the procedure under the Dole life exception. Instead, this bill would require physicians to use an alternative life-saving procedure, even if the alternative renders the woman infertile, or increases her risk of infection, shock or bleeding. Thus, the result of this provision is that women's lives would be jeopardized not saved.

This bill would create an unwarranted intrusion into the physician-patient relationship by preventing physicians from providing necessary medical care to their patients. Furthermore, it would impose a horrendous burden on families who are already facing a crushing personal situation.

Furthermore, the term ''Partial birth abortion'' is not found in any medical dictionaries, textbooks or coding manuals. It is a term made up by the author of H.R. 1833 to suggest that a living baby is partially delivered and then killed. The definition in H.R. 1833 is so vague as to be uninterpretable, yet chilling. Many OB/GYNs fear that this language could be interpreted to ban all abortions where the fetus remains intact. The supporters of this bill want to intimidate doctors into refusing to do abortions. Given the bill's vagueness, few doctors will risk going to jail in order to perform this procedure. As a result, women and their families will find it even more difficult, if not impossible, to find a doctor who will perform a late-term abortion, and women's lives will be put in even more jeopardy.

Late term abortions are not common; 95.5 percent of abortions take place before 15 weeks. Only a little more than one-half of 1 percent take place at or after 20 weeks. Fewer than 600 abortions per year are done in the third trimester and all are done for reasons of life or health of the mother, severe heart disease, kidney failure, or rapidly advancing cancer, and in the case of severe fetal abnormalities incompatible with the life—no eyes,no kidneys, a heart with one chamber instead of four or large amounts of brain tissue missing or positioned outside of the skull, which itself may be missing.

An abortion performed in the late second trimester or in the third trimester of pregnancy is extremely difficult for everyone involved. However, when serious fetal anomalies are discovered late in a pregnancy, or the mother develops a life-threatening medical condition that is inconsistent with the continuation of the pregnancy, abortion—however heart-wrenching—may be medically necessary.

In such cases, the intact dilation and extraction procedure [IDE]—which would be outlawed by this bill—may provide substantial medical benefits. It is safer in several respects than the alternatives, maintaining uterine integrity, and reducing blood loss and other potential complications. In addition, the procedure permits the performance of a careful autopsy and therefore a more accurate diagnosis of the fetal anomaly. Intact delivery allows geneticists, pathologists, and perinatalogists to determine what exactly the fetus's problems were. As a result, these families, who are extremely desirous of having more children, can receive appropriate genetic counseling and more focused prenatal care and testing in future pregnancies. Often, in these cases, the knowledge that a woman can have another child in the future is the only thing that keeps families going in their time of tragedy.

Political concerns and religious beliefs should not be permitted to take precedence over the health and safety of patients. The determination of the medical need for, and effectiveness of, particular medical procedures must be left to the medical profession, to be reflected in the standard of care.

In passing H.R. 1833, this Congress would set an undesirable precedent which goes way beyond the scope of the abortion debate. Will we someday be standing here debating the validity of a triple bypass or hip replacement procedure? Aren't these dangerous and unpleasant procedures?

The legislative process is ill-suited to evaluate complex medical procedures whose importance may vary with a particular patient's case and with the state of scientific knowledge. The mothers and families who seek late term abortions are already severely distressed. They do not want an abortion—they want a child. Tammy Watts told us that she would have done anything to save her child. She said, ''If I could have given my life for my child's I would have done it in a second.''

Unfortunately, however, there was nothing she could do. For Tammy, and women like her, a late term abortion is not a choice it is a necessity. We must not compound the physical and emotional trauma facing these women by denying them the safest medical procedure available.

This bill unravels the fundamental constitutional rights that American women have to receive medical treatment that they and their doctors have determined are safest and medically best for them. By seeking to ban a safe and accepted medical technique, members of Congress are intruding directly into the practice of medicine and interfering with the ability of physicians and patients to determine the best course of treatment. The creation of felony penalties and Federal tort claims for the performance of a specific medical procedure would mark a dramatic and unprecedented expansion of congressional regulation of health care.

H.R. 1833 contains no exception for adverse health consequences and no true life exception. The Dole amendment is dangerously narrow and it would force doctors to forgo the safest choice for a woman whose life is at risk.

This bill is bad medicine, bad law, and bad policy. Women facing late term abortions due to risks to their lives, health or severe fetal abnormalities incompatible with life must be able to make this decision in consultation with their families, their physicians, and their God. Women do not need medical instruction from the Government. To criminalize a physician for using a procedure which he or she deems to be safest for the mother is tantamount to legislating malpractice. I urge my colleagues to defeat this dangerous legislation.

Mrs. SMITH of Washington. Mr. Speaker, this evening the House will be voting on the partial birth abortion ban legislation. As a nation, we have created a veil of silence when it comes to the reality of abortion procedures. It is easy to be pro-choice when one can claim ignorance about the ways and means of abortion: whether it is a saline abortion, dilation and extraction, or suction, just to name a few.

Tonight, we are talking about a particular procedure commonly referred to as the ''partial

birth abortion.'' The very use of the word ''birth'' should be a clue as to how this procedure is performed. By inducing a ''breech'' birth, and I would like to note that I was a ''breech'' baby, a doctor is able to deliver a baby feet first and while the child's head is still in the birth canal, insert surgical scissors into the base of the baby's skull and remove the brain tissue, thus collapsing the skull and then finishing the delivery of a now dead baby. We are tantalizing a young life as it enters the world, only to collapse its skull and end its life.

I used to be pro-choice, but I am confident that I would have changed my views years earlier had I been aware of the truly horrid nature of abortion. Had I known that this procedure was being performed, my decision to choose life would have been that much simpler. As a mother and grandmother, it is mind boggling to imagine having labor induced, to be giving birth, only to have the opportunity to be a mother stopped in midstream. One mother, Brenda Pratt Shafer, is a nurse who witnessed this procedure. In her own words, she has stated that she ''had often expressed strong pro-choice views to my two teenage daughters.'' However, upon witnessing the partial delivery and death of a baby, she realized that it is easy to be pro-choice when one does not now what abortion is all about.

Some will say that this procedure is only used on children who would otherwise have serious birth defects or other abnormalities. The testimony of the doctors who have performed this procedure say otherwise. One such doctor, Martin Haskell of Ohio, has stated that 80 percent of abortions he has performed using this procedure were elective. Furthermore, as Americans, what is our life ethic if we continue down this slippery slope of wanting only the ''perfect'' child? I am fearful that as we increasingly hear terms like ''gender selection'' and the like, we will be banishing more innocent lives to a grisly death. As a mother, I know that there are no ''perfect children.'' Health alone does not make the perfect child. If nothing else, the parents of a child whose life may only last a few hours or days or weeks have the opportunity to bond with their child and then say ''goodbye.''

Banning this procedure does not mean that other forms of abortion are acceptable. However, I challenge my colleagues in the House and Americans everywhere to justify the partial birth abortion. I ask my colleagues tonight to face the facts and accept this procedure for what it is. Many of us would like to turn the other way and have found ourselves angry that we are being ''forced'' to look at first hand the graphic nature of this act. I can only respond by saying that man's inhumanity to man is never pleasant. It is necessary to understand what we are up against.

I ask my colleagues in the House to accept the reality of the partially birth abortion and join with me in banning this procedure. It is just plan sick and does not reflect the values upon which this Nation was founded and still embraces to be true today.

Thank you and please join with me in supporting H.R. 1833, the Partial Birth Abortion Ban Act.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in opposition to this misguided and deceptive legislation before us known as H.R. 1833, the Partial Birth Abortion Ban Act. I believe this bill is both bad politics and bad policy.

Mr. Speaker, it is critical to protect women's health and preserve the ability of these women to have future healthy pregnancies. H.R. 1833 prevents women from receiving the safest medical care in the rare cases when a wanted pregnancy has gone tragically wrong. Women need access to the safest medical procedure. Under Roe versus Wade and later reaffirmed in Planned Parenthood versus Casey the Supreme Court explicitly declared that States can ban late term abortions, unless the woman's life or health is endangered, and in fact 41 States have already done so. As passed by the Senate, and earlier by the House, H.R. 1833 is a direct constitutional challenge to both Roe and Casey because it fails to provide a health exception.

Mr. Speaker, we must not be misled by the Senate's addition of language purporting to be a ''life exception.'' As drafted, the ''life exception'' language is so narrowly crafted that a doctor would still risk criminal prosecution to perform this procedure. It is important to note that the Senate, by a narrow margin, rejected a true ''life and adverse health'' amendment that would have protected women who face life and health threatening pregnancies.

Mr. Speaker, since the House has considered this bill, public debate on the issue has shifted. The House acted to ban a specific abortion procedure and jail doctors after only brief debate and a prohibition on all amendments. When the far-reaching effects of this legislation were more fully debated both in the Senate and in the news media the bill passed the Senate by only a thin margin. The statements of the bill's proponents both in Congress and in anti-choice movements make it clear that H.R. 1833, far from being a moderate measure, is in fact the first step in an ambitious strategy to use the new congressional anti-choice majority to overturn Roe. I ask my colleagues to stop that from happening.

Mrs. VUCANOVICH. Mr. Speaker, as many of you know, I have 15 grandchildren. Two of my grandchildren, the miracle twins as I call them, were born prematurely at 7 months. They were so tiny that they could fit in your hands but they were perfectly formed little human beings and they are now 14 years old.

It makes me shudder to think that somewhere, perhaps even today, in this country that there are other little pre-born human beings 7 months old in their mothers womb that are going to be subject to this brutal, horrible procedure known as a partial birth abortion.

I am not the only one who finds this procedure horrifying. The American Medical Association's Legislative Council unanimously decided that this procedure was not ''a recognized medical technique'' and that ''this procedure is basically repulsive''. This is especially true when you realize that 80 percent of these types of abortion are done as a purely elective procedure. It is important to note that this bill does make exception for this type of abortion if it is necessary to save the life of the mother however, this is an exception that will have to be used rarely.

I think we can all agree that it is inhuman to begin the birthing process and nearly complete the delivery of the baby, only to suck the life out of the child.

I strongly urge my colleagues to support H.R. 1833, with the Senate amendments, which would ban this brutal procedure known as partial birth abortion.

Mr. ZELIFF. Mr. Speaker, I rise today in support of the conference report to H.R. 1833, the Partial Birth Abortion Ban Act, which will prohibit the use of a single medical procedure in the performance of abortions. I do believe that this particular procedure is unnecessary and a particularly cruel method of ending a late-term abortion. I believe that saying no to one procedure (with exemptions for life-threatening situations) in this case is appropriate, and does not affect the reproductive rights of women with regard to the *Roe* v. *Wade* decision, which I support. Enactment of this legislation will not in itself have significant impact on those Constitutionally-guaranteed rights.

But let me be clear, Mr. Speaker, that I will not support a strategy in this body to slowly dismantle reproductive rights under *Roe* v. *Wade* piece by piece, and I will oppose further measures that are part of such a strategy. Having an abortion is a right as guaranteed under the Constitution and upheld by the Supreme Court. To embark on a congressional strategy aimed at slowly striking down that right is not only wrong-headed, it is backhanded. The American people support the right to choose and that fact would make any effort in this House to further restrict the right to choose an effort without the support of the American public.

In sum, Mr. Speaker, while I support this legislation today I will not continue to support an effort by anti-choice forces to slowly dismantle the constitutional rights of women in the country.

Mr. STOCKMAN. Mr. Speaker, I raise in support of the motion and ask you insert this information into the RECORD.

''FETAL DEATH'' OR DANGEROUS DECEPTION? THE EFFECTS OF ANESTHESIA DURING A PARTIAL-BIRTH ABORTION

The claim that anesthesia given to a pregnant woman kills her fetus/baby before a partial-birth abortion is performed has ''absolutely no basis in scientific fact,'' according to Dr. Norig Ellison, the president of the American Society of Anesthesiologists. It is ''crazy,'' says Dr. David Birnbach, the president-elect of the Society for Obstetric Anesthesia and Perinatology.

Despite such authoritative statements, this medical misinformation is still being disseminated. Here are a few examples:

ABORTION ADVOCATES

KATE MICHELMAN OF THE NATIONAL ABORTION RIGHTS ACTION LEAGUE (NARAL)

One of the leading proponents of the ''anesthesia myth' is Kate Michelman, president of the National Abortion Rights Action League (NARAL). For example, in an interview on ''Newsmakers,'' KMOX–AM in St. Louis on Nov. 2, 1995, Ms. Michelman said:

The other side grossly distorted the procedure. There is no such thing as a 'partial-birth'. That's that's a term made up by people like these anti-choice folks that you had on the radio. The fetus—I mean, it is a termination of the fetal life, there's no question about that. And the fetus, is, before the procedure begins, the anesthesia that they give the women already causes the demise of the fetus. That is, it is not true that they're born partially. That is a gross distortion, and it's really a disservice to the public to say this.

DR. MARY CAMPBELL OF PLANNED PARENTHOOD

Prior to the November 1, 1995, House vote on the bill, Planned Parenthood circulated to lawmakers a ''fact sheet'' titled, ''H.R. 1833, Medical Questions and Answers,'' which includes this statement:

''Q: When does the fetus die?

''A: The fetus dies of an overdose of anesthesia given to the mother intravenously. A dose is calculated for the mother's weight which is 50 to 100 times the weight of the fetus. The mother gets the anesthesia for each insertion of the dilators, twice a day. This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb.''

THE PRESS

THE NEW YORK DAILY NEWS

The fetus is partially removed from the womb, its head collapsed and brain suctioned out so it will fit through the birth canal. The anesthesia given to the woman kills the fetus before the full procedure takes place. But you won't hear that from the anti-abortion extreme. It would have everybody believe the fetus is dragged alive from the womb of a woman just weeks away from birth. Not true. (Editorial, Dec. 15, 1995)

USA TODAY

''The fetus dies from an overdose of anesthesia given to its mother.''

THE ST. LOUIS POST-DISPATCH

''The fetus usually dies from the anesthesia administered to the mother before the procedure begins.'' (News story, Nov. 3, 1995)

SYNDICATED COLUMNIST ELLEN GOODMAN

Syndicated columnist Ellen Goodman wrote in mid-November that, if one relied on statements by supporters of the bill, ''You wouldn't even know that anesthesia ends the life of such a fetus before it comes down the birth canal.''

THE TRUTH

''Medical experts contend the claim is scientifically unsound and irresponsible, unnecessarily worrying pregnant women who need anesthesia.'' (American Medical News, January 1, 1996)

''[A]nesthesia does not kill an infant if you don't kill the mother.'' (Dr. David Birnbach quoted in American Medical News, January 1, 1996)

''I am deeply concerned, moreover, that widespread publicity . . . may cause pregnant women to delay necessary and perhaps life-saving medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus.'' (Dr. Norig Elisson, Nov. 17, 1995, testimony before Senate Judiciary Committee)

''Drugs administered to the mother, either local anesthesia administered in the paracervical area or sedatives/analgesics administered intramuscularly or intravenously, will provide no-to-little analgesia [relief from pain] to the fetus.'' (Dr. Norig Ellison, November 22, 1995, letter to Senate Judiciary Committee)

STATEMENT OF NORIG ELLISON, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Chairman CANADY, members of the Subcommittee. My name is Norig Ellison, M.D., I am the President of the American Society of Anesthesiologists [ASA], a national professional society consisting of over 34,000 anesthesiologists and other scientists engaged or specially interested in the medical practice of anesthesiology. I am also Professor and Vice-Chair of the Department of Anesthesiology at the University of Pennsylvania School of Medicine in Philadelphia and a staff anesthesiologists at the Hospital of the University of Pennsylvania.

I appear here today for one purpose, and one purpose only; to take issue with the testimony of James T. McMahon, M.D., before this Subcommittee last June. According to his written testimony, of which I have a copy, Dr. McMahon stated that anesthesia given to the mother as part of dilation and extraction abortion procedure eliminates any pain to the fetus and that a medical coma is induced in the fetus, causing a ''neurological fetal demise'', or—in lay terms—''brain death''.

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary, even lifesaving, medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus. Annually over 50,000 pregnant women are anesthetized for such necessary procedures.

Although it is certainly true that some general analgesic medications given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant women are routinely heavily sedated during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death or ''brain death''. In my medical judgment, it would be necssary—in order to achieve ''neurological demise'' of the fetus in a ''partial birth'' abortion—to anesthetize the mother to such a degree as to place her own health in serious jeopardy.

As you are aware, Mr. Chairman, I gave the same testimony to a Senate committee 4 months ago. That testimony received wide circulation in anesthesiology circles and to a lesser extent in the lay press. You may be interested in the fact that since my appearance, not one single anesthesiologist or other physician has contacted me to dispute my stated conclusions. Indeed, two eminent obstetric anesthesiologists appear with me today, testifying on their own behalf and not as ASA representatives. I am pleased to note that their testimony reaches the same conclusions that I have expressed.

Thank you for your attention. I am happy to respond to your questions.

Mr. GEJDENSON. Mr. Speaker, today I rise to express my opposition to H.R. 1833, the so-called ''Partial-Birth'' Abortion bill. I voted against this measure last year when it was first considered by the House and I will do so again today because I do not believe that Congress is the proper authority to decide the appropriateness of a particular medical procedure. This decision should be made by a woman, her family and her physician.

Further, in addition to being the first step in an all-out assault on a woman's right to choose, this bill is also unconstitutional since it fails to make an exception for the life and health of the mother as required by Roe v. Wade. For that reason, President Clinton has indicated that he will veto this measure.

Proponents of H.R. 1833 would like the public to believe that the women who have third trimester abortions do so because after 6 months of pregnancy, they suddenly decide that they do not want a baby. This could not be further from the truth. The women I have heard speak about their experiences—Mary-Dorothy Line, Tammy Watts, Coreen Costello—all desperately wanted their babies, but severe fetal abnormalities left no chance of the child surviving outside of the womb. Nevertheless, they have all insisted that while their decision to have this procedure was a painful one, it was their decision, not one forced upon them by the Federal Government.

With this in mind, it is ironic that while the Republican majority in Congress has spent much of the past year denouncing Government intervention in an individual's private life, they are intent on passing this bill which is the ultimate imposition of Government on a woman's health care choices.

The SPEAKER pro tempore. Pursuant to the rule, the previous question is ordered.

The question in on the motion offered by the gentleman from Florida [Mr. CANADY].

The question was taken; and the Speaker pro tempore announced that the ayes appear to have it.

Mr. CANADY of Florida. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 286, nays 129, answered ''present'' 1, not voting 15, as follows:

[Roll No 94]

YEAS—286

Allard	Cunningham	Hobson
Archer	Danner	Hoekstra
Armey	Davis	Hoke
Bachus	de la Garza	Holden
Baesler	Deal	Hostettler
Baker (CA)	DeLay	Houghton
Baker (LA)	Diaz-Balart	Hunter
Ballenger	Dickey	Hutchinson
Barcia	Dingell	Hyde
Barr	Doolittle	Inglis
Barrett (NE)	Doyle	Istook
Barrett (WI)	Dreier	Jacobs
Bartlett	Duncan	Jefferson
Barton	Dunn	Johnson (SD)
Bass	Ehlers	Johnson, Sam
Bateman	Ehrlich	Jones
Bereuter	Emerson	Kanjorski
Bevill	English	Kaptur
Bilbray	Ensign	Kasich
Bilirakis	Everett	Kennedy (RI)
Bliley	Ewing	Kildee
Blute	Fawell	Kim
Boehner	Fields (TX)	King
Bonilla	Flake	Kingston
Bonior	Flanagan	Kleczka
Bono	Foglietta	Klink
Borski	Foley	Klug
Brewster	Forbes	Knollenberg
Browder	Fox	LaFalce
Brownback	Franks (NJ)	LaHood
Bryant (TN)	Frisa	Largent
Bunn	Frost	Latham
Bunning	Funderburk	LaTourette
Burr	Gallegly	Laughlin
Burton	Ganske	Lazio
Buyer	Gekas	Leach
Callahan	Gephardt	Lewis (CA)
Calvert	Geren	Lewis (KY)
Camp	Gilchrest	Lightfoot
Canady	Gillmor	Lincoln
Castle	Goodlatte	Linder
Chabot	Goodling	Lipinski
Chambliss	Gordon	Livingston
Chenoweth	Goss	LoBiondo
Christensen	Graham	Longley
Chrysler	Gunderson	Lucas
Clement	Gutknecht	Manton
Clinger	Hall (OH)	Manzullo
Coble	Hall (TX)	Martinez
Coburn	Hamilton	Martini
Collins (GA)	Hancock	Mascara
Combest	Hansen	McCollum
Condit	Hastert	McCrery
Cooley	Hastings (WA)	McDade
Costello	Hayes	McHale
Cox	Hayworth	McHugh
Cramer	Hefley	McInnis
Crane	Hefner	McIntosh
Crapo	Heineman	McKeon
Cremeans	Herger	McNulty
Cubin	Hilleary	Metcalf

Mica
Miller (FL)
Minge
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Murtha
Myers
Myrick
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Ortiz
Orton
Oxley
Packard
Parker
Paxon
Payne (VA)
Peterson (MN)
Petri
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Regula
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shuster
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Spratt
Stearns
Stenholm
Stockman
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thornberry
Thornton
Tiahrt
Traficant
Upton
Volkmer
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff

NAYS—129

Abercrombie
Ackerman
Andrews
Baldacci
Becerra
Beilenson
Bentsen
Berman
Bishop
Boehlert
Boucher
Brown (CA)
Brown (FL)
Brown (OH)
Campbell
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (MI)
Conyers
Coyne
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dixon
Doggett
Dooley
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Fields (LA)
Frank (MA)
Franks (CT)
Frelinghuysen
Furse
Gejdenson
Gilman
Gonzalez
Green
Greenwood
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Horn
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Johnson (CT)
Johnson, E. B.
Johnston
Kelly
Kennedy (MA)
Kennelly
Kolbe
Lantos
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney
Markey
Matsui
McCarthy
McDermott
McKinney
Meehan
Meek
Menendez
Meyers
Miller (CA)
Mink
Morella
Nadler
Olver
Owens
Pallone
Pastor
Payne (NJ)
Pelosi
Peterson (FL)
Pickett
Rangel
Reed
Rivers
Rose
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Shays
Skaggs
Slaughter
Stark
Studds
Thompson
Thurman
Torkildsen
Torres
Towns
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates
Zimmer

ANSWERED ''PRESENT''—1

Richardson

NOT VOTING—15

Bryant (TX)
Collins (IL)
Dornan
Filner
Ford
Fowler
Gibbons
Harman
Roukema
Smith (WA)
Stokes
Thomas
Torricelli
Ward
Weldon (PA)

□ 2008

The Clerk announced the following pairs:

On this note:

Mr. Thomas of California for, with Ms. Harman against.

Mr. Fowler of Florida for, with Mr. Stokes against.

Mr. MYERS of Indiana changed his vote from ''nay'' to ''yea.''

So the motion was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ROGERS). Pursuant to the provisions of clause 5 of rule I, the chair will now put the question on each motion to suspend the rules on which further proceeding were postponed on Tuesday, March 26, 1996, in the order in which that motion was entertained.

Votes will be taken in the following order: House Resolution 379, by the yeas and nays: and House Concurrent Resolution 102, by the yeas and nays.

The Chair will reduce to 5 minutes the time for the second electronic vote.

ANNIVERSARY OF MASSACRE OF KURDS BY IRAQI GOVERNMENT

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and agreeing to the resolution, House Resolution 379.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York [Mr. GILMAN] that the House suspend the rules and agree to the resolution, House Resolution 379, on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 409, nays 0, not voting 22, as follows:

[Roll No. 95]

YEAS—409

Abercrombie
Ackerman
Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Bono
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clay
Clayton
Clement
Clyburn
Coble
Coburn
Coleman
Collins (GA)
Collins (MI)
Combest
Condit
Cooley
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeFazio
DeLauro
Dellums
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Ensign
Eshoo
Evans
Everett
Ewing
Farr
Fattah
Fawell
Fazio
Fields (LA)
Fields (TX)
Flake
Flanagan
Foglietta
Foley
Forbes
Fox
Frank (MA)
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Geren
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Graham
Green
Greenwood
Gunderson
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hilliard
Hinchey
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Lantos
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Longley
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McDade
McHale
McHugh
McInnis
McIntosh
McKeon
McKinney
McNulty
Meehan
Meek
Menendez
Metcalf
Meyers
Mica
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Rush
Sabo
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schroeder
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Solomon
Souder
Spence
Spratt
Stearns
Stenholm
Stockman
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thompson
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torres
Towns
Traficant
Upton
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Ward
Watt (NC)
Watts (OK)
Waxman
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wilson
Wise