We will have two votes this morning and then we will have that period of morning business. Following some time for a bill introduction, there will be time available for the Senators to express their gratitude.

The PRESIDING OFFICER. That is 12:30. If following the two votes which are about to begin, will begin at 12:30, and will be on invoking cloture on the Estrada nomination. Additional votes will occur this afternoon. I will update Members later this morning.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

PARTIAL-BIRTH ABORTION BAN

ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of S. 3, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 3) to prohibit the procedure commonly known as partial-birth abortion.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I ask unanimous consent to have printed in the RECORD prior to the vote on S. 3, four letters from specialists in maternal-fetal medicine. In response to the letter the Senator from California had printed in the RECORD yesterday.

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


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

DEAR SENATOR SANTORUM: I am writing to contest the letter the Senator from California had printed in the RECORD yesterday.

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

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of the medical indications. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such outcomes have been described as extreme preterm delivery (also called hysteroscopy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead fetus. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

Therefore, I believe the whole of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional “medical exemption” for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Maternal-Fetal Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emergency hysterectomy before fetal viability then I will utilize a medically appropriate method of delivery, including the use of medical emergency measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is not a procedure that will move away from the cervix, and potentially through the previa, is contraindicated. It is not surprising to anyone that the patient went, from a previa just appears reckless and totally unnecessary.

Sincerely,

BYRON C. CALHOUN, MD.


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

DEAR SENATOR SANTORUM: The purpose of this letter is to counter the letter of Dr. Philip Darney, M.D. to Senator Diane Feinstein by Philip D. Darney, MD supporting the “medical exemption”; to the proposed restriction of the partial birth abortion which is now under consideration. Most physicians and citizens recognize that in rare life-threatening situations a gruesome procedure might be necessary. But it is certainly not a procedure that should be used to accomplish abortion in any other situation.

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of the medical indications. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such outcomes have been described as extreme preterm delivery (also called hysteroscopy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead fetus. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

Therefore, I believe the whole of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional “medical exemption” for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Maternal-Fetal Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emergency hysterectomy before fetal viability then I will utilize a medically appropriate method of delivery, including the use of medical emergency measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is not a procedure that will move away from the cervix, and potentially through the previa, is contraindicated. It is not surprising to anyone that the patient went, from a previa just appears reckless and totally unnecessary.

Sincerely,

STEVE CALVIN, MD.

agree that D&amp;X was a necessary option. In fact, a bad outcome would have been indefensible in court. A hysterotomy (caesarean delivery) under controlled non-emergent circumstances would not have the same risk. I would be more certain to avoid disaster when placenta previa occurs in the latter second trimester.

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

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

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

Sincerely,  

SUSAN E. RUTHERFORD, MD.  
UNIVERSITY OF SOUTHERN CALIFORNIA, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY,  

Hon. Rick Santorum,  
U.S. Senate Office Building,  
Washington, DC.

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

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

I have had occasion to review the cases described by Dr. Philip Darney, offered in support of the position that partial birth abortion, or intact D&amp;X, was the best care for the patient in those situations. Mindful of Dr. Darney’s broad experience with surgical abortion, I nevertheless disagree strongly that the procedures he describes for these two cases was best under the circumstances. These cases are infrequent, and there is no single standard for management. However, it would certainly be considered atypical, in my experience, to wait 12 hours to dilate the cervix with laminaria while the patient was actively hemorrhaging, as was described in his first case. I am not aware of the approach to pre-sumed placenta accreta, described in the second case, is highly unusual. Although the mother survived with significant morbidity, it is not clear to me how any approach to presumed placenta accreta, described in the second case, is highly unusual. Although the mother survived with significant morbidity, it is not clear to me how any approach to...
future fertility. On the contrary, this procedure can pose a significant threat to both.

Banning partial-birth abortion has been addressed in every Congress since the 104th session, and banned in both the 104th and 105th sessions. We now have a President in office who has vowed to sign this Partial-Birth Ban Act when it comes before him without hostile amendments that would allow the continuance of this procedure. It is our moral duty to ban this repulsive practice once and for all, and it is my sincere hope that Congress will be able finally pass the Partial-Birth Abortion Ban Act of 2003.

Mr. GRASSLEY. Mr. President, I rise today in support for the Partial-Birth Abortion Ban Act of 2003.

As a father of five, a grandfather of nine, and a proud great-grandfather, I regard life as a precious gift. During my tenure in the Congress—that is, since 1974—I have long supported policies that stand up for life and protect the unborn.

We made great strides in the 104th, 105th, and 106th Congresses on banning partial-birth abortions. It was unfortunate that President Clinton vetoed the ban. Not once, but twice.

The Supreme Court considered and struck down as unconstitutional the Nebraska State law making partial-birth abortion illegal. In Stenberg v. Carhart, the Court believed that the Nebraska law (1) did not contain an exception for the health of a mother, and (2) was too broad and could be construed to cover other types of procedures. The bill before us specifically addresses the Supreme Court’s concerns.

I am disappointed and sickened that these abortion procedures are legal in the United States of America. I’m not alone. According to a recent Gallup poll, 70 percent of Americans want a ban.

My constituents want a ban on partial-birth abortions:

A woman from Nora Springs wrote, “I’m horrified that under current law, thousands of partial-birth abortions are committed in America every year.”

A man from Atlantic, IA wrote, “I believe that when women would see that they would be terminating a life then they would opt ‘no’ to abortion.”

A woman from Tabor, IA, wrote, “I’m concerned that, if approved, this bill would not only undermine a woman’s right to choose, but would endanger the lives of thousands of women who no longer would have access to safe abortion procedures when their health or their life is in jeopardy.

Before I go further, let me say that I fully understand the very real and legitimate concerns of those who support this legislation. The issue of abortion raises the most profound of moral and ethical dilemmas. These are emotional issues. They raise many hard questions. And the practical reality of abortion, all types of abortion, is hard for all involved.

Speaking for myself, I support a woman’s right to choose. And I support it strongly. As I see it, a decision about abortion generally should be made by a woman and her doctor, not by politicians.

Having said that, I recognize that men and women of good faith can and will reach different conclusions about the difficult ethical questions involved in the debate on this legislation. And, I share concerns raised by many bill proponents about some of the most disturbing examples of procedures conducted post-viability. That’s why I intend to support an amendment to restrict such procedures. The legislation I am supporting, however, is much more carefully crafted than the underlying bill, and it complies with the constitution by providing an exception where the health of the woman is at stake.

While I understand the genuine concerns of many advocates for this legislation, the language of the bill actually goes well beyond a ban on late-term abortions. In fact, its real effect would be to deny women’s access to some of the safest abortion procedures at all stages of pregnancy. Because the legislation omits any mention of fetal viability, it bans abortions throughout all stages of pregnancy. And it bans one of the safest abortion methods—the “intact D&E”—that is used when a woman’s life and health are in danger and for severe fetal anomalies.

I hope my colleagues will think long and hard about the implications of the legislation before us. We need to be very careful to avoid returning to a period in which abortion was illegal and the only choice women had was to seek an illegal and unsafe abortion. In those days, thousands of women died each year as a direct result of these legal prohibitions. And it would be tragic if this Congress were to forget the lessons of that history.

It also would be unconstitutional. In Roe v. Wade, the Supreme Court held that a woman has the right to choose legal abortion until fetal viability. States have the authority to ban abortion post-viability, so long as exceptions are made to protect a woman’s life and health. And, indeed, 41 States have chosen to ban postviability abortions in instances in which a woman’s life and health are not at stake. But, under no circumstances do the Congress or the States have the authority to ban medical procedures that are essential to preserving a woman’s life or health, nor do they have the authority to completely ban access to abortion viability. This is a constitutionally protected right.

Unfortunately, the majority leader has brought to the Senate floor an abortion ban that has been struck down by courts in 21 States, including my State of New Jersey, and the Supreme Court. Based on that precedent, there is little doubt that, if this bill is enacted, it also will be struck down, and therefore it will not reduce the number of abortions at all. It makes you wonder: Why are we even spending our time debating this legislation?

If we really are interested in reducing the number of abortions in this country, we should ensure that all women have access to the full array of family planning services, including prescription contraception, emergency contraception, and prenatal care. We also should support an expansion of funding for abortion, and I fully support the amendment offered by Senator MURRAY and Reid that would have addressed these issues.
Every week, 8,500 children in our country are born to mothers who lacked access to prenatal care. Too many of these children are born with serious health problems because their mothers lacked adequate care during their pregnancies. As a result, 28,000 infants die or are born with long-term disabilities each year in the United States. That, Mr. President, is the real tragedy. And we ought to act immediately to address this issue by expanding access to prenatal care, as several of my colleagues and I have proposed.

What we should not do, however, is pass legislation that we know is unconstitutional, that would ban a common and safe form of abortion at all stages of pregnancy, and that would increase maternal mortality—all without improving the health of a single child.

For these reasons, I urge my colleagues to oppose this bill. I ask unanimous consent to print in the RECORD the letters, one from Physicians for Reproductive Choice and Health, and the other from Mr. Felicia Stewart, Professor of Obstetrics and Gynecology at the University of California. I believe these letters describe better than I the important medical reasons for voting against this bill.

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

PHYSICIANS FOR REPRODUCTIVE
CHOICE AND HEALTH,
Hon. Jon S. Corzine,
U.S. Senate,
Washington, DC.

DEAR SENATOR CORZINE: We are writing to urge you to stand in defense of women’s reproductive health and vote against S.3, legislation regarding so-called “partial birth” abortion.

We are practicing family physicians; obstetricians-gynecologists; academics in obstetrics, gynecology and women’s health; and a variety of other specialties in medicine. We believe it is imperative that those who perform abortion, or who manage the prenatal and post-operative care of women receiving abortions are given a voice in a debate that has largely ignored the two groups whose lives would be affected by this legislation: physicians and patients.

It is misguided and unprincipled for lawmakers to legislate decision-making in medicine. We all want safe and effective medical procedures for women; on that there is no dispute. However, the business of medicine is not and cannot be palatable to those who do not practice it on a regular basis. The description of a number of procedures—from liposuction to cardiac surgery—may seem distant and unfamiliar, and even repugnant to others. When physicians analyze and refine surgical techniques, it is always for the best interest of the patient. The risk of death associated with childbirth is about 11 times as high as that associated with abortion. Abortion is proven to be one of the safest procedures available in order to provide the best medical care possible.

Tying the hands of physicians endangers the health of patients. It is unethical and dangerous for legislators to dictate the details of specific surgical procedures. Until a surgeon examines the patient, she does not necessarily know which procedure would be in the patient’s best interest. Banning procedures puts women’s health at risk.

(3) Politicians should not legislate medical decision-making.

To do so would violate the sanctity and legality of the physician-patient relationship. The right to have an abortion is constitutionally-protected. To falsify scientific evidence in an attempt to deny women that right is unconscionable and dangerous.

The American Obstetricians and Gynecologists, representing 45,000 ob-gyns, agrees: “The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.”

The American Medical Women’s Association, representing 10,000 female physicians, is opposed to an abortion ban because it “represents a serious impingement on the rights of physicians to determine appropriate medical management for individual patients.”

THE SCIENCE

We know that there is no such technique as “partial birth” abortion and we believe this legislation is a thinly-veiled attempt to outlaw all abortions. Those supporting this legislation base both their case before legislator and the public about abortion procedures are actually used. Since the greatest confusion seems to center around technique, the first trimester, we will address those: dilation and evacuation (D&E), dilation and extraction (D&X), instillation, hysterectomy and hysterotomy (commonly known as a-section).

Dilation and evacuation (D&E) is the standard approach for second-trimester abortion. It is similar to first-trimester vacuum aspiration except that the cervix must be further dilated because surgical instruments are used. Morbidity and mortality associated with D&E is preferential to labor induction methods (instillation), hysterotomy and hysterectomy because of issues regarding complications and safety.

From the years 1972-76, labor induction procedures carried a maternal mortality rate of 16.5 (note: all numbers listed are out of 100,000); the corresponding rate for D&E was 0.4. From 1977-82, labor induction fell to 6.8, but D&E dropped to 3.3 From 1983-87, induction methods had a 3.5 mortality rate, while D&E fell to 2.9. Although the difference between the two procedures in the mid-1980s, the use of D&E had already quickly outpaced induction.

Morbidity trends indicate that dilation and evacuation is much safer than labor induction procedures and for women with certain medical conditions, labor induction can pose serious risks. Rates of complications from labor induction, including bleeding, infection, and unnecessary surgery, were at least twice as high as those from D&E. There are also higher rates of retained products of conception following failed inductions, acquired infections necessitating emergency D&Es as a last resort.

Hysterotomy and hysterectomy, moreover, are more likely to cause permanent damage to reproductive organs and increase the risk of infection.”

There is also a technique known as dilation and extraction (D&X). There is a limited medical literature on D&X because it is uncommonly used. However, it is sometimes a physician’s preferred method of termination for a number of reasons: It offers a woman the chance to see the intact body of a desired child passed up the grieving process; it provides a greater chance of acquiring valuable information regarding hereditary illness or fetal anomaly; and D&E provides a decreased risk of injury to the woman, as the procedure is quicker than induction and involves less use of sharp instruments in the uterus, providing a decrease chance of uterine scars or tears and cervical lacerations.

The American College of Obstetricians and Gynecologists addressed this in their statement in opposition to so-called “partial birth” abortion when they said that D&E “may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman’s particular circumstances, can make this decision.”

It is important to note that all late-stage abortions are used at varying gestational ages. Both D&E and D&X are options for surgical abortion prior to viability. D&E and D&X are rarely used because of the availability and safety of other methods.

Because this legislation is so vague, it would outlaw D&E and D&X (and arguably techniques used in the first trimester). Inaca and the Congress go into detail, albeit in non-medical terms—do not remotely correlate with the language of the bill. This legislation is reckless. The outcomes could be devastating. Women could be returning to the days when an unwanted pregnancy led women to death through illegal and unsafe procedures, self-inflicted abortion, and dangerous and unproven methods.

The cadre of physicians who provide abortions should be honored, not vilified. They are heroes to millions of women, offering the opportunity of choice while helping others to resolve devastating decisions. It is imperative that you consider scientific data rather than partisan rhetoric when voting on such far-
reaching public health legislation. We strongly oppose legislation intended to ban so-called “partial birth” abortion.

Sincerely,

Natalie E. Roche, MD, Assistant Professor of Obstetrics and Gynecology, New Jersey Medical College, Newark, NJ
Roger A. Rosenblatt, MD, MPH, Professor and Vice Chair, Department of Family Medicine, Rural underserved opportunity Program Director—School of Medicine University of Washington School of Medicine Seattle, WA.

Courtney Schreiber, MD, Chief Resident, Obstetrics and Gynecology, University of Pennsylvania Health System, Philadelphia, PA.

Jody Steinauer, MD, Clinical Fellow, Dept. of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, CA.

Steven B. Tamarin, MD, St. Luke’s Roosevelt Medical Group, Seattle, WA.

Katherine Van Kessel, MD, Attending Physician, Harborview Medical Center, Department of Obstetrics and Gynecology, University of Washington, Seattle, WA.

Gerson Weiss, MD, Professor and Chair, Department of Obstetrics, Gynecology and Reproductive Sciences, New York Medical College, New York, NJ.

Bevery Winkoff, MPH, President, Gun Rights Policy and Research Association, New York, NY.

And the board of Physicians for Reproductive Choice and Health


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

DEAR SENATOR BOXER: I understand that you will be considering Senate S. 3, the ban on abortion procedures, soon and would like to offer some medical information that may assist you in your efforts. Important stakes are at hand.

By way of background, I am an adjunct professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco, where I co-direct the Center for Reproductive Health Research and Policy. Formerly, I directed the Reproductive Health Program for the Henry J. Kaiser Family Foundation and served as Deputy Assistant Secretary for Population Affairs for the United States Department of Health and Human Services. I represented the United States at the International Conference on Population and Development (ICPD) in Cairo, Egypt, and currently serve on a number of Boards for organizations that promote emergency contraception and new contraceptive technologies, and support reducing teen pregnancy. My medical and policy areas of expertise are in the family planning and reproductive health, prevention of sexually transmitted infections including HIV/AIDS, and enhancing international aid in providing them.

The proposed ban on abortion procedures criminalizes abortions in which the provider “deliberately and intentionally vaginally delivers a living fetus . . . for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus.” The criminal ban being considered might be more accurately described as “inact d&x,” dilation and extraction (d&x), or “inact d&x” the most common second-trimester procedure. In addition, such a ban would also apply to induced abortion. Even if a physician is using induction as the primary method for abortion, he or she may not be able to assure that the procedure could be effectively ban safe and common, pre-viable abortion procedures.

I’d like to focus my attention on that subset of the women affected by this bill who face grievous underlying medical conditions. The proposed ban on abortion procedures will be a sad day for medicine if Congress is unable to assure that the procedure could be safely continued.

Take for instance women who face hypertensive disorders such as eclampsia—convulsions precipitated by pregnancy-induced or preeclampsia (high blood pressure). This, along with infection and hemorrhage, is one of the most common causes of maternal death. With eclampsia, the kidneys and liver may be affected. In some cases, if the woman is not provided an abortion, her liver could rupture, she could suffer a stroke, brain damage, or coma. Hypertensive disorders can develop over time or spiral out of control in short order, and doctors must be given the latitude to terminate a pregnancy if necessary in the safest possible manner.

If the safest medical procedures are not available to terminate a pregnancy, severe adverse health consequences are possible for some women who have underlying medical conditions necessitating a termination of their pregnancies, including: death (risk of death higher with less safe abortion methods); strokes, hemorrhage, brain damage, infection, liver damage, and kidney damage.

Legislation forcing doctors to forego medically indicated abortions or to use less safe but politically-palatable procedures is simply unacceptable for women’s health.

Thank you very much, Senator, for your efforts to educate yourself about the implications of the proposed ban on abortion procedures.

Sincerely,

FELICIA H. STEWART, M.D.

Mr. SANTORUM. Mr. President, I ask for the yeas and nays.

THE PRESIDENT. Is there a sufficient second? There is a sufficient second.
The bill having been read the third time, the question is, Shall the bill pass? The clerk will call the roll.

The legislative clerk called the roll. Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from North Carolina (Mr. EDWARDS), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

I further announce that, if present and voting, the Senator from North Carolina (Mr. EDWARDS) and the Senator from Massachusetts (Mr. KERRY) would each vote "no."

The PRESIDING OFFICER (Ms. MURKOWSKI). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 64, nays 33, as follows: [Kollac Vote No. 51 Log.]

YEAS—44

Alexander
Allard
Allen
Bayh
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Byrd
Campbell
Carper
Chambliss
Coats
Coleman
Conrad
Corzine
Crapo
Daskis
DeWine
Dole
Domenici
Dorgan
Enzi
Fischer
Graham (SC)
Graham (FL)
Hatch
Holliings
Hagel
Inhofe
Inouye
Ikeda
Johnson
Kyl
Lieberman
Lautenberg
Leahy
Lincoln
Loebs
Lugar

McCaIN
McConnell
Miller
Murray
Nickles
Parmer
Reid
Sessions
Shelby
Smith
Spector
Stevens
Santorum
Santorum
Santorum
Talent
Thomas
Voinovich
Warner

NAYS—33

Akaka
Banker
Bingaman
Boxer
Cantwell
Chafee
Clinton
Collins
Corzine
Dayton
Dodd

Duruin
Feingold
Feinstein
Franken
Harkin
Inouye
Jeffords
Kennedy
Kloezner
Laugenberg
Levin

Lieberman
Miluski
Murray
Nelson (FL)
Reed
Rockefeller
Sarbanes
Schumer
Smith
Stabenow
Wyden

CHANGE OF VOTE

Mr. DURBIN. Madam President, on the previous rollick call vote on S. 3, I inadvertently cast a vote I did not intend to cast. On rollick call vote No. 51, I voted yea. It was my intention to vote nay. Therefore, I ask unanimous consent that I be permitted to change my vote since it will not affect the outcome.

The PRESIDING OFFICER. Without objection, it is ordered. (The foregoing tally has been changed to reflect the above order.)

The bill (S. 3), as amended, was passed, as follows:

NAYS—33

Akaka
Banker
Bingaman
Boxer
Cantwell
Chafee
Clinton
Collins
Corzine
Dayton
Dodd

Duruin
Feingold
Feinstein
Franken
Harkin
Inouye
Jeffords
Kennedy
Kloezner
Laugenberg
Levin

Lieberman
Miluski
Murray
Nelson (FL)
Reed
Rockefeller
Sarbanes
Schumer
Smith
Stabenow
Wyden

STENBERG

NOT VOTE—5

Biden

Edwards

Kerry

CHANGE OF VOTE

Mr. DURBIN. Madam President, on the previous rollick call vote on S. 3, I inadvertently cast a vote I did not intend to cast. On rollick call vote No. 51, I voted yea. It was my intention to vote nay. Therefore, I ask unanimous consent that I be permitted to change my vote since it will not affect the outcome.

The PRESIDING OFFICER. Without objection, it is ordered. (The foregoing tally has been changed to reflect the above order.)

The bill (S. 3), as amended, was passed, as follows:

BYRES—64

Alexander
Allard
Allen
Bayh
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Byrd
Campbell
Carper
Chambliss
Coats
Coleman
Conrad
Corzine
Crapo
Daskis
DeWine

Dole
Domenici
Dorgan
Enzi
Fischer
Graham (SC)
Graham (FL)
Hatch
Holliings
Hagel
Inhofe
Inouye
Ikeda
Johnson
Kyl
Lieberman
Lautenberg
Leahy
Lincoln
Loebs
Lugar

McCaIN
McConnell
Miller
Murray
Nickles
Parmer
Reid
Sessions
Shelby
Smith
Santorum
Santorum
Santorum
Talent
Thomas
Voinovich
Warner

S3658 CONGRESSIONAL RECORD — SENATE March 13, 2003

(1) A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion—an abortion in which a physician delivers an unborn child's body into the world in such a way that the child's head is expelled and the rest of its body is extracted with a Sharp instrument, and sucks the child's brain out before completing delivery of the child—is contrary to medical practice, is never medically necessary and should be prohibited.

(2) Rather than being an abortion procedure that is essential to the medical community, particularly among physicians who routinely perform other abortion procedures, contrary to popular belief, the EPA is not an approved abortion procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some instances their lives. As a result, at least 27 States banned the procedure as did the United States Congress which voted to ban the procedure during the 104th, 105th, and 106th Congresses.

(3) In Stenberg v. Carhart (530 U.S. 914, 932 (2000)), the United States Supreme Court opined that serious medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure for pregnant women who are in late-stage abortion. Thus, the Court struck down the State of Nebraska’s ban on partial-birth abortion procedures, concluding that it placed an “unjust burden” on women and failed to include an exception for partial-birth abortions deemed necessary to preserve the “health” of the mother.

(4) In reaching this conclusion, the Court deferred to the Federal district court’s fact findings that the partial-birth abortion procedure is statistically as safe as, and in many circumstances safer than, alternative abortion procedures.

(5) However, the great weight of evidence presented at the Stenberg trial and other trials challenging partial-birth abortion bans, as well as at extensive Congressional hearings, demonstrates that a partial-birth abortion is never necessary to preserve the health of a woman, poses significant health risks to a woman upon whom the procedure is performed, and is outside of the standard of care in the United States.

(6) Despite the dearth of evidence in the Stenberg trial record supporting the district court’s factual findings when it addressed the constitutionality of Nebraska’s ban on partial-birth abortion, the Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest less intruding than the situation, and draws reasonable inferences based upon substantial evidence.

(9) In Katzenbach v. Morgan (384 U.S. 641 (1966)), the Supreme Court articulated its highly deferential review of Congressional factual findings when it addressed the constitutionality of the Voting Rights Act of 1965. Regarding Congress’ factual determination that section 4(e) would assist the Puerto Rican community in “gaining representation in public services,” the Court stated that “[i]t was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations. . . . It is not for us to review the constitutional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might believe the measure to be adopted.” Clearly, there was such a basis to support section 4(e) in the application in question in this case.” (Id. at 653).

(10) In Katzenbach v. Morgan, a highly deferential review of Congress’s factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the prohibition against breathing in any manner or by any means other than through the natural orifices of the nose and mouth (384 U.S. 641 (1966)), the Supreme Court articulated its highly deferential review of Congressional factual findings when it addressed the constitutionality of the Voting Rights Act of 1965. Regarding Congress’ factual determination that section 4(e) would assist the Puerto Rican community in “gaining representation in public services,” the Court stated that “[i]t was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations. . . . It is not for us to review the constitutional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might believe the measure to be adopted.” Clearly, there was such a basis to support section 4(e) in the application in question in this case.” (Id. at 653).


(12) Three years later in Turner II, the Court upheld the “must-carry” provisions based upon Congress’ findings, stating the Court’s “obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress’ factual predictions with ours. Rather, it is assured that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.” (Id. at 656).

(13) In three years later in Turner II, the Court upheld the “must-carry” provisions based upon Congress’ findings, stating the Court’s “obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress’ factual predictions with ours. Rather, it is assured that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.” (Id. at 656).
equipped than the judiciary to "evaluate and make the vast amounts of data" bearing upon legislative questions," (Id. at 195), and added that it "owes[d] Congress' findings an additional deference, both because of its respect for its authority to exercise the legislative power." (Id. at 196).

(13) There exists substantial record evidence in Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a "health" exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

(14) Pursuant to the testimony received during extensive legislative hearings during the 104th, 105th, and 107th Congresses, Congress was informed by extensive hearings held during the 104th, 105th, and 107th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These findings reflect the very informed judgment of the Congress that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

SEC. 3. PROHIBITION OF PARTIAL-BIRTH ABORTIONS.

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

"CHAPTER 74—PARTIAL-BIRTH ABORTIONS"

"Sec. 1531. Partial-birth abortions prohibited.

"(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years or both. This subsection does 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, physical illness, or physical injury, including a life- endangering physical condition caused by or arising from the pregnancy itself. This subsection takes effect 1 day after the date of enactment of this Act.

"(b) As used in this section—"(1) the term "partial-birth abortion" means an abortion in which—"(J) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is visible to the person performing the abortion and the person performing the abortion then delivers, all but the head, out of the womb, in order to end that life. Partial-birth abortion thus appropriates the terminology and technique of the delivery of living children—obstetricians who preserve and protect the life of the mother and the child—and instead uses those techniques to end the life of a partially-born child; and

"(K) Thus, by aborting a child in the manner that purposefully seeks to kill the child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

"(L) The gruesome and inhumane nature of the partial-birth abortion procedure and its outcome for a newborn infant promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure.

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

"(c) The father, if married to the mother at the time she receives a partial-birth abortion, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the

Carhart, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

(E) The physician credited with developing the partial-birth abortion procedure has testified that in any situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve a woman's health, such an abortion has never been subject to even a minimal inquiry of the medical profession, and promises respect for human life.

(F) A ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy.

(G) In light of this overwhelming evidence, Congress and the States have a compelling interest in regulating partial-birth abortions. In addition to prompting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, the policy of the medical profession, and promotes respect for human life.

(H) Based upon Roe v. Wade (410 U.S. 113 (1973)) and Planned Parenthood v. Casey (505 U.S. 833 (1992)), a governmental interest in protecting the life of a child during the delivery process arises by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. This distinction was recognized in Roe when the Court noted, without comment, that the "Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack. This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a living person. Congress has a heightened interest in protecting the life of the partially-born child.

(I) This, too, has not gone unnoticed in the medical community, where a prominent medical association has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb". According to this medical association, the "partial-birth" gives the fetus an "infant" status when it is "born from the right of the woman to choose treatments for her own body".

(J) Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of the child, instead of just delivering, all but the head, out of the womb, in order to end that life. Partial-birth abortion thus appropriates the terminology and techniques of the delivery of living children—obstetricians who preserve and protect the life of the mother and the child—and instead uses those techniques to end the life of a partially-born child.

(K) Thus, by aborting a child in the manner that purposefully seeks to kill the child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

(L) The gruesome and inhumane nature of the partial-birth abortion procedure and its outcome for a newborn infant promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure.

"(M) The mother has the right during partial-birth abortions are alive until the end of the procedure. It is a medical fact, however, that unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and can feel pain when subjected to the same stimuli. Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing their mother's skull and sucking out his or her brain.

(N) Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further erode society's respect for the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life. Thus, Congress has a compelling interest in acting—indeed it must act—to prohibit this inhumane procedure.

(O) For these reasons, Congress finds that partial-birth abortion is never necessary to preserve the health of a woman; poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.
fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff’s criminal conduct or the plaintiff consented to the abortion.

"(2) Such relief shall include—

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

(b) such relief shall be equal to three times the cost of the partial-birth abortion.

"(3)(A) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician’s conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

"(B) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for at least more than 30 days to permit such a hearing to take place.

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

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

"74. Partial-birth abortions ....... 1531'.

SEC. 4. SENSE OF THE SENATE CONCERNING ROE V. WADE.

(a) FINDINGS.—The Senate finds that—

(1) abortion has been a legal and constitutionally protected medical procedure throughout the United States since the Supreme Court decision in Roe v. Wade (410 U.S. 113 (1973)); and

(2) the 1973 Supreme Court decision in Roe v. Wade established constitutionally based limits on the power of States to restrict the right of a woman to choose to terminate a pregnancy.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the decision of the Supreme Court in Roe v. Wade (410 U.S. 113 (1973)) was appropriate and secures an important constitutional right; and

(2) such decision should not be overturned.

Mr. SANTORUM. I move to reconsider the vote.

Mr. ROBERTS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. HATCH. Madam President, I rise today to applaud this body for passing S. 3, the Partial-Birth Abortion Ban Act of 2003. I know the people of my home state of Utah share my sentiments because they recognize, as I do, that the practice of partial-birth abortion is immoral, offensive and impossible to justify. This procedure is so heinous that even many that consider themselves pro-choice cannot defend it. While we have passed a similar measure before, it was never certain to be signed into law. Today it is. It saddens me that this legislation was even necessary, and even more that it took 7 years to achieve. I thank the Senator from Utah for working with me and the leadership in bringing this about. I hope he knows he has my admiration and respect.

Basic human decency has prevailed. I pray that never again will it be legal in this country to perform this barbaric procedure. Unfortunately, I am sure that opponents of this measure will seek to challenge the law in court—where I hope good judgment will ultimately prevail. Specifically, in Carhart the Supreme Court confirmed, and I quote, "By no means must physicians [be granted] ‘unfettered discretion’ in their selection of abortion methods.'

There are those who consider every type of abortion sacrosanct and will oppose any effort to apply common-sense reasoning to the debate. I don’t know how to get through to these people, except by forcing them to witness this barbaric procedure. A baby is almost fully delivered with only her head remaining inside the birth canal when the doctor stabs scissors into the base of her skull to open a hole through which he then sucks out her brain and spinal cord. I honestly don’t know how anyone can avoid being truly sickened when they see a baby being killed in this gruesome manner. It is not done on a mass of tissue but to a living baby capable of feeling pain and, at the time this procedure is typically performed, capable of living outside of the womb.

All this bill would do is ban this one procedure. We are not talking about the entire framework of abortion rights here, but just one procedure. The fact is that there is no medical need to allow this type of procedure. It is never medically necessary, it is never the safest procedure available, and it is morally reprehensible and unconscionable.

In recent years, we have heard about teenaged girls giving birth and then dumping their newborns into trash cans. One young woman was criminally charged after giving birth to a child in a bathroom stall during her prom, and then stabbing her child before leaving the body in the trash. Tragically, there have been several similar incidents around the country in the past few years.

This is what happens, when we continue to devalue human life. William Raspberry argued in a column in the Washington Post several years ago that ‘only a short distance [exists] between what [these teenagers] have been sentenced for doing and what doctors get paid to do.’ How right he is.

When you think about it, it’s incredible that there is a mere 3 inches separating a partial-birth abortion from murder.

Partial-birth abortion simply has no place in our society and rightly should be banned. President Bush has described partial-birth abortion as ‘an abhorrent’ procedure that offends human dignity. I wholeheartedly agree.

Mr. DASCHLE. Madam President, few issues divide our country more markedly than the issue of abortion. This debate is a difficult one, and I commend those on both sides of the issue who have given their time on the floor to express their very deeply held views on this matter. While the debate has had some unfortunate low points, it has also had some very high ones. In particular, I believe the vote on the Democratic side Senators BOXER, MURRAY, DURBIN, HARKIN, and FEINSTEIN—who have helped manage the floor this week. Each of them has worked diligently to ensure these difficult issues were given the most constructive attention they deserve. I know very well how thankless that job can be, and I am grateful for their efforts.

I am personally opposed to abortion, and I oppose Federal funding of abortion except in cases of rape, incest, or medical necessity. Far too many abortions are performed in this country, and I want to do everything reasonable to discourage abortion.

That is why I support efforts to facilitate and promote adoption as an alternative to abortion, and that is why I support voluntary family planning, including improved access to contraception and research on improved contraceptive options for both men and women. That is why I supported Senator MURRAY’s amendment.

Every abortion is a tragedy. But I recognize that there are extraordinary medical circumstances that make abortion necessary to save the mother’s life or prevent grave harm to her health.

I also recognize and respect the Supreme Court’s clear message on abortion stated first in the landmark Roe v. Wade decision and later in Planned Parenthood v. Casey.

The Court consistently upheld two basic tenets. First, before the stage of fetal viability—when the fetus is capable of living outside the womb with or without life support—a woman has a constitutional right to choose whether or not to terminate her pregnancy. Second, a woman’s health must be protected throughout her pregnancy.

The Court has not, as the junior Senator from Pennsylvania has wrongly suggested, endorsed “abortion anywhere at any time.” In Casey, the Court clearly drew a distinction between abortions performed before fetal viability and those performed after viability. Clearly allowing the Government to restrict abortion after fetal viability.

While I am deeply troubled by the procedure described in S. 3, and voted again to ban it, I have real concerns that S. 3 is not the most effective means of limiting the late-term abortions the bill’s sponsors claim to target.

Like many of my colleagues, I would prefer to ban all post-viability abortions regardless of the procedure used. In 1997, I was given an opportunity to engage in an effective compromise that would actually stop far more abortions than the bill we have been debating today, I offered...
a broader ban much like the one offered by the Senator from Illinois yesterday.

The Durbin amendment, like the earlier Daschle amendment, banned all post-viability abortions, allowing an exception if the abortion is absolutely necessary to protect the mother.

An ironic fact that the sponsors of S. 3 don’t readily acknowledge is that, if their statements are accurate, S. 3 will not stop a single abortion. In contrast, the Durbin amendment would stop all post-viability abortions except those that are absolutely medically necessary. This may seem counterintuitive, so let me explain why this is true.

The sponsors of S. 3 are choosing to take that gamble, and I deeply regret that the Senate has chosen to take that gamble, with 20 words, by the way, are allegedly powerful enough to change the outcome in the Supreme Court, but not significant enough to merit a hearing in the Judiciary Committee.

If the sponsors of S. 3 are wrong, then this week’s exercise will serve only to delay meaningful progress toward restrictions on not only this procedure, but all post-viability abortions. It will also fuel the unnecessary bitterness surrounding this issue.

At this point, it is my hope that this Senate bill will go quickly to the President so that the Supreme Court can rule on it. If the Court strikes it down, then I hope people on both sides of this issue will be willing to work together to stop all post-viability abortions except those that are absolutely necessary to protect a woman’s life and health.

Finally, I want to say a few words about the women whose lives are impacted by our actions this week. One of the saddest aspects of this debate is the suggestion that countless women, for frivolous reasons, are choosing unnecessarily late-term abortions. Their proposal had the Durbin amendment would stop all late-term abortions. Their proposal had the Nebraska law banning this procedure.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.

If our true desire is to protect viable fetuses whenever possible, I think we can do that by a less restrictive approach.

An across-the-board ban on all post-viability procedures with a constitutional mudder by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that it does not restrict a woman’s Court-affirmed right to choose because all abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court’s concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

If all those statements are true and I confess I am not confident that they are—then S. 3 will not stop a single abortion; it will merely cause women and doctors to choose a different abortion procedure. If S. 3 is any way disturbed by this procedure, I oppose any unnecessary abortion once a fetus becomes viable.
Because the wisdom of using a given medical procedure is best left with medical professionals. We are legislators, not doctors.

Second, the partial-birth ban contained in this legislation will not protect a woman’s health. The few women who might require this procedure to protect their health from severe injury will be completely barred from receiving it. A pregnancy gone awry is a tragedy. The partial-birth abortion will only compound that tragedy by forcing a woman to forego a safer procedure.

The partial-birth abortion ban, as its supporters readily admit, is intended not to find common ground and reduce unnecessary abortions, but to lead to a ban of any and all abortions in America—regardless of whether they are needed to protect a woman’s life and health. I find this argument simply unacceptable and blatantly unconstitutional in light of Roe vs. Wade. Therefore, it is for this reason and the reasons stated above that I voted against final passage of the Partial Birth Abortion Ban Act of 2003.

While the Durbin amendment would not have ended the national debate over abortion, it rejected the deeply held views of people on both sides of this issue. It offered the Senate and our country an opportunity—not to debate our differences, but to affirm our similarities. It would have allowed us to come together in a bipartisan fashion, pro-life and pro-choice—and offer something that would have reduced the number of abortions while preserving a woman’s life, health and constitutional freedom.

Mr. ROCKEFELLER. Mr. President, I want to talk about the debate in the Senate this week regarding late-term abortion. I am a strong opponent of late-term abortions, and I know many Americans find them as deeply troubling as I do.

As I have done in the past, I voted this week to support a comprehensive ban on late-term abortions. The comprehensive ban I supported—offered as an amendment by Senator Durbin—would have put an end to all late-term post-viability abortions, unlike Senator Santorum’s proposal, including but not limited to those performed using the procedure known as “partial birth.” The Durbin ban also would have included a very narrow exception for the rare case when a woman’s life or health is threatened by a troubled pregnancy, as required by the United States Supreme Court and the Constitution.

I want to end unnecessary late-term abortions, and I also agree with the Supreme Court that it is not right for a woman who faces grievous injury, or even death, to have no protection under the law. In those rare cases of a serious threat to a woman’s life or health, the Durbin amendment would have allowed the woman, her family and no less than two physicians to pursue the best medical options. Except in an emergency, the two physicians—to include her attending physician and an independent non-treated physician—would have been required to certify in writing that in their medical judgment continuation of the pregnancy would constitute a risk of grievous injury to her physical health. Grievous injury was carefully defined as a severely debilitating disease or impairment specifically caused or exacerbated by the pregnancy, or an inability to provide necessary treatment for a life-threatening condition.

I want to emphasize that if we are serious about ending the practice of late-term abortions then we must pass a law that will be upheld by our courts. The U.S. Supreme Court has been quite clear that to be deemed constitutional, any law banning late-term abortions must be narrowly focused and must include an exception for the health of the mother. Several previous bans ignored these tests and were struck down, and consequently there has been no end to this troubling practice. Senator Santorum’s bill does not adequately meet the Court’s requirements for constitutionality and will almost surely meet the same fate.

The Durbin amendment, on the other hand, was a clear and comprehensive ban that does comply with the constitutionality tests set forth by the Supreme Court. It would have ended the practice of late-term abortions, with a narrow exception for protecting a woman from grievous injury to her life or health. In those rare and extraordinarily difficult situations, the Durbin amendment would have ensured that a woman—not by the dictates of the Congress, but with the private counsel of her family, her doctors, and her clergy—makes the final decision.

I deeply regret that a majority of my colleagues did not recognize the Durbin amendment was a more effective ban than Senator Santorum’s proposal. I continue to hope that in the end we will find a way to enact a comprehensive ban on late-term abortions that meets the demanding and constitutional test of the U.S. Supreme Court and Constitution by protecting the life and physical health of the mother in extreme situations.

EXECUTIVE SESSION

The PRESIDING OFFICER. The nomination of Thomas A. Varlan, of Tennessee, to be United States District Judge for the Eastern District of Tennessee?

Mr. HATCH. Madam President, I ask for the yeas and nays.

The nomination was confirmed.

Mr. HATCH. Madam President, I am pleased the Senate has confirmed Thomas Varlan for the United States District Court for the Eastern District of Tennessee. Mr. Varlan’s distinguished record of service in both the private and public sectors makes him a great addition to the Federal bench.

Mr. Varlan graduated Order of the Coif from Vanderbilt University School of Law, where he served as managing editor for the Vanderbilt Law Review. In his 11 years in private practice, Mr. Varlan has focused on governmental relations, civil litigation, and employment law, and representation of quasi-governmental corporations and schools.