HB

65

HOUSE COMMITTEE REPORT

3/12/97
Rules

(7)
Date Referred to Committee: February 21, 1997 **FURTHER REFERRALS:**

Date of Committee Action: 3/10/97

The JUDICIARY Committee considered: **HB 65**

HOUSE BILL NO. 65 **PARTIAL-BIRTH ABORTIONS**

"An Act relating to partial-birth abortions."

recommends it be replaced with the following committee substitute _____ [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [X] (1) fiscal note(s) ADMIN. (INDETERMINATE) 2/21/97

[ ] zero fiscal note(s) _____ [X] (1) zero fiscal note(s) DHSS 2/21/97

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
CROFT			✓	
ROKEBERG			✓	
PORTER			✓	
GREEN	✓			
JAMES	✓			
BERKOWITZ		✓		
	(2)	(1)	(3)	

CHAIR'S SIGNATURE _____

Robert G. Thompson, M.D., F.A.C.O.G.
Reproductive Surgeon - Society of Reproductive Surgeons
Diplomate - American Board of Obstetrics and Gynecology
Catherine A. Thompson, R.N., M.S.N.
Advanced Nurse Practitioner

FAX: (907) 465-2819

March 7, 1997

The Honorable Pete Kott
Representative - State of Alaska
Juneau, Alaska

ATTENTION: George Dozier

Re: House Bill 65
Partial Birth Abortion

Dear Sirs:

I am sending this letter in support of your HB 65 which outlaws "partial birth abortions" as specified in the bill. I've reviewed the bill and the arguments of other physicians, including those of the American College of Obstetrics and Gynecology, Physicians Ad Hoc Coalition for the Truth (PHACT), Doctors Susan Lemagie, Cynthia Brook, and Jan Whitefield.

I feel that the testimony of the PHACT is, in fact, the most accurate with regards to the conflicts and issues expressed by the present forces opposed to the bill; there are procedures that are much safer, including the use of prostaglandin medications.

While the use of prostaglandins takes more time, it stresses the patience of the abortionist, it is imminently more save, and has had more significant peer review, literature, research, and medical data to support its application in appropriate circumstances. The restrictions in House Bill 65 are very specific, and in my opinion, as well as those of the physicians of the PHACT, those specifications do not encompass other abortion procedures as they are currently practiced.

The Honorable Pete Kott:
March 7, 1997

Page Two

Once again, however, with regards to the specifications of the abortion procedure as specified, there are no known situations which have been published or peer reviewed for which this procedure would be necessary, nor is it taught in any obstetric or gynecologic residency program in the United States, to the best of my knowledge and that of the professors and physician members of the PHACT.

In summary: I hope you will continue on your course to ensure passage of this bill. There are far safer procedures when medically indicated that pose less of a threat of infection, retained products of conception, uterine perforation, hemorrhage, or death to the patient.

If I can be of further assistance in clarifying these issues, please contact me at your earliest convenience,.

Thank you.

Sincerely,

MD

Robert G. Thompson, M.D., FACOG
Reproductive Surgeon

League of Women Voters
of Anchorage P.O. Box 101345, Anchorage, Alaska 99510 (907) 274-8477

February 28, 1997

House Judiciary Committee
Chair Joe Green
Juneau, AK 99801-1182

RE: Letter to be entered into the official record for HB 65.

Dear Honorable Representatives:

The League of Women Voters of Anchorage opposes HB 65 and we urge you to defeat it.

The League of Women Voters of Anchorage affirms the constitutional right to privacy. This legislation would be additional government intrusion into the private lives of citizens. The doctor/patient relationship should not include the government. Abortion should be a decision made by a woman with her family, her physician and her God.

By removing the safest and most widely available method of late second trimester abortions our state would be placing undue burden on a woman's right to terminate her pregnancy. In addition, this would be denying women access to quality health care, best determined by the medical community and not government. (We may be forcing a woman to carry a dead or deteriorating fetus to term. Alternative medical procedures have increased risk of infection, infertility or death.)

The League of Women Voters of Anchorage believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices.

Sincerely,

Mary Lou Lawhorn

Mary Lou Lawhorn
President

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY committee name

committee on HB65 PARTIAL BIRTH ABORTIONS bill/subject dated MARCH 5, 1997.

The Partial-birth abortion bill is now before you and you must decide whether this procedure should to continue to be legal in Alaska.

This procedure is not rare and used only to save the life of the mother as we heard President Clinton espouse last year when he vetoed the bill in Congress. We learned just last week that one of foremost proponents of partial birth abortion lied when he testified about how often this atrocity occurs. Can you continue to believe the rhetoric the pro-aborts are putting forth on this matter? They have lost their credibility and it is time to face the bitter truth about how awful and tragic this procedure is for that unborn child.

Just think, minutes before the child would be born, the baby is turned around while still in the uterus so that the feet are born first. Then while those little feet are kicking, scissors are plunged into the back of the child's head and the brain is sucked out, leaving the baby dead. How can this type of procedure possibly be for the benefit of the mother's health? Everyone knows that a breach birth is more difficult and potentially more dangerous so why would anyone take the extra time to turn the baby around just to kill it? Any doctor concerned for the mother would take that baby in the most expeditious manner, probably by cesarean section and not allow the baby to pass through the birth canal.

This brutal procedure must stop. Babies should not be allowed to be slaughtered in this way any longer. Please use your common sense and compassion and make a decision to outlaw this procedure. Thank you.

Thank you.

Signed: Mary J. McNally
Testifier

SELF
Representing (Optional)

608 SAWMILL CK. RD., SITKA, 99835
Address

907-747-3877
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB 65 , dated March 5, 1997.
bill/subject

I strongly urge the House Judiciary committee to support HB65, banning all Partial Birth abortions. This procedure is cruel, barbaric and now is being used as a form of birth control. This is murder and a very cruel form of murder. Do what is morally right and support HB 65 and ban all partial birth abortions.

Thank you.
Stephanie A Vieira

Signed: Stephanie A. Vieira
Testifier

Unborn children
Representing (Optional)

611 Birch St
Address

747 3698
Phone No.

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House Judiciary Committee on HB 65, an act relating to a ban on "Partial Birth Abortions", dated March 5, 1997.

I support HB 65 which would ban partial birth abortions. That any legislation would even be considered which would destroy life at a stage which is acknowledged by the medical profession to be "viable" is beyond comprehension. The term for that is murder, specifically infanticide, and to label it anything else is dishonest.

The entire subject of human life at any stage being controlled by government or laws enacted by humans is in direct opposition to the most fundamental concept of the sacredness of life. Legislatures, composed of human beings do not breathe life and spirit into new beings. That breath of life is reserved to a greater power, as is the end of human life.

Who, in our limited wisdom, will be the final judge of who will be allowed to be born and who will be destroyed? Do you, the House Judiciary Committee, wish to determine that and to take full responsibility for the decision? Next year or next decade will you also determine which of the elderly, terminally ill, infirm, poor or mentally defective will be destroyed?

I strongly believe your authority includes levying taxes, enacting laws to preserve law and order and addressing the well-being and "life, liberty and pursuit of happiness" of the citizens. It does not. I also believe, in any way extend to determining who lives and who dies. To presume that it does displays an arrogance exceeding your job description.

I respect your positions as elected officials and would not wish to make the hard decisions you have to make during each term. I appreciate that the majority of legislators do the job at considerable personal sacrifice and with little personal gain. I urge you to not attempt to involve yourselves in matters which are beyond your jurisdiction.

Signed: Debra Farrell
Testifier

Representing (Optional)

3501 Halibut Pt. Hwy. Sitka, AK 99835
Address

(907) 747-6718
Phone Number

3-6-97

PLEASE ENTER INTO THE RECORD MY TESTIMONY TO THE HOUSE JUDICIARY COMMITTEE ON HB65 DATED March 7, 1997:

My name is Ruth Ewig and I am a mother and an advocate of the Right to Life at all ages including the pre-born babies and the elderly. I completely without any hesitation support HB65, a bill banning the hideous partial birth abortions.

There is something wrong with this picture. We hear on the news of the public outcry to protect laboratory rats, yet the killing of baby humans is not worthy of defense or media coverage. Right now animal rights groups are breaking Alaskan law to protect wolves. This is front page news. What about the baby humans? This month's LIFE magazine features animals that are endangered. What about the endangerment of the value of HUMAN life? Today there was coverage in the newspaper of dogs dying while on the Yukon Quest. Just consider the public outcry if the owner of a Yukon Quest dog decided to jab scissors into the dogs head, and suck out its brains in order to kill it.

Recently in our local newspaper (February 28, 1997) an article reported that an alleged murderer could be found guilty of a double murder because he had killed a woman who was pregnant. If this is the case then what about abortion also being murder?

I am ashamed and embarrassed that the Alaskan Medical Association is opposing the right to life. The newsletter advises members, our medical experts, to oppose HB65 "because [it] interferes with the physician/patient relationship and [will] criminalize activities...engaged by physicians." A physician treating a pregnant woman has TWO patients. Doctors who execute their patients, morally are criminals. Physicians are supposed to save lives and should have led the charge to stop the killing.

Research has proven that these babies in the womb can hear their mother's voice, and other familiar voices. They can feel pain and do feel pain when they are aborted. When the procedure is done you may not hear the screams because their heads are still inside the vagina but the physician and nurses can see the baby struggling as their arms and legs wave around.

It doesn't take a medical degree to realize that human life is being destroyed. The AMA should be advising physicians to refuse to participate in this American holocaust. Since abortion was legalized in 1972, 32,000,000 babies have been killed. In dollar bills we would consider that quite a bit of money.

I would like to express my appreciation to the legislators down there who have the courage to help put our state in a position to lead the nation back to understanding right from wrong. We need gatekeepers like you to help us get off this slippery slope.

Thank you for this opportunity.

SIGNED Ruth Ewig

2325-30th Avenue. Fairbanks, AK 99701

ALASKA STATE LEGISLATURE

PLEASE ENTER INTO THE RECORD MY TESTIMONY TO THE Judiciary
COMMITTEE NAME

COMMITTEE ON HB 65 DATED 3/7/97
BILL/SUBJECT

all abortions are morally and ethically wrong. The partial-birth abortion procedure, however, is a particularly egregious type of abortion not only because it kills a viable unborn baby but because it is potentially very dangerous for the mother.

Consider the dangers inherent in p.b. abortion. A woman's cervix is forcibly dilated over several days, which risks creating an incompetent cervix, the leading cause of premature deliveries. It is also an invitation to infection, a major cause of infertility. A p.b. abortion is essentially a breech birth, sometimes a physician avoid whenever possible. But in this case it is done intentionally at great risk to the mother's uterus. The abortionist then forces scissors through the baby's skull which remains locked just within the

SIGNED Peggy Feeley
TESTIFIER

Interior Right to Life
REPRESENTING (OPTIONAL)

P.O Box 61661 Fairbanks AK 99706
ADDRESS/PHONE NUMBER

479-5902

birth canal - again risking injury to the uterus and laceration of the cervix or lower uterine segment. This could result in immediate and massive bleeding and the threat of shock or even death to the mother.

None of this risk is ever necessary for any reason as many ob/gyn's have verified. If vaginal delivery is not possible, a doctor performs a Caesarean section. But in no case is it necessary to partially deliver an infant through the vagina, and then kill the infant.

Former Surgeon General C. Everett Koop, has testified that the p-6 procedure is never medically necessary for either the mother & certainly not the baby. Women who thought they underwent p-6 abortions for "medically necessary" reasons have been tragically misled. Ron Fitzsimmons, exec. director of the Nat'l Coalition of Abortion Providers, told the N.Y. Times that he lied on ABC's Nightline last week that p-6 abortions are rare.

I am very disappointed that the Alaska State Medical Assn. is opposing HB 65. According to the Jan/Feb 1997 "Heartbeat," the Committee stated it is improper to legislate medical treatment which should be left to good science & appropriate medical care." No abortion, but especially the p-6 abortion is "good science" or "appropriate medical care." In fact, it is perverted & dangerous science.

My name is Anna Scheller and I am a resident of Fairbanks. Thank you for taking the time to read my testimony in support of HB 65, the Ban on Partial Birth Abortion. I urge the legislature to vote in favor of the ban. I believe this issue transcends party lines and even the abortion debate. That a doctor may deliver a baby's body outside the mother, cut a hole in the base of the infant's skull, then vacuum the child's brain out is inhumane and gruesome. If such a procedure were applied to the offspring of animals, the outcry would be great, yet it is done to children who could survive birth. We are a country that fights child abuse, will not buy products if they have been tested on animals, but we will pull a child from it's mother's womb and kill it before it can take a breath. If we will prosper as a state, as a country, we must begin fulfilling our responsibility to protect those who cannot speak out for themselves. Those who believe abortion should not be restricted under any circumstance are blind to the truth of the procedure. I believe to support the HB 65 is the only reasonable course of action for people who seek to protect the quality of life for all people. The reason I must submit this written testimony instead of speaking at a mike is because I have 5 young children who would have to sit with me during the teleconference. My husband and I were concerned that medical testimony in favor of HB 65 would be emotionally terrifying to them.

To those who sponsored this bill, you are courageous. May you continue to fight on behalf of those who cannot defend themselves.

DATE: 9-19-96
PAGE: A22

Partial-Birth Abortion Is Bad Medicine

By NANCY ROMER, PAMELA SMITH, CURTIS R. COOK AND JOSEPH L. DECOOK

The House of Representatives will vote in the next few days on whether to override President Clinton's veto of the Partial Birth Abortion Ban Act. The debate on the subject has been noisy and rancorous. You've heard from the activists. You've heard from the politicians. Now may we speak?

We are the physicians who, on a daily basis, treat pregnant women and their babies. And we can no longer remain silent while abortion activists, the media and even the president of the United States continue to repeat false medical claims about partial-birth abortion. The appalling lack of medical credibility on the side of those defending this procedure has forced us—for the first time in our professional careers—to leave the sidelines in order to provide some sorely needed facts in a debate that has been dominated by anecdote, emotion and media stunts.

Since the debate on this issue began, those whose real agenda is to keep all types of abortion legal—at any stage of pregnancy, for any reason—have waged what can only be called an orchestrated misinformation campaign.

First the National Abortion Federation and other pro-abortion groups claimed the procedure didn't exist. When a paper written by the doctor who invented the procedure was produced, abortion proponents changed their story, claiming the procedure was only done when a women's life was in danger. Then the same doctor, the nation's main practitioner of the technique, was caught—on tape—admitting that 80% of his partial-birth abortions were "purely elective."

Then there was the anesthesia myth. The American public was told that it wasn't the abortion that killed the baby, but the anesthesia administered to the mother before the procedure. This claim was immediately and thoroughly denounced by the American Society of Anesthesiologists, which called the claim "entirely inaccurate." Yet Planned Parenthood and its allies continued to spread the myth, causing needless concern among our pregnant patients who heard the claims and were terrified that epidurals during labor, or anesthesia during needed surgeries, would kill their babies.

The latest baseless statement was made by President Clinton himself when he said that if the mothers who opted for partial-birth abortions had delivered their children naturally, the women's bodies would have been "eviscerated" or "ripped to shreds" and they "could never have another baby."

That claim is totally and completely false. Contrary to what abortion activists would have us believe, partial-birth abortion is never medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility. It seems to have escaped anyone's attention that one of the five women who appeared at Mr. Clinton's veto ceremony had five miscarriages after her partial-birth abortion.

Consider the dangers inherent in partial-birth abortion, which usually occurs after the fifth month of pregnancy. A woman's cervix is forcibly dilated over several days, which risks creating an "incompetent cervix," the leading cause of premature deliveries. It is also an invitation to infection, a major cause of infertility. The abortionist then reaches into the womb to pull a child feet first out of the mother (internal podalic version), but leaves the head inside. Under normal circumstances, physicians avoid breech births whenever possible; in this case, the doctor intentionally creates one—and risks tearing the uterus in the process. He then forces scissors through the base of the baby's skull—which remains lodged just within the birth canal. This is a partially "blind" procedure, done by feel, risking direct scissor injury to the uterus and laceration of the cervix or lower uterine segment, resulting in immediate and massive bleeding and the threat of shock or even death to the mother.

None of this risk is ever necessary for any reason. We and many other doctors across the U.S. regularly treat women whose unborn children suffer the same conditions as those cited by the women who appeared at Mr. Clinton's veto ceremony. Never is the partial-birth procedure necessary. Not for hydrocephaly (excessive cerebrospinal fluid in the head), not for polyhydramnios (an excess of amniotic fluid collecting in the women) and not for trisomy (genetic abnormalities characterized by an extra chromosome). Sometimes, as in the case of hydrocephaly, it is first necessary to drain some of the fluid from the baby's head. And in some cases, when vaginal delivery is not possible, a doctor performs a Caesarean section. But in no case is it necessary to partially deliver an infant through the vagina and then kill the infant.

How telling it is that although Mr. Clinton met with women who claimed to have needed partial-birth abortions on account of these conditions, he has flat-out refused to meet with women who delivered babies with these same conditions, with no damage whatsoever to their health or future fertility!

Former Surgeon General C. Everett Koop was recently asked whether he'd ever operated on children who had any of the disabilities described in this debate. Indeed he had. In fact, one of his patients—"with a huge encephalocele (a sac containing the baby's organs) much bigger than her head"—went on to become the head nurse in his intensive care unit many years later.

Mr. Koop's reaction to the president's veto? "I believe that Mr. Clinton was misled by his medical advisers on what is fact and what is fiction" on the matter, he said. Such a procedure, he added, cannot truthfully be called medically necessary for either the mother or—he scarcely need point out—for the baby.

Considering these medical realities, one can only conclude that the women who thought they underwent partial-birth abortions for "medical" reasons were tragically misled. And those who purport to speak for women don't seem to care.

So whom are you going to believe? The activist-extremists who refuse to allow a little truth to get in the way of their agenda? The politicians who benefit from the activists' political action committees? Or doctors who have the facts?

Dr. Romer is clinical professor of obstetrics and gynecology at Wright State University and chairman of obstetrics and gynecology at Miami Valley Hospital in Ohio. Dr. Smith is director of medical education in the department of obstetrics and gynecology at Chicago's Mt. Sinai Medical Center. Dr. Cook is a specialist in maternal fetal medicine at Butterworth Hospital, Michigan State College of Human Medicine. Dr. DeCook is a fellow of the American College of Obstetricians and Gynecologists. The authors are founding members of the Physicians' Ad Hoc Coalition for Truth, which now has more than 300 members.

TO: H. Jud.
FROM: DEBRA JOSLIN

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB 65
bill/subject
, dated 3/7/97 .

I strongly oppose HB 65 banning certain types of late-term abortions. Not only is the bill poorly worded and could potentially limit many types of abortions, but I don't think think the government's place lies in mandating health care.

Signed: Julie Magnuson
Testifier

Representing (Optional)

Box 6071 Sitka, 99835
Address

907) 747-2667
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name

committee on #37 HB bill/subject, dated 3/6/97.

Please oppose HB 37, Parental Consent for Minor Abortions.

I don't believe the government can mandate health / medical procedures, nor is it the government's role to mandate communication.

Please oppose HB 37.

Signed: Julie Magnuson
Testifier

Representing (Optional)

Box 6071 Sitka, AK. 99835
Address

907) 747-2617
Phone No.

9/86 Legislative Information Office

To The Alaska State Legislature

Please enter into the record my testimony to the **House Judiciary Committee** on **HB 65**, dated March 7, 1997.

Since the 1960's, we've all witnessed a steady decline in the moral standards of our country. Then, with the passage of Roe v Wade, a Pandora's box was literally opened up.

In our quest for "freedom" I believe those individuals who passed Roe v Wade lost their sense of determining right from wrong. Abortion at any stage of pregnancy is repugnant, but this partial birth abortion procedure is beyond belief. We as a nation are being strangled by "Our Freedoms". When will it end?

AFTER reading and or seeing pictures in which that tiny, helpless little human is being yanked out of the safe haven of his or her mother's womb by someone who supposedly has dedicated their life to the healing arts (not the killing arts). Having that "person" - and I use the term loosely - deliver all but that little baby's head and proceeds to cut open the back of the skull with blunt scissors, inserting a device that literally sucks out the baby's brain.

Those of you who are not in favor of passing this bill, are you able to sleep at night? If you have children, are you able to look at them and NOT think about how those other precious, tiny innocent victims of partial birth abortions met their demise? If you say that you are unaffected, I feel very sorry for you.

Please take a step in 'righting' a wrong by trying to put the lid back on this Pandora's box by saying **YES** to the passage of this bill.

Sincerely,

Linda G. Smith

Linda G. Smith
P. O. Box 3726
Palmer, Ak 99645
(907) 746-7232

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name

committee on HB65 , dated Mar 7, 1997 .
bill/subject

Partial Birth abortion needs to be renamed partial birth enfanticide - for indeed it is a deliberate, premeditated act of enfanticide. It is an act of murder. And the fact that the baby is kept alive while extricating organs is downright disgusting and barbaric. It's not even civilized! And under the guise of harvesting organs for research, big money is paid. It's about creating another income source for the abortionist, it's about perpetuating the appalling practice of fetal tissue research, a government funded program, it's about saving the abortionist from the embarassment of accidentally delivering a live baby that the saline method of abortion can produce. There is no good reason to ever justify a partial birth act of enfanticide.

Signed: Rebecca L Perry / Rebecca L. Perry
Testifier

Kenai/Soldotna Right to Life
Representing (Optional)

P.O. Box 3623, Soldotna AK 99669
Address

907-260-3887
Phone No.

Susan Lemagie, M.D., F.A.C.O.G
Chariman, ACOG Alaska Section District VIII
425 E. Dahlia, Suite J
Palmer, Alaska 99645
907-745-8379 fax:907-745-0153

9

Thank you for the opportunity to testify on HB65 "an act relating to partial birth abortions."

My name is Susan Lemagie. I am a board certified physician in the private practice of obstetrics and gynecology in Palmer, Alaska, where I have lived and worked for the last 14 years. I am a clinical instructor at the University of Washington and I serve on the State Review Committee for Maternal and Infant Mortality. I am currently Chairman of the Alaska Section of the American College of Obstetrics & Gynecology (ACOG),

Women come to me for help in prenatal care, in delivering their babies, in diagnosing and treating cancer, in surgery related to infertility, in counseling for the stresses of their lives, and in selecting appropriate contraception. I see women with illnesses ranging from sore throats and bladder infections to terminal cancer and AIDS, women in healthy loving families to women in relationships of longstanding verbal abuse and domestic violence. And I see women with unexpected pregnancies, or wanted pregnancies where something is terribly wrong, who desire to terminate their pregnancies.

Partial Birth Abortion is a political term, not a medical term. I am enclosing a statement of policy from the American College of Obstetrics & Gynecology relating to this, that was passed January 12, 1997.

The procedure incorporates standards of care for our field that have been used for centuries, when women would have otherwise died in childbirth.

Intact dilatation and extraction was developed to assist mothers whose fetuses had severe anomalies. Genetic testing, through maternal blood screening tests, ultrasound, or amniocentesis, is used to identify fetuses who are nonviable, that is, fetuses that would die before or shortly after birth. Intact dilatation and extraction allows the mother to avoid the risks of labor, allows better confirmation of the birth defects to improve testing, and enhances parental grieving with an intact fetal body.

While I have never personally seen it done, I have referred women, on occasion, to one of the few centers in the United States where this procedure is available. These were women who were hoping against hope that their babies were normal, that they would be able to give birth to healthy children. After future consultation confirmed the serious abnormalities, and nondirective counseling was performed, they chose to end the pregnancies, and grieved their losses.

Most states, Alaska included, already have limits as to the gestational age at which an elective abortion can be obtained. Alaska's limit is 21 weeks 3 days, well below potential fetal viability. Terminating a pregnancy prior to this limit is a woman's private matter, with physician consultation. She is free to follow her conscience, her morals, and her religious beliefs. Attempting to restrict abortion using any method, at this stage, violates her legal rights in America.

Pregnancy termination at later gestational ages in the vast majority of situations involves attempting to save the life of the baby while preserving the mother's health. Women may develop cancer or heart disease, have strokes, or preeclampsia a disease which is unique to pregnant women. Labor is induced early; if the fetus is viable, resuscitation and neonatal intensive care units are available. Some babies survive this early delivery, some develop permanent handicaps, some die. But no babies survive if the mothers die first.

In some rare cases late in gestation the fetuses are the ones newly identified with the life threatening conditions: they have the wrong number of chromosomes, they have severe cardiac problems, they have tumors, they have no brains or too much fluid on the brain, or they may have already died in utero. Intact dilation and extraction allows delivery of these babies that are nonviable in a manner that may be safest for the mother. She may not have to have a cesarean section for a baby that is dead or will die soon. She will not experience an obstructed labor, or an amniotic fluid embolism with resulting heart and lung problems and bleed to death because her blood has lost the ability to clot.

With any empathy you can get a hint of the agonizing position this mother may be in. Imagine then her horror at being told that she may not receive the best medical care available because the government—or more specifically you, as a legislator—have decided that you understand medicine better than her physician, that you understand her religious beliefs better than she does, that you understand what is best for her and her family. This attitude is profoundly disrespectful to her bodily and spiritual integrity, and to her physician's medical knowledge and professionalism. This is government intrusion into the most private concerns that a woman has.

As the American College of Obstetrics and Gynecology has stated "the intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous." It is very likely that this type of legislation would not survive a court challenge. Please do not waste our taxpayer monies on your personal religious agenda.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name.

committee on HB 65, dated March 5, '97.
bill/subject

The truth is now out. This procedure is not only used to save the lifes of mothers or because of abnormal babies. There should be some way of stopping this killing of babies. What must it do to a mother to participate in directly killing her child? While it might be possible to make folks think an unborn, early term, baby isn't a real baby - with this act we have a child only seconds from birth, a fully formed infant. As one whose give birth I can't imagine the trama of having a baby turned and then killed. At least with the usual trama we forget when we hold that little one.

Signed: Martha Lou Braun
Testifier

Representing (Optional)
Sitka, Alaska
Address
747-3688
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the All House Members
committee name

committee on HB65 / Partial Birth Abortion dated 3/3/97.
bill/subject

It occurs to me that the fetus is going to end if the umbilical cord is attached abortion is still an option.
Do Not Allow Partial Birth, or any other type of Abortions.

Signed: M. A. Laburne M. A. LaBurne
Testifier

Representing (Optional)

Box 6369 Sitka AK 99835
Address

907 747-4850
Phone No.

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF PUBLIC SERVICES

Jan Peterson
Legislative
Information Office
P.O. Box 845
Tok, AK 99780
Phone (907) 883-5020
Fax (907) 883-5021

DATE: ~~Feb~~ March 4, 1997

Please accept the enclosed original(s) of written testimony for the HJUD (HB65) teleconference hearing that was scheduled on 3-4-97.

A copy of this testimony was transmitted to your committee via fax on 3-4-97.

Thank you,

Jan L Yzyana

I support the intent of this bill if it is to ban partial birth abortions. I am very concerned with the wording of line ~~6 & 7~~ 8 & 9 in Section 2 (a). I believe if you want to allow abortions to save the physical life of the mother you need to say just that "... a physical disorder, illness or injury..." does not mean & only mean to save the life of the mother. To me it could ~~be~~ leave the door open to mean episiotomy as an injury or mental deress caused by raising children as an illness.

I would like this language changed to be more specific to include only avoiding physical death.

My name is Ann Cray and I am a mother of four children, two living grandchildren, two grandchildren who have died, and another that is in my daughter-in-law's womb. I have experienced the joy of holding two tiny babies that were born prematurely. Jessie was 2 pounds, two ounces and seven and a half months into gestation when he was delivered by caeserian section. Christian was one pound, one ounce and seven months into gestation when he was delivered.

Have any of you even seen let alone held a two to three pound baby? I have, and one thing I'll never forget is how sweet and precious these perfectly developed babies were, with their tiny little toes and fingers, with their tiny little mouths looking like they were trying to whistle, and their tiny little eyes looking all around.

Have you ever had a three pound baby look at your face and listen to you while you were holding them and talking to them? I have, and I will never forget it. I remember when Christian or Jessie would cry, you could see by their faces that they were crying but you did not hear them because they were so little. There was no sound.

Because of my experience of having watched my tiny grandbabies, there is no doubt in my mind that babies go through alot of pain during partial birth abortions or any abortion for that matter. These babies may have been tiny but they were still human beings with feelings and a need to be cuddled and loved. I was not holding some embryo, some piece of tissue, or fetus but a living baby, a tiny human being.

I wish you could all go to the neo-natal intensive care unit at Providence hospital in Anchorage and see these babies and how tiny and sweet and precious they are. They deserve a chance at life too.

I am asking you to support HB65 and ban partial birth abortions. I know in my heart that if you could only see these babies you would not want them to go through an abortion of any type. They are just so sweet.

Ann Cray

1103 JOHN KALINAS
FBKS. AK 99712
907-488-6821

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB 65 & HB 37, dated 3/5/97
bill/subject

HB 65: I have enjoyed life for over 70 years. I would like to see others enjoy that same privilege. It is time now for all to take responsibility to see this happens for all. I am opposed to partial birth abortions.

HB 37: There are many laws that require parents to be responsible for their minor children. We do not need laws that circumvent any area of parental responsibility to their children. I oppose abortions perfomed on minor without parental consent.

Signed: Francis J. Macken
Testifier

Representing (Optional)

P.O. Box 2095
Address

907-747-7816
Phone No.

9/86 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB65/partial birth abortions dated 3/5/97
bill/subject

Partial birth abortion (p.b.a.) is a commonly used barbaric procedure. I'm not talking about Auschwitz or the past, I'm talking about USA, today. There is NO medical condition of the mother that would call for the fetus to be bodily delivered, stabbed in the back of the head and have its brains sucked out, in order to physically save the life of the mother. There is NO POSSIBLE way a "birth" as barbaric as this would save anyones life. It is just NOT possible.

The truth is: p.b.a does not EVER save the life of the mother.

What COULD save the life of the mother? What you, the legislators + we the people deem "politically correct"?

What COULD save the life of the mother is how we define the boundaries of justice globally and locally. How we care for each other on a small planet called Earth. How we work together to pass just laws which show respect for each other, no matter what side of the fence we sit on. We all need each other.

IF I learn, via the media, that our State says it's OK to kill a child during birth, then should I reason that it must be OK to kill at other times for other reasons?

Would p.b.a. bring justice to our State?

In order to determine what is false, we need to know the TRUTH. For that we must each look inside, beyond our hearts and into our own souls.

We then need to re-establish boundaries of mutual respect, instead of erasing them bill by bill, House by House, Senate by Senate.

Lets support HB65 AND each other.

Signed: Mary A Soltis
Testifier

Representing (Optional)

405 Verstovia Sitka, AK 99835
Address

747-5624
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name

committee on HB 65 bill/subject, dated 3/5/97.

The decision to have or not have an abortion needs to be a decision which a woman makes ~~alone~~ on her own. This is a personal decision which a woman may make with the help of her doctor.

I am opposed to House Bill No. 65 as the decision to have an abortion needs to remain a personal decision.

Signed: Jennifer A. Mason
Testifier

self and Sitkans for Choice
Representing (Optional)

1701 Halibut Point Rd. #5 Sitka, Ak 99835
Address

(907) 747-4897
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House State Affairs Comittee on H.B. 65, an Act Relating to a Ban on Partial Birth Abortions, dated Tuesday, February 18 at 8am.

We have reached a point in our nation where we need to say enough before it is too late to turn back.

The horror of partial birth abortion is nothing less than infanticide (homicide) and a painful homicide at that.

I support H.B. 65 for the good of the future of our great state.

Signed Kathryn L Johnson
Testifier

Representing(Optional)

110 Finn Alley Sitka
Address

907 747-8368
Phone Number

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY
committee name

committee on HB65 / PARTIAL-BIRTH TOP, dated 03-07-97.
bill/subject

IT IS AMAZING THAT SOME MEMBERS OF THE MEDICAL COMMUNITY INSIST THAT EVEN THE D&X PROCEDURE "IS A DECISION BETWEEN THE PATIENT AND HER DOCTOR. PLEASE SUPPORT HB-65 AND MAKE IT VERY DIFFICULT TO OBTAIN D&X IN ALASKA.

IT IS PRESUMPTUOUS TO THINK IT NECESSARY TO KILL [redacted] INFANTS WITH "GENETIC" OR "PHYSICAL" ANOMOLIES — IT MAY BE A GOOD THING THAT SOME DOCTORS ONLY "THINK" THEY ARE GOD.

PLEASE SUPPORT HB-65

THANK YOU.

Signed: Teresa Lundy TERESA LUNDY
Testifier

Representing (Optional)

P.O. BOX 2975 SITKA AK 99835
Address

907-966-2204
Phone No.

9/86 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY
committee name

committee on HB65 / PARTIAL BIRTH ABORTION, dated 03-05-97.
bill/subject

I SUPPORT THE BASIS FOR HB-65. HOWEVER, I ALSO STRONGLY SUGGEST THAT HB-65 BE REVISED AS EXACT INSTRUCTION & INTENT MUST LEAVE NO ROOM FOR ERROR OR QUESTION LATER ON. AT THE LAST TELECONFERENCE IN FEBRUARY, THERE WERE A HANDFUL OF INDIVIDUALS WHO FOUGHT HB-65. HAVE THESE SUPPORTERS OF PARTIAL-BIRTH ABORTION EVEN READ "DILATION & EXTRACTION FOR LATE 2ND TRIMESTER ABORTION" BY MARTIN HASKELL, M.D.? ONE HAS TO WONDER. IF THEY READ HB-65, OR EVEN HAVE A TRUE CONCEPT REGARDING THE NASTY BUSINESS OF THE D&X ABORTION PROCEDURE — WHAT WE ARE STANDING FIRM ON IS ETHICAL INTEGRITY, SOBERNESS OF MIND, AND THE VERY HOPE THAT DR. HASKELL'S INNOVATIVE, NAZI-LIKE ELECTIVE ABORTION PROCEDURE WILL BE EXTREMELLY DIFFICULT TO OBTAIN IN THE STATE OF ALASKA, IF NOT BANNED. ON CBS NEWS LAST WEEK, I HEARD RON FITZSIMMON'S (WHO IS A LEADING PRO-ABORT SPOKESMAN) STATE HE HAD LIED ABOUT THE D&X PROCEDURE. HE STATED IT WAS "NOT RARE", AND WAS DONE ON "HEALTHY FETUSES" AT 5-6 MONTHS GESTATION. HE FIGURED ON "2-3-4000" DONE. ANOTHER RADIO REPORTER HIM KNOWING OF 5000. ASKED WHY HE LIED, HE SIMPLY SAID, "... FOR POLITICAL REASONS." PLEASE REVISE HB-65 USING STRONG LANGUAGE TO PROTECT INFANTS FROM ELECTIVE & CONVENIENT PARTIAL-BIRTH INFANTICIDE.

Signed: Teresa Lundy
Testifier

Representing (Optional)

P.O BOX 2975 SITKA AK 99835
Address

986 907-966-2204
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary on H.B. 65, an Act Relating to a Ban on Partial Birth Abortions, dated Wed. March 5. from 1-4pm

I support H.B. 65 because the procedure used in Partial birth Abortions are detrimental to the woman's physical and mental health. Because a breach birth is so hard on the mother's body every effort is made to turn the baby before birth. If they fail to turn the baby a cesarean section is performed for the *health* of the *mother* and the *life* of the *baby*. Why is our nation *victimizing women* and *torturing* and *killing innocent human babies*? O, yes, I forgot, this is an expensive procedure and some people are getting rich, very rich indeed.

Would you allow this procedure used on your pet cat, dog, horse, or even a rat, or anyone's animal? The human rights activists for animals would be up in arms at the very suggestion. I am asking you to be up in arms for the humane and ethical treatment of women.

Please vote for H.B. 65. Thank You.

Signed Virginia C. Phillips

Testifier

write-4-Life, NAT'L Right TO Life Spokesperson FOR American Indians + ALASKA NATIVES

Representing(Optional)

404 LAKE ST, 2D SITKA, AK 99835

Address

907-747-8024

Phone Number

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name

committee on House Bill 65 Partial Birth Abortions bill/subject, dated March 5, 1997.

It is my belief that partial birth abortion is wrong. I support legislation that would ban this practice. Legislation should include requirements that alternative information be provided to the mother, such as adoption if pregnancy is unwanted. I would support tax dollars being spent to provide more information and services to these mothers.

Signed: Richard M. Sage
Testifier

Representing (Optional)

307 Islander Drive Sitka Ak 99835
Address

907-747-5185
Phone No.

ALASKA STATE LEGISLATURE

PLEASE ENTER INTO THE RECORD MY TESTIMONY TO THE HOUSE JUDICIARY
COMMITTEE NAME

COMMITTEE ON PRIVATE PRISON HOUSE BILL 53 DATED
BILL/SUBJECT

HB 53 IS NOT IN THE BEST INTEREST OF THE PEOPLE OF ALASKA. HB 53 IS PUTTING THE CART BEFORE THE HORSE IN THAT HB 150 WHICH IS PENDING IS THE CORRECT AND FISCALLY RESPONSIBLE SOLUTION. THE FACILITIES CURRENTLY AVAILABLE, FUNCTIONALLY SUPPORT COMMUNITY NEEDS AND SAFETY ISSUES TO THE PUBLIC. YEARS AGO THE FACILITIES WERE BUILT WHICH COULD SERVE INCARCERATION NEEDS AND BE EXPANDED AS NEEDED IN THE FUTURE. WELL THE FUTURE IS UPON US AND THE PLANS SIT IN CABINETS. WHY REINVENT A PLAN SUCH AS HB 53 AND CREATE A FISCAL DEFICIT FOR FUTURE ALASKANS CHILDRENS EDUCATION NEEDS FAR OUTWEIGH A PRIVATE PRISON, AND PUBLIC SAFETY AND TRUST CAN NOT BE EASILY REGAINED ONCE AN ALL DOLLAR AND NO SENSE DECISION IS MADE. THE GRASS IS'NT ALWAYS GREENER WHEN IT COULD IMPACT ON PUBLIC SAFETY. SPRING CREEK AND OTHER PRISONS NEED THE UPGRADES, AND WE NEED TO COMPARE AND CONTRAST THE COST OF SPRING CREEK IMPROVEMENT COSTS BEFORE REINVENTING THE WHEEL.

SIGNED Mark E Crandall
TESTIFIER
COMMUNITY MEMBER
COMMUNITY OF FAIRBANKS
REPRESENTING (OPTIONAL)

2205 TURNER STREET FAIRBANKS AK 99701
ADDRESS/PHONE NUMBER

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name

committee on HB 37 , dated March 4, 1997 .
bill/subject

This nation was founded on freedom and equality for all her citizens. How foolish it seems that we now hold meetings to discuss the fate of the most innocent and purest of our citizens, the unborn. Their blood cries out against us, Hypocrites. The Bible speaks to us telling us to speak out for these who cannot speak for themselves. Our unborn have no voice, no rights, and no freedom. We must speak for them or we forfeit our own rights to speak for ourselves. When one group of citizens takes away the rights of others they will soon lose their own rights. Not since slavery has an issue faced this nation of this magnitude. We must see through the hypocrisy. Once slavery was legal but it did not make it right. The courts have ruled that abortion is legal but again we error. It is time we turn back to our true constitutional rights. I oppose all abortion, and therefore I am against a bill that gives a minor the right to have an abortion without parental consent. Thankyou for hearing this testimony and may God grant us his wisdom in this matter.

Signed: Kelly P. Lundy Kelly P. Lundy
Testifier

Representing (Optional)

205 Vitskari Street Sitka, AK. 99835
Address

907 - 747 - 3746
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on H.B. -37 , dated 3/5/97 .
bill/subject

I wish to express my opinion in favor of the upcomming Parental Consent bill. If a minor can't have their ears pierced or take an aspirin in high school without their parents consent, something as life changing + traumatic as having a abortion should certainly be included. The judge, school or government official would in the majority of cases have childs best interest at stake, more than parents. At a time when the traditional family is under attack, we as people should stand to strengthen it and not pass laws that would lessen its positive influence. I would appreciate your voting in favor of this bill.

Signed: [signature]
Testifier

Self
Representing (Optional)

Bill Weintraub Loop - Sitka
Address

907-747-8881
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Members of The House
committee name

committee on HB 351 , dated 3/3/97
bill/subject

THE FAMILY IS THE CORE UNIT OF THIS GREAT COUNTRY! IT IS THE RESPONSIBILITY OF THE PARENT(S) TO GUIDE THE UNEMANCIPATED MINORS WITHIN THE FAMILY UNIT. IF THE GOVERNMENT TAKES AWAY ANY OF THE RESPONSIBILITIES ASSOCIATED WITH THAT PARENTAL GUIDING POWER, INCLUDING BUT NOT LIMITED TO CHILDREN HAVING SURGERY, THIS CORE UNIT WILL BE DIMINISHED AND THE COUNTRY AS A WHOLE WILL SUFFER.

PLEASE VOTE TO PRESERVE THE FAMILY UNIT. VOTE TO INSURE THAT PARENTAL CONSENT IS NECESSARY FOR MINORS TO HAVE AN ABORTION.

SINCERELY,

MICHAEL LAGUIRE
BOX 6369
SITKA, ALASKA

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Judiciary Committee on House Bill No. 37, dated March 4, 1997.

At this time, I would like to extend my support toward the passing of HB No. 37. I feel that we must expedite the passing of this Bill because of the suffering that Abortion brings not only to the young woman, but their parents and relatives as well. I also believe that the Judges should not have control over a young women's life, they don't care about the lasting affect that such a heinous act produces in the heart of any age women.

Thank you for your considering my testimony.

Marie E. Dimond

Marie E. Dimond
P.O. Box 1101
Sitka, Ak. 99835
(907)747-5621

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Judiciary Committee on House Bill No. 37, dated March 4, 1997.

At this time, I would like to extend my support toward the passing of HB No. 37. I feel that we must expedite the passing of this Bill because of the suffering that Abortion brings not only to the young woman, but their parents and relatives as well. I also believe that the Judges should not have control over a young women's life, they don't care about the lasting affect that such a heinous act produces in the heart of any age women.

Thank you for your considering my testimony.

William E Dimond

William E. Dimond
P.O. Box 1101
Sitka, Ak. 99835
(907)747-5621

ALASKA STATE LEGISLATURE

Please enter into the record my tesimony to the House Judiciary Committee on HB37, an act relating to parental consent before a minor receives an abortion, dated March 5, 1997.

I support HB37, which would require parental consent before a minor obtains an abortion. I consider that a decision as important as whether to seek an abortion one with such serious and long term impact not only on the young woman but also on close family members and the father of the child that it deserves serious consideration and discussion among those most intimately involved.

Even dispensing of headache medication at the local high school requires parental permission! Will not an abortion have more far-reaching effects than a headache?

Please support HB37, helping insure that parents of teens accept their parental role and responsibility and that teens understand that an abortion rates right up there with headaches!

Signed: [signature]
Testifier

Representing (Optional)

3501 Halibut Pt. Hwy. Sitka, AK 99835
Address

(907) 747-6718
Phone Number

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM March 10, 1997

SUBJECT: Effect of Certain Amendments (HB 65)

TO: Representative Ethan Berkowitz
Attn: Patrick

FROM: Terri Lauterbach
Legislative Counsel

You have asked whether the amendments you faxed me would, if added to HB 65, make the bill more defensible if it were challenged in court as being unconstitutional. One amendment would restrict the bill to third trimester abortions, one amendment gives a detailed definition of "partial-birth abortion," and the other amendment adds protection of the health of the pregnant woman as an exception to the prohibition against partial-birth abortions.

There is no doubt that any one of these amendments would help bring HB 65 in line with U.S. Supreme Court decisions on the subject of abortion. All three together would address the three most important constitutional flaws in the bill.

The amendment that would add a detailed definition of "partial-birth abortion" would significantly reduce the chance that the bill would fail because of vagueness in that definition.

The amendment that would restrict the definition of "partial-birth abortion" to those occurring in the "third trimester" would further reduce the vagueness of the definition and would also ensure that the legislature stayed within the constitutional boundaries established by U.S. Supreme Court decisions that allow states to prohibit abortions (with exceptions) or restrict the procedures that may be used for abortions only after the viability of the fetus.

The amendment that would add "health" considerations as an exception to the prohibition of partial-birth abortions would bring the bill in line with the U.S. Supreme Court requirement that abortion prohibitions or restrictions on the procedures that may be used, even after viability, must contain exceptions based not only on preserving the pregnant woman's life but also her health.

The U.S. Supreme Court decisions on which this memo is based are Roe v. Wade, 410 U.S. 113 (1973) and Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), which affirmed the basic trimester framework of Roe. If you need copies of these cases or if I can be of further assistance on this matter, please let me know.

TML:jdr
97-158.jdr

0-LS0246\B
Lauterbach
3/4/97

CS FOR HOUSE BILL NO. 65( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES KOTT, Kohring, Ogan

A BILL

FOR AN ACT ENTITLED

"An Act relating to partial-birth abortions."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** LEGISLATIVE FINDINGS. The legislature finds that

(1) partial-birth abortions are not necessary to preserve the life or health of pregnant women;

(2) partial-birth abortions are potentially more injurious to the health of a pregnant woman than other abortion procedures;

(3) partial-birth abortions are cruel and gruesome;

(4) partial-birth abortions are inherently disrespectful of the dignity that should be accorded human life;

(5) partial-birth abortions tend to blur the distinction between constitutional persons and nonpersons and between infanticide and legal abortions;

(6) partial-birth abortions, because of their gruesome nature and because they incorporate two disparate roles of physicians, the role of healer and the role of abortionist, tend to undermine public confidence in the medical profession; and

(7) the state has a compelling interest in protecting the health of pregnant women, preventing cruelty to human life, protecting the dignity of human life, ensuring public confidence in the medical profession, and maintaining a clear distinction between infanticide and legal abortions.

* **Sec. 2.** AS 18.16 is amended by adding a new section to read:

Sec. 18.16.050. Partial-birth abortions. (a) Notwithstanding compliance with AS 18.16.010, a person may not knowingly perform a partial-birth abortion unless a partial-birth abortion is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury and no other medical procedure would suffice for that purpose. Violation of this subsection is a class C felony.

(b) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section.

(c) In this section, "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

AMENDMENT

CROFT

OFFERED IN HOUSE JUDICIARY

TO: CS HB 65 ( ) work draft dated 3/4/97

Page 2, line 8 following "save the life":

Insert "or health"

Page 2, line 8 following "mother":

Delete "whose life"

Insert "who"

Alaska State Legislature
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE, CHAIRMAN
MILITARY & VETERANS AFFAIRS, CHAIRMAN
COMMUNITY & REGIONAL AFFAIRS
RESOURCES
INTERNATIONAL TRADE / TOURISM
LEGISLATIVE COUNCIL

INTERIM:
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EAGLE RIVER, AK 99577
PHONE (907) 694-8945
FAX 694-8949

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE (907) 465-3777
FAX (907) 465-2819

SECTIONAL ANALYSIS
HB 65

Section 1: Makes partial-birth abortions illegal, except where necessary to save the life of the mother; exempts the mother from prosecution; defines "partial-birth abortion as the act of partially vaginally delivering a living fetus before killing it and completing the delivery.

Representative Pete Kott

Alaska State Legislature
House of Representatives

COMMITTEE ASSIGNMENTS:

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SPONSOR STATEMENT
HB 65

Partial-birth abortions, which typically occur in late-term pregnancies, involve the following steps: First, the abortionist locates the baby's leg and pulls it into the birth canal; Second, the entire baby is delivered except the head; Third, scissors are inserted into the live baby's head and the hole enlarged; Fourth, a suction catheter is inserted into the hole and the baby's brains are sucked out, thereby collapsing the skull; Finally, the dead baby is completely removed.

In testimony before the US House of Representatives Judiciary Committee, Nurse Shafer described her experience of partial-birth abortions as follows:

> "...His little fingers were clasping together. He was kicking his feet. All the while his little head was still stuck inside. [The doctor takes] a pair of scissors and insert[s] them into the back of the baby's head. Then he opened the scissors up. Then he stuck the high-powered suction tube into the hole and sucked the baby's brains out."

This gruesome and hideous procedure, which but for a few centimeters would be punishable as infanticide, would be outlawed by HB 65, as unworthy of civilized people. Such behavior coarsens our society, undermines people's trust in the medical profession, and blurs the legal distinction between abortion and homicide.

HB 65 makes it a felony for a person to perform a partial-birth abortion, except where necessary to save the life of the mother. While leaving intact the right to all other types of abortion procedures, HB 65 punishes the abortionist but not the mother.

Partial-birth abortions are not something that we need in the State of Alaska. Your support of HB 65 is urged.

Representative Pete Kott

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 65

Revision Date:
Title: "An act relating to partial-birth abortions."

Sponsor: Representative Kott
Requestor: (H) STA

Department Affected: Administration
BRU: Public Defender Agency
Component: Public Defender Agency

COMPONENT SERIAL NO. 1631

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	**	**	**	**	**	**
CAPITAL EXPENDITURES	**	**	**	**	**	**
CHANGE IN REVENUES ( )	**	**	**	**	**	**

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	**	**	**	**	**	**

Estimate of any current year (FY 97) cost: $ **

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill would make performing a "partial-birth abortion" in Alaska a class C felony offense. It creates a new crime, and may result in additional cases and additional work for the Public Defender Agency. Although (presumably) only physicians would be prosecuted and it would be highly unusual for a physician to be a public defender client, other persons could be prosecuted as aiders or abettors. There is even the potential that people who form an agreement to have such an procedure outside the state could be prosecuted under the conspiracy laws. However, without an accurate prediction of the numbers of prosecutions expected, fiscal impact is impossible to quantify.

Prepared by: Barbara K. Brink, Director
Division: Public Defender Agency

Phone: (907) 264-4414
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration

Date: 2/17/97

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Rev: 11/96

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 65

Revision Date:
Title: Relating to partial-birth abortions

Sponsor: Kott
Requestor: House State Affairs

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Division assumes that a partial-birth abortion refers to a third trimester abortion of a viable fetus, and therefore does not believe this bill would have any affect on the cost of abortions for the Medicaid and General Relief Medical Assistance Programs. There would be no way to identify a partial-birth abortion procedure on a medical claim form, but the division believes that facilities in Alaska, and those out-of-state facilities commonly used by Alaskans, do not perform third trimester abortions.

Prepared by: Nancy Weller
Division: Medical Assistance
Phone: 465-3355
Date: 01/16/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/5/97

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For further distribution information, call the Governor's Legislative Office

Alaska Perinatology Associates

February 17, 1997

FEB 27 1997

Representative Ethan Burkowitz
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Re: Senate Bills #'s 12 & 14

Honorable Representative Ethan Burkowitz:

I would like to take this opportunity to express my concern as a provider of medical services to pregnant women and their fetuses. As a brief introduction, my name is Sherrie Richey, and I am a board-certified Obstetrician/Gynecologist with sub-specialty training in Maternal Fetal Medicine (Perinatology). This sub-specialty deals with high-risk and medically complicated pregnancy, prenatal diagnosis, including high resolution ultrasound to diagnose fetal abnormalities, and intrauterine fetal therapy, such as fetal blood sampling and fetal blood transfusions. As the first, and now one of only three perinatologists in the State of Alaska, I am in a unique position to comment on the effect that Senate Bills 12 & 24, if enacted, would have on health care for women in our state.

My partners and I spend hundred of hours a week attempting to diagnose and treat genetic and structural abnormalities in unborn children. We do this for several reasons: We firmly believe that knowledge of these abnormalities will provide for opportunities to prepare the parents to care for a child with an abnormality, to provide for optimal early newborn care including informing the sub-specialists required to be present at the birth of a child with an abnormality, and in some cases, to perform life-saving intrauterine therapy. Unfortunately, several times a month we have the tragic responsibility of informing a couple that their child has a lethal abnormality, and that there is nothing that we can do to change that outcome. We attempt to provide the best support possible, both medically and emotionally, during this most difficult time.

There is a wealth of scientific data supporting the fact that termination of pregnancy at any gestational age is safer for the mother than being pregnant. In many cases, if the mother's affected fetus is allowed to continue gestation, it will be born only to add the horror of watching the child die in the first few hours of life; often a painful death for the infant, the parents, and the health care providers. From a medical standpoint, it makes no sense to allow a pregnancy to continue, increasing the mother's risk of hemorrhage, pre-eclampsia (toxemia), anemia, and other complications which occur more commonly in later gestation, when a fetus has no chance of living. Additionally, the emotional trauma of carrying a child that will not live, having to endure the comments of well-meaning, but uninformed friends, acquaintances, and even strangers on the street, is no trivial matter.

There are many different methods of terminating a pregnancy, with advantages and disadvantages, indications and complications of each one. Obstetricians/gynecologists are uniquely trained to individualize each patient's case to determine the safest method for her as a individual. It appears that Senate Bill No. 12, banning so-called "partial-birth " abortions, was intended to prohibit a type of pregnancy termination which actually takes place very infrequently in the United States, and one that is virtually always chosen because it is the safest way to terminate a pregnancy complicated by a lethal fetal abnormality or a life threatening maternal medical complication. Specific examples of such cases are available if desired. To deprive even one grieving mother and family of the safest

option available to her in these circumstances is unethical and immoral. I cannot, for this reason support Senate Bill No. 12.

Senate Bill No. 24 would seek to require that the legal parents or guardians of minors give consent prior to abortion. I wish to add my voice to that of The American Academy of Pediatrics, The American Academy of Family Physicians, and the American College of Obstetrics and Gynecology, of which I am a member, opposition to this bill. The majority of teenage women voluntarily seek the counsel of a trusted adult when faced with an unwanted pregnancy. Those who do not generally have experienced violence in their family and fear that it will recur. Others believe that parental knowledge would damage their relationship, escalate conflict of coercion in their family, or subject a vulnerable parent to stress and disappointment. The fact that I have to face as a perinatologist, is that regardless of the law, the vast majority of these young women will terminate their pregnancies, many under desperate circumstances. Enactment of this bill will only ensure that more of them will have the pregnancy terminated at a later gestational age, in an unsterile, unsafe, and unregulated environment, and some will lose their fertility, and even their lives in the process.

All it takes is one telephone call to any of my mentors at the University of Texas Southwestern Medical School in Dallas, several of whom are co-authors of the leading obstetrical textbook "Williams Obstetrics", who will recount the days prior to the legal termination of pregnancy, when wards of women were gravely ill and dying, or rendered incapable of bearing children due to complications of "back-alley" abortions. Regardless of one's personal moral beliefs about abortion, no physician who remembers those days would choose to relive them.

As a physician who spends many of my waking hours fighting to preserve and improve the lives of unborn children and save the lives of women with complicated pregnancies, I must in all good conscience, strongly urge you to oppose these dangerous pieces of legislation, as I believe they will do nothing but jeopardize the lives and well-being of a particularly vulnerable and unfortunate group of women.

Thank you for allowing me to express my professional views on bills no. 12 & 24 and I will be looking forward to talking with you in Washington on March 18th regarding these and other health care issues.

Sincerely,

Sherrie D. Richey MD
Alaska Perinatology Associates

cc: Cynthia Brooke MD
Jan Whitefield MD
Susan Lemagie MD
Ethan Burkowitz MD

Alaska Women's Lobby

P.O. Box 210685 Anchorage 99521
211 Fourth Street Suite 108 Juneau 99801

phone: 907-586-1107
fax: 907-586-1097

POSITION PAPER

HB 65: Partial Birth Abortion

The Alaska Women's Lobby opposes HB 65. It is the wrong thing to do.

First, a few facts as we understand the situation from reviewing literature and talking to health care providers:

1. Late term abortion is used in the late second and third trimesters of pregnancy. It is a rare event: 99% of abortions occur in the first half of pregnancy; only four one hundredths of one percent (0.4%) are performed in the third trimester.

2. Only three doctors in the entire United States, located in California, Colorado and Kansas, are known to offer abortion services during the last three months of pregnancy as a regular part of their practice.

3. Doctors we have talked to tell us they have never met a patient who did not want and was not completely bonded to her baby by the third trimester, nor have they known a health care provider who was not equally concerned about the health of the baby and the mother by the third trimester.

4. There are many circumstances besides the saving of the life of a mother when delivery of a late term pregnancy are indicated. This procedure may be used when a woman's health (but not life) is seriously compromised, where there is a dead fetus with a healthy mother, where there is a healthy fetus in the body of a dead

mother, and when the fetus has been diagnosed with severe disorders. Factors that the doctor must consider when choosing a medical option is such cases are the length of gestation, the patient's previous obstetrical history and current presenting condition, the facilities available and the availability and amenability of various techniques.

5. While there is a broad spectrum of possibilities, specific examples of late term delivery include: the baby has no lungs or no brain and will not be able to survive after birth; early delivery would reduce the risk to the mother of C-section, pre-eclampsia and hypertension; the baby has a proven fatal congenital disorder and the mother has medical problems made worse by pregnancy (e.g. kidney disease, liver disease, breast cancer); or where the baby is normal and extremely premature but the mother is extremely ill and her condition may soon make the baby ill (e.g. malignant hypertension; and juvenile diabetes out of control) - in these situations, labor and delivery may kill the baby or save the baby, and no one can tell ahead of time which course is absolutely best for either baby or mother.

6. This procedure is the safest available for some women. Consider the case of Vikki Stella. At 32 weeks into her much-wanted pregnancy, she learned that her fetus had nine serious disorders. Vikki and her husband, the parents of two children, consulted a series of specialists. None of them could offer any hope. For Vikki, the safest procedure to protect her health and preserve her fertility was this late term procedure. "As a diabetic...this surgery was...safer for me than induced labor or a C-section, since diabetics don't heal as well as other people...I've been told mothers like me all want perfect babies...[My son] wasn't just imperfect - he was incompatible with life. The only thing that was keeping him alive was my body." Because Vikki's procedure preserved her fertility, she and her husband were able to have another child.

Last Fall, Tammy Wats and her husband were elated by the news of her pregnancy. An ultrasound in the seventh month, however, revealed that the fetus was

suffering from a devastating chromosonal disorder and would not live. Knowing that the fetus was going to die, the Watts made the most difficult decision of their lives, and Tammy had the type of procedure that would be banned by this bill. Commenting on her family's tragedy, Tammy said, " Until you've walked a mile in my shoes don't pretend to know what it's like for me. Everybody has a reason for what they have to do. Nobody should be forced into having to make the wrong decision..."

7. Limiting this procedure as proposed will place women's health at risk. Delays that result from having to travel outside the state for necessary treatment exacerbate this problem.

8. Finally, American Medical Association policy adamantly opposes attempts to interfere with the freedom of communication and choice between a physician and patients: "It is the policy of the AMA...to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient... [and] to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients.

Madame Chair, these facts tell us that this rare and proper medical procedure should not be the subject of yet another restrictive law that will have a chilling effect on a physician's exercise of discretion in determining the best course of treatment and that unduly burdens a women's right to choose by unnecessarily compromising her life and health.

As is always the case in this arena, professional judgment and individual considerations must govern actions taken over the broad spectrum of medical possibilities. Families and their physicians, not politicians, must be permitted to make the difficult decisions posed by the rare and heartbreaking circumstances of wanted

pregnancies gone tragically awry.

This bill is unnecessary, may result in harm to Alaskan women and only serves to further polarize concerned Alaskans. For these reasons, the Alaska Women's Lobby strongly opposes HB 65.

Statement of Brenda Pratt Shafer, R.N.

Before the

Subcommittee on the Constitution

Committee on the Judiciary

U.S. House of Representatives

Hearing on The Partial-Birth Abortion Ban Act (HR 1833)

March 21, 1996

Mr. Chairman and honorable members of the Judiciary Committee, I am Brenda Pratt Shafer. I am here before you, at the request of the Committee, to relate to you my experience as an eyewitness to what is now known as the partial-birth abortion procedure.

I am a registered nurse, licensed in the State of Ohio, with 14 years of experience. In 1993, I was employed by Kimberly Quality Care, a nursing agency in Dayton, Ohio. In September, 1993, Kimberly Quality Care asked me to accept assignment at the Women's Medical Center, which is operated by Dr. Martin Haskell. I readily accepted the assignment because I was at that time very pro-choice. I had even told my teenage daughters that if one of them ever got pregnant at a young age, I would make them get an abortion. They disagreed with me on this, and one of them even wrote an essay for a high school class that mentioned how we differed on the issue.

So, because of the strong pro-choice views that I held at that time, I thought this assignment would be no problem for me.

But I was wrong. I stood at a doctor's side as he performed the partial-birth abortion procedure-- and what I saw is branded forever on my mind.

I worked as an assistant nurse at Dr. Haskell's clinic for three days-- September 28, 29, and 30, 1993.

On the first day, we assisted in some first-trimester abortions, which is all I'd expected to be involved in. (I remember that one of the patients was a 15-year-old-girl who was having her third abortion.)

On the second day, I saw Dr. Haskell do a second-trimester procedure that is called a D & E (dilation and evacuation). He used ultrasound to examine the fetus. Then he used forceps to pull apart the baby inside the uterus, bringing it out piece by piece and piece, throwing the pieces in a pan.

Also on the first two days, we inserted laminaria to dilate the cervixes of women who were being prepared for the partial-birth abortions-- those who were past the 20 weeks point, or 4½ months. (Dr. Haskell called this procedure "D & X", for dilation and extraction.) There were six or seven of these women.

On the third day, Dr. Haskell asked me to observe as he performed several of the procedures that are the subject of this hearing. Although I was in that clinic on assignment of the agency, Dr. Haskell was interested in hiring me full time, and I was being given orientation in the entire range of procedures provided at that facility.

I was present for three of these partial-birth procedures. It is the first one that I will describe to you in detail.

The mother was six months pregnant (26½ weeks). A doctor told her that the baby had Down Syndrome and she decided to have an abortion. She came in the first two days to have the laminaria inserted and changed, and she cried the whole time. On the third day she came in to receive the partial-birth procedure.

Dr. Haskell brought the ultrasound in and hooked it up so that he could see the baby. On the ultrasound screen, I could see the heart beating. As Dr. Haskell watched the baby on the ultrasound screen, the baby's heartbeat was clearly visible on the ultrasound screen.

Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms-- everything but the head. The doctor kept the baby's head 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.

I was really completely unprepared for what I was seeing. I almost threw up as I watched the doctor do these things.

Mr. Chairman, I read in the paper that President Clinton says that he is going to veto this bill. If President Clinton had been standing where I was standing at that moment, he would not veto this bill.

Dr. Haskell delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw that baby in a pan, along with the placenta and the instruments he'd used. I saw the baby move in the pan. I asked another nurse and she said it was just "reflexes."

I have been a nurse for a long time and I have seen a lot of death-- people maimed in auto accidents, gunshot wounds, you name it. I have seen surgical procedures of every sort. But in all my professional years, I had never witnessed anything like this.

The woman wanted to see her baby, so they cleaned up the baby and put it in a blanket and handed the baby to her. She cried the whole time, and she kept saying, "I'm so sorry, please forgive me!" I was crying too. I couldn't take it. That baby boy had the most perfect angelic face I have ever seen.

I was present in the room during two more such procedures that day, but I was really in shock. I tried to pretend that I was somewhere else, to not think about what was happening. I just couldn't wait to get out of there. After I left that day, I never went

back. These last two procedures. by the way, involved healthy mothers with healthy babies.

I was very much affected by what I had seen. For a long time, sometimes still, I had nightmares about what I saw in that clinic that day.

That's why, last July. I wrote a letter to Congressman Tony Hall of Dayton, in support of the bill, telling what I had seen. And that led to me being asked to tell others what I 'd seen, just as I am doing here today.

Mr. Chairman, since I wrote that letter to Congressman Tony Hall, I have been subjected to some strange attacks on my credibility, and I would like to address these briefly.

Last July 12. I sat in the audience as the full Judiciary Committee debated this legislation, and I heard Congresswoman Schroeder read a letter from Dr. Haskell to the Judiciary Committee (also dated July 12) in which he said, "I have examined our records and found no evidence of a Brenda Shafer working for us during 1993."

Fortunately, I had previously provided the Constitution Subcommittee with the pertinent payroll records from Kimberly Quality Care, including their invoice to Dr. Haskell's clinic. After these documents were circulated, Congresswoman Schroeder withdrew that particular allegation. explaining it away as resulting from confusion over my married name. But it seemed peculiar to me at the time that neither she nor her staff had contacted me. or the subcommittee staff. to request documentation, before she basically called me a liar in front of everybody. But there was much more of that sort of thing to come.

In his July 12 letter. Dr. Haskell said also said that my account was "inaccurate," because "she describes procedures at 26 1/2 weeks and 25 weeks... This is contrary to my own self-imposed and established limit of 24 weeks." But in recent times I've seen an article published in *American Medical News* for July 5, 1993-- just a few months before I worked for him-- in which Dr. Haskell said that he performs the procedure "up until about

25 weeks," which conflicts with his letter to the Judiciary Committee.

Also, in Dr. Haskell's 1992 paper describing the partial-birth procedure, "Dilation and Extraction for Late Second Trimester Abortion," which you have all seen, he wrote, "This author routinely performs this procedure on all patients 20 through 24 weeks LMP [i.e., from last menstrual period] with certain exceptions. The author performs the procedure on selected patients 25 through 26 weeks LMP." Keep in mind that this 26½-week little boy had Down syndrome, so this was a "selected patients" case.

Later, I learned another letter had been produced by Dr. Haskell's operation, dated July 17, this one signed by Christie Gallivan, a nurse. This letter was cited by opponents of the bill before and during the House and Senate floor debates, and was even entered into the *Congressional Record* by Senator Barbara Boxer.

In this letter, Christie Gallivan acknowledged that I had worked at the clinic for three days, but went on to claim that since I was a temporary nurse, I "would not have been present" at such a procedure-- ***or,*** then again, in the alternative, that if I ***did*** see such a procedure, then my memory must be faulty, or else that I must be deliberately "misrepresenting" what I saw.

Well, as I've said from the beginning, although I was assigned by a temporary agency, Dr. Haskell needed another surgical nurse-- I was told that he was having a hard time keeping them-- and he seemed to be interested in hiring me on a permanent basis. He wanted me to observe the procedure.

Christie Gallivan was the surgical nurse and she spent those three days giving me an "orientation," as it says on the Kimberly Quality Care invoice. But what is striking to me is how blatantly inconsistent Nurse Gallivan's letter is, not only with what I saw, but with what Dr. Haskell himself has written and said elsewhere.

Christie Gallivan wrote, "Dr. Haskell does not use ultrasound in the performance of second-trimester procedures." Then she went on, regarding my account, "Therefore, her entire description of her experience with viewing the second-trimester abortion, which

includes Dr. Haskell using the ultrasound while doing this procedure, is clearly questionable."

Yet, in Dr. Haskell's paper explaining how he performs the procedure, he clearly states that the surgical assistant "places an ultrasound probe on the patient's abdomen and scans the fetus, locating the lower extremities." And a little further on, referring to the forceps, he wrote, "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."

So when Christie Gallivan writes that I could not have seen a baby moving, you can evaluate that statement in the light of her other statements on these points on which there is such a clear written record. And, you should notice that she never tries to explain, in this letter, why anyone should believe that these babies supposedly don't move. I've been given a copy of a transcript of the tape-recorded interview with Dr. Haskell conducted by the *American Medical News* in June, 1993-- only three months before my time at his clinic-- in which he explicitly acknowledged that most of these babies are alive when he pulls them out.

On November 17, I testified before the Senate Judiciary Committee. Senator Kennedy asked me why it had been reported, in a nursing newsletter, that I was employed by the National Right to Life Committee. As replied, and I tell you know, I've never been a member of, or a donor to, that organization, and certainly in no sense an employee.

Certainly, since last summer I have cooperated with National Right to Life in their efforts to make my experience more widely known, because I think it's important that people know the truth about this matter. But National Right to Life has not paid me for anything, and nobody else has paid me for anything in connection with this subject either, beyond reimbursing travel and accommodation expenses. By the way, the editor of the nursing newsletter subsequently retracted the erroneous claim.

Most recently, I got a copy of a letter sent to a constituent by Congresswoman Lynn Rivers of Michigan, written in longhand, in which this distinguished member of

Congress claimed that I "was unwilling to testify under oath or submit herself to cross-examination in front of Congress-- even though she was sitting in the hearing room while testimony was being taken."

Of course, Mr. Chairman, that is all pure fiction. By the time I heard of your bill and wrote my letter to Congressman Hall, on July 9, you had already concluded the hearing on your legislation. I was present for the July 12 markup, and spoke with various members of the committee and the press informally, but of course there was no opportunity for me to formally testify on that occasion, although I certainly would have welcomed the opportunity.

In November, when Senator Hatch invited me to testify before the Senate Judiciary Committee, I accepted immediately and without qualification. During the question period, Senator Kyl asked me if I would be willing to testify to these things under oath and I replied, "Yes, sir, I would. Or under a lie detector or anything else I need to do." [Senate hearing record, p. 63] And I tell you the same thing.

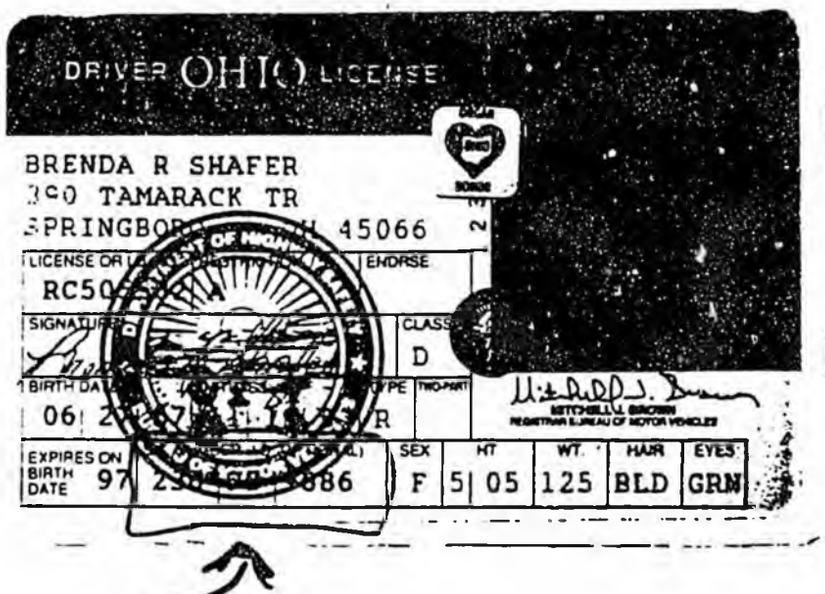
Mr. Chairman, thank you for indulging me in unburdening myself on these points. It is been frustrating to hear, and hear of, these attacks on my truthfulness, and not be able to respond.

It is still amazing to me that certain individuals who hold high elective offices, offices for which I hold great respect, have been so willing to publicly spread this kind of blatant misinformation about me, without making the slightest effort to investigate or look at any of the documentation.

Mr. Chairman, these people who say I didn't see what I saw-- I wish they were right. I wish I hadn't seen it. But I did see it, and I will never be able to forget it. That baby boy was only inches, seconds away from being entirely born, when he was killed. What I saw done to that little boy, and to those other babies, should not be allowed in this country.

Thank you.

Pratt is Brenda Shafer's maiden name. Below are her social security number and RN license number listed on her Ohio driver's license and Ohio Board of Nursing card, respectively. Both numbers are listed on the bill submitted by the nursing agency to Dr. Haskell's clinic. Nurse Shafer worked as an assistant nurse at Dr. Haskell's abortion clinic for three days in September, 1993, an experience she described in a letter to Congressman Tony Hall and in the attached testimony.



OHIO BOARD OF NURSING
77 South High Street, 17th Floor
Columbus, Ohio 43266-0316
614/466-3947

LICENSE

This is to certify that

1993 1997

BRENDA R SHAFER

License Number: RN

SSN:

has met the requirements of the Law Regulating the Practice of Nursing, is duly licensed, and is entitled to practice nursing in OHIO as a REGISTERED NURSE until AUGUST 31, 1997.

KQC Staffing

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INVOICE DATE 10/01/93

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VOUCHERED INVOICE

ACCT.# - 219 002 01735

To ►
WOMENS MED+ CENTER
ATTN: CHRIS
1401 E. STROOP ROAD
DAYTON, OH 45429

REMIT TO
KIMBERLY QUALITY CARE, INC.
P.O. BOX 60410
CHARLOTTE, N.C. 28260

PATIENT NAME WOMENS MED+ CENTER

PLEASE CALL WITH QUESTIONS CONCERNING THIS INVOICE.

	PERFORMED BY	SKILLS	LICENSE NO.	DATE	SHIFT	TIME FROM	TIME TO	NO. OF HOURS	RATE	AMOUNT
1	PRATT, BRENDA	REGNUR		9 29 93	1	1030	1500	4 50	20 00	90 00
2	PRATT, BRENDA	REGNUR		9 29 93	1	930	1730	8 00	20.24 00	160.192 00
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KIMBERLY QUALITY CARE — EMPLOYEE TIME CARD

EMPLOYEE NAME (Last Name, First Name): Pratt, Brenda

SOCIAL SECURITY NO. WRITE CLEARLY: 236-92-[illegible]

LICENSE NO: 21-7060

CLIENT NAME (Last Name, First Name): WMC

CLASSIFICATION CODE - SEE REVERSE: 016

OFFICE USE ONLY (COMPUTER): 1735

DAY	DATE	CIRCLE SHIFT WORKED	AREA WORKED 1 HOSP PVT	2 GEN STAFF	3 ICU/CCU	4 SUP CHG	5 ICU CHG	TIME CARD 7 HOURS BILLED	8 HOURS PAID	9	10	TIMES IN	TIMES OUT	TOTAL HOURS TO BE BILLED AND PAID	CLIENT MUST SIGN EACH DAY
SAT		4 5 6													
SUN		4 5 6													
MON		1 2 3													
TUES	9/28	(1) 2 3		✓								1030	3	4½	orientation
WED	9/29	(1) 2 3		✓								930	5	8	
THUR	9/30	(1) 2 3		✓								930	5	8	
FRI		1													

orientation

EMPLOYEE SIGNATURE: Brenda Pratt RN

GRAND TOTAL HOURS TO BE BILLED AND PAID ➡ 20½

CLIENT MUST SIGN THIS RECEIPT

BILLABLE EXPENSE	TRAVEL - NO BILL	CHECK NUMBER	INSTANT PAY NUMBER
HANDLING CHARGE	PAYROLL DED. AMT	LOCATION	WEEK ENDING

I AGREE TO TOTAL HOURS AND HAVE READ AND AGREE TO TERMS AND CONDITIONS ON REVERSE SIDE

x [signature]

*KQC 691 32815

*** CRITICAL ***

*** CRITICAL ***

PYRG35 10/06/93
PAGE 17
CO/DIV: 219-002

KIMBERLY QUALITY CARE
P A Y R O L L R E G I S T E R
FORMERLY QUALITY CARE, INC.

PERIOD ENDING 10/01/93
PAY DATE 10/08/93

HOURS	CURRENT PERIOD GROSS	CURRENT PERIOD DEDUCTIONS					YEAR TO DATE TOTALS				
TOTAL VACATN	REGULR REIMBRS	GRS PAY	FICA-O	SIT	DIS GARNISH	OTHER	GROSS	FICA-O	SIT	SDI	CHECK#
OVRTIM PERSNL	OVRTIM BONUS	TAX GRS	FICA-M	CIT	MISC		TX GR	FICA-M	CIT	GARNISH	ADJST
SICK	SICK GRS-ADJ		FIT	LIT	ADVANCE		SICK	FIT	LIT	TOT HRS	NET PAY
PRATT, BRENDA		236-92-9686									
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PRATT, BRENDA	236-92-9686	06	H	

PATIENT NAME	HOURS	RATE	M.E DATE	PAYOR
HOMEMS MED+ CENTER	4.50	10.00R		
HOMEMS MED+ CENTER	8.00	16.20R		
HOMEMS MED+ CENTER	8.00	16.20R		

THE WOMEN'S MEDICAL CENTER,
Dayton, July 17, 1995.

DEAR CONGRESSWOMAN SCHROEDER: I am a registered nurse and have worked since July, 1993, in the Dayton office of Dr. Martin Haskell. In this capacity, I was the nurse that supervised the training of Brenda Pratt during her brief temporary employment at the Women's Medical Center of Dayton. As you know, we initially conducted a search of our employment records under the name "Brenda Shafer," as this was the name she signed to the letter which was given to us. When provided with the correct last name, we did in fact find the record of her three-day employment at our Dayton facility.

The information provided by Ms. Pratt as to our practices at the Women's Medical Center of Dayton is largely inaccurate. First, she describes Dr. Haskell performing one 25-week and one 26-week abortion procedure. Dr. Haskell does not perform abortions past 24 weeks of pregnancy. This is a self-imposed limit to which he has scrupulously adhered throughout the time I have worked for him.

Second, Dr. Haskell does not use ultrasound in the performance of second-trimester procedures. We use ultrasound only to determine the pregnancy's gestation. Therefore, her entire description of her experience when viewing a second-trimester abortion, which includes Dr. Haskell's using the ultrasound while doing the procedure, is clearly questionable.

Finally, at no point during a dilatation and extraction or intact D&E is there any fetal movement or response that would indicate awareness, pain or struggle. Ms. Pratt absolutely could not have witnessed fetal movement as she describes. We do not train temporary nurses in second trimester dilatation and extraction, since it is a highly technical procedure and would not be performed by someone in a temporary capacity. If, indeed, Ms. Pratt entered the operating room at any point during D&X procedure, she clearly either is misrepresenting what she saw or remembers it incorrectly.

If you have any further questions, please feel free to contact our office.

Sincerely,

CHRISTIE GALLIVAN, RN.

Rep Jeannette James

As a retired health care professional I believe the issues of abortion should be in the hands of those professionals who deal with the issue on a regular basis rather than by those who may be politically or religiously motivated. In none of the text books that I have ever read is the phrase "partial birth abortion" listed. Abortion is a safe procedure where pre and post counseling and exams are given whether to minors or adults. Inquiry at the time of counseling addresses parental involvement when counseling minors. Please oppose SB24 and HB 37 and 65.

Elinore Jacobsen
225-3395 p
247-3395 fx
2125 Second Ave
Ketchikan

FACT SHEET: PARTIAL-BIRTH ABORTIONS
MEDICALLY NECESSARY?

Those who oppose the Partial Birth Abortion Ban Act (HR 1833) sometimes claim that partial birth abortions are necessary to preserve a mother's health or future ability to have children. The medical evidence to the contrary is overwhelming:

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

--Dr. Harlan 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), Professor Giles said:

> [After 23 weeks], I don't think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent. . . But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt. [transcript, p. 240].
>
> ...
>
> And I cannot think of a fetal condition or malformation, no matter how severe, that actually causes harm or risk to the mother of continuing the pregnancy. I guess one extremely rare example might be a partial hydatidiform mole. But that's a one in a million situation. In most cases mothers [are] carrying an abnormal fetus such as with Down's syndrome, anencephaly, the absence of a brain itself, dwarfism. Other severe even lethal chromosome abnormalities, those mothers if you follow their pregnancy have no higher risk of pregnancy complications than for any other mother who's progressing to term for a delivery. [transcript 241-42]

--Some claim partial birth abortion is needed when a baby suffers from severe hydrocephalus (enlargement of the head due to excess fluid on the brain). But an eminent authority on such

matters, Dr. Watson A. Bowes, Jr., professor of obstetrics and gynecology at the University of North Carolina, and 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.

--Dr. James Jones, chairman of the department of obstetrics and gynecology at the New York Medical College, has stated that he "can't think of any situation where you would have to carry out a specific, direct attack on the fetus." With regard to the partial birth procedure, he said that he "can't imagine that being an indicated procedure for the saving of a life or well-being of the mother." [*Catholic New York*, 5/2/96]

--In an article in the *American Medical News* ["Outlawing abortion method," 11/20/1995], Dr. Warren Hern, late-term abortion provider and author of the nation's most widely used textbook on late-term abortions said of the partial birth procedure: "You really can't defend it. . . . I would dispute any statement that this is the safest procedure to use." He noted that turning the fetus to a breech position is "potentially dangerous," and added: "You have to be concerned about causing amniotic fluid embolism or placental abruption if you do that."

--The American Medical Association's legislative council voted unanimously to recomend that the AMA endorse the Partial Birth Abortion Ban Act. While the entire AMA remained neutral on the act, the council concluded that the procedure is "not a recognized medical technique," "almost does not exist in the medical literature," and is a "basically repulsive" procedure. [*Congress Daily*, 10/10/95, p. 1].

June 1996

AMERICAN MEDICAL NEWS

Published by the AMA

American Medical
NEWS

Published by the American Medical Association/515 North State Street/Chicago, Illinois 60610/(312) 464-5000
Barbara Bolsen, Editor

July 11, 1995

Material on Dr. Martin Haskell

The Hon. Charles T. Canady
Chairman, Subcommittee on the Constitution
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Bldg.
Washington, D.C. 20515-6216

Dear Representative Canady:

We have received your July 7 letter outlining allegations of inaccuracies in a July 5, 1993, story in American Medical News, "Shock-tactic ads target late-term abortion procedure."

You noted that in public testimony before your committee, AMNews is alleged to have quoted physicians out of context. You also noted that one such physician submitted testimony contending that AMNews misrepresented his statements. We appreciate your offer of the opportunity to respond to these accusations, which now are part of the permanent subcommittee record.

AMNews stands behind the accuracy of the report cited in the testimony. The report was complete, fair, and balanced. The comments and positions expressed by those interviewed and quoted were reported accurately and in-context. The report was based on extensive research and interviews with experts on both sides of the abortion debate, including interviews with two physicians who perform the procedure in question.

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

Let me also note that in the two years since publication of our story, neither the organization nor the physician who complained about the report in testimony to your committee has contacted the reporter or any editor 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

Barbara Bolsen
Editor

Attachment

American Medical News transcript - page 1

Relevant portions of recorded interview with Martin Haskell, MD:

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...

IRENE S. LOHKAMP, M.D.
BOARD CERTIFIED IN FAMILY PRACTICE

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February 16, 1997

Regarding: H.B. 65

Dear Representative Kott:

I am a physician in private practice specializing in family medicine. I agree that partial birth abortions should be outlawed in Alaska as stated in Section 18.16.050. This is not the only method available for inducing abortion in the 2nd and 3rd trimester.

As you already know, this procedure is used in late term pregnancy just prior to and beyond gestational age viability.It probably is not successful earlier because the baby's sinews are too delicate to tolerate the traction required to pull the lower extremities and trunk out of the uterus and vaginal canal. The baby is intentionally rotated into breach position, extracted through the birth canal, with the head last remaining within the canal (often forcibly held within) to perform the cranial evacuation that terminates the baby's life functions.

This procedure has met with profound controversy by medical professionals and the general public alike because of its shocking violence and appearance of being infanticide. This procedure is not the sole method of achieving late term abortion. There are other methods available which have been practiced for many years before this procedure was developed. These are as safe, and possibly safer, for the mother. Banning partial birth abortions would still preserve the health of the mother and be protective of her rights.

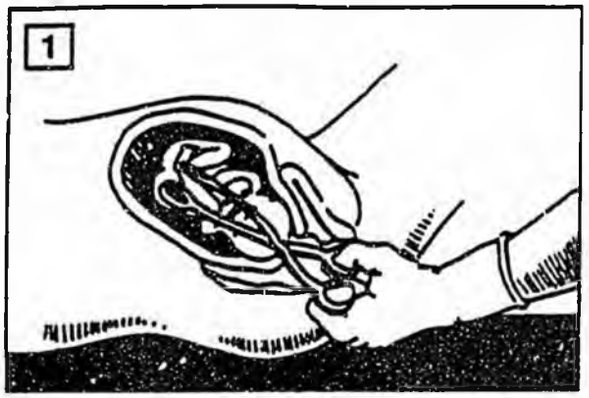
Please sustain a ban on partial birth abortion in Alaska.

Sincerely yours,

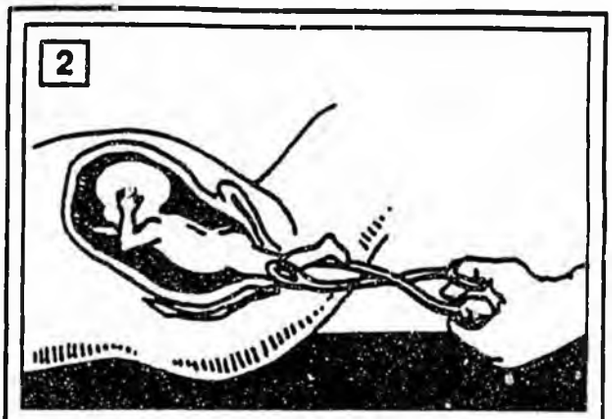
Irene Lohkamp MD

Irene Lohkamp, M.D.

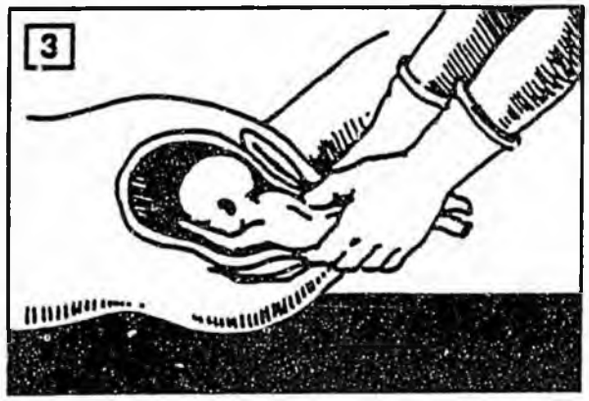
PARTIAL-BIRTH ABORTION



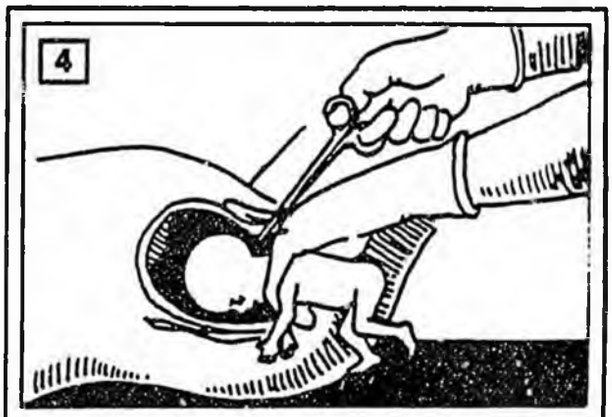
Guided by ultrasound, the abortionist grabs the baby's leg with forceps.



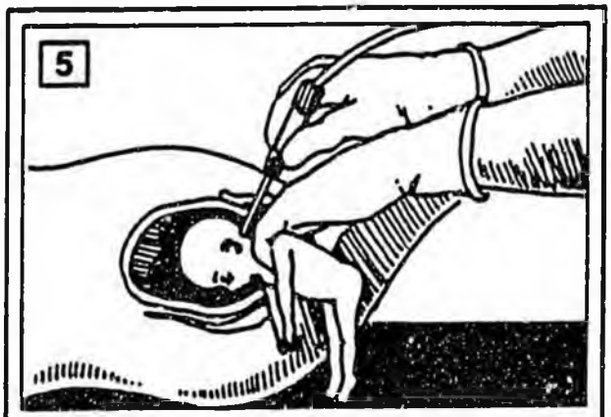
The baby's leg is pulled out into the birth canal.



The abortionist delivers the baby's entire body, except for the head.

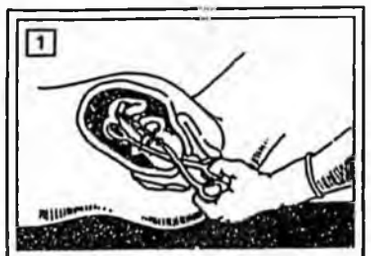


The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

PARTIAL-BIRTH ABORTION



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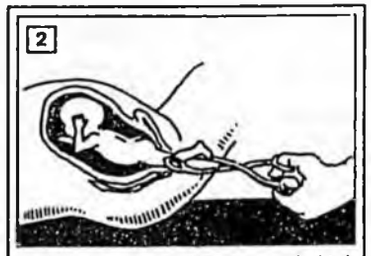

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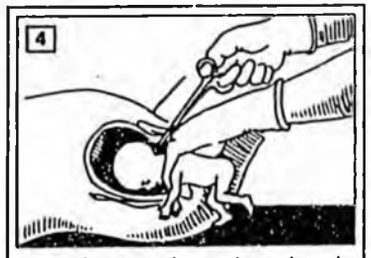

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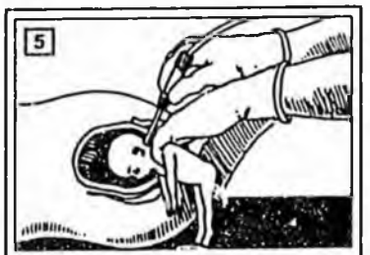

The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

PARTIAL-BIRTH ABORTION— COLD BLOODED KILLING

For the past two years, the National Right to Life Committee has undertaken a major effort to educate Americans about the growing use of an abortion technique called "D&X." D&X is a partial-birth, brain suction abortion procedure and is nothing less than cold-blooded killing. It is used to kill babies between 18 and 39 weeks of gestation.

When this kind of abortion is performed, the abortionist removes all but the head of the living baby from the mother's womb. The back of the baby's head is next stabbed with a pair of scissors. Finally the brains are suctioned out to collapse the head making it easier to remove the now dead baby from the mother's womb.

Two years ago, NRLC distributed over six million brochures that attacked partial-birth brain suction abortion and depicted the brutal D&X method. We were immediately attacked by many pro-abortion groups, including the National Abortion Federation.

In this current legislative session of the 104th Congress, legislation that outlaws brain suction abortion methods will be introduced. It is now being drafted by Representative Charles Canady of Florida. With the strong support of grassroots pro-lifers, NRLC is prayerfully hopeful that a bill prohibiting the killing of a living baby can be passed.

PHACT

Physicians' Ad Hoc Coalition for Truth

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Communications Counsel:
Gene Terns, Michelle Powers

January 29, 1997

Fredric D. Frigoletto, Jr. M.D.
President of the Executive Board.
American College of Obstetricians and Gynecologists

Dear Dr. Frigoletto:

We write to you on behalf of the hundreds of doctors nationwide who are members of the Physicians' Ad hoc Coalition for Truth (PHACT). PHACT was formed to address expertly one issue: partial-birth abortion. While the coalition includes physicians from all medical specialties, the vast majority of its members are obstetricians and gynecologists. Of these, a sizeable number are also Fellows of the American College of Obstetricians and Gynecologists (ACOG).

With this in mind, we are writing to express our surprise and concern over a recent statement issued by ACOG, dated January 12, 1997, on the subject of partial-birth abortion. Surprise, because those of us who are fellows were never informed that ACOG was even investigating this subject, with the goal of issuing a public statement, presumably on behalf of us and the others within ACOG's membership. And concern, because the statement that was issued, by endorsing a practice for which no recognized research data exist, would seem to be violating ACOG's own standards.

Let us address the latter concern -- content -- first.

The statement correctly notes at the outset that the procedure in question is not recognized in the medical literature. The same, it should be noted, can be said of the name you have chosen to call it -- "Intact Dilatation and Extraction," or "Intact D&X" -- and all the other names proponents of this procedure have concocted for it. We have closely followed the issue of partial-birth abortion -- again, it is the *only* issue PHACT addresses -- and the term Intact Dilatation and Extraction is new to us and would appear to be unique to you. The late Dr. James McMahon, until his death a leading provider of partial-birth abortions, called them "Intact Dilation and Evacuation (Intact D&E)" while another provider, Dr. Martin Haskell of Ohio, calls them "Dilation and Extraction (D&X)." Planned Parenthood, for example, calls them D&X abortions, while the National Abortion Federation prefers Intact D&E, so there is no agreement, even among proponents of this procedure, as to what to call it. Indeed, in its January, 1996 newsletter, ACOG then referred to it as "intact dialation (sic) and evacuation." Your new coinage would seem to be a combination of these various "names" floating about, but to what end is not clear. What is clear is that none of these terms, including your own "Intact D&X" can be found in any of the standard medical textbooks or databases.

It is wrong to say, as your statement does, that descriptions, at least the description in last year's Partial-Birth Abortion Ban Act, are "vague" and "could be interpreted to include elements of many recognized" medical techniques. The description in the federal legislation is very precise as to what is being proscribed and is based on Dr. Haskell's own descriptions. Moreover, the legislation is so worded as to clearly distinguish the procedure being banned from recognized obstetric techniques, and recognized abortion techniques, such as D&E, which would be unaffected by the proposed ban.

By far, however, the most disturbing part of ACOG's statement is the assertion that "An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the mother."

On what possible basis does ACOG make this rather astounding assertion?

Many of our members hold teaching positions or head departments of obstetrics and gynecology or perinatology at universities and medical centers. To our knowledge there are no published peer-reviewed safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure. We can think of no data that could possibly support such an assertion. If ACOG or its "select panel" has such data, we would, as teachers and practicing ob/gyns, certainly like to review it.

The best that your statement does to back this claim is the very vague assertion that "other data show that second trimester transvaginal instrumental abortion is a safe procedure." While this may be true, it is, as surely you must be aware, totally beside the point. Such data may exist regarding, e.g., second trimester D&E abortion, but this is irrelevant to the fact that no similar data, at least to our knowledge, exists with respect to partial-birth abortion (or, as you prefer, "intact D&X" or whatever other medical-sounding coinage supporters of this procedure may use). To include such an assertion that can only refer to second trimester abortion procedures *other* than partial-birth is deceptive and misleading at best.

ACOG clearly recognizes that in no circumstances is partial-birth abortion the only option for women. In other words, ACOG agrees that there are other, *medically recognized*, and standard procedures available to women other than partial-birth abortion. Given ACOG's acceptance of this medical fact, your claim that a totally unrecognized, non-standard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations, simply defies understanding.

If ACOG is truly committed to standing by this claim, then it would appear to be violating its own standards by recommending the use of a procedure for which no peer-reviewed studies or safety data exist.

In contrast, our research of the subject leads us to conclude that there are no obstetrical situations that would necessitate or even favor the medically unrecognized partial-birth abortion procedure as the safest or most appropriate option. Indeed, we have concerns that this procedure may itself pose serious health risks for women.

Ordinarily, we would agree that the intervention of legislative bodies into medical decision making is usually inappropriate. However, when the medical decision making *itself* is inappropriate, and may be putting women at risk by subjecting them to medically unrecognized procedures, then the intervention of a legislative body, such as the U.S. Congress, may be the only way to protect mothers and infants threatened by the partial-birth abortion procedure.

In addition to these concerns over the content of the statement, we are also concerned as to the procedure by which it came to be issued.

As mentioned, the vast majority of PHACT members are specialists and sub-specialists (i.e. perinatologists) in obstetrics and gynecology, and many of these are also fellows of ACOG. After them, our membership consists largely of family practitioners and pediatricians. Former Surgeon General C. Everett Koop, perhaps the nation's leading pediatric surgeon, has been associated with PHACT and his public statements on partial-birth abortion are in agreement with PHACT. Our membership is open to any doctor, regardless of his or her political views on the larger question of abortion rights, precisely because our focus is strictly on the medical realities that relate to this procedure. (In fact, doctors who are pro-choice have publicly stated their opposition, on medical grounds, to the use of this abortion method).

We cannot recall receiving any notification whatsoever that the American College of Obstetricians and Gynecologists was even reviewing the issue of partial-birth abortion toward the end of issuing a statement of policy. We cannot recall ever being informed that ACOG was going to convene a "select panel" to accomplish this. We find it unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations. Those of us who are fellows of ACOG were kept completely in the dark as to what ACOG's leadership was doing in regard to this issue.

In truth, this statement is the product of a panel — whose membership ACOG has not made public — that was working behind closed doors and with no real participation from ACOG's membership itself. In crafting this statement, ACOG simply ignored its own members. There is the danger that in issuing this statement, ACOG is giving the lay public the impression that the statement somehow represents the thinking of its members on this subject. It does not. ACOG members had no knowledge of this statement until it was issued as a *fait accompli.*

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

Sincerely:

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Director, Division of Ob/Gyn
University of South Florida
College of Medicine
FACOG

Curtis Cook, M.D.
Maternal-Fetal Medicine
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PHACT

Physicians' Ad Hoc Coalition for Truth

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Communications Counsel:
Gene Tarne, Michelle Powers

"...They will rip your bodies to shreds and you could never have another baby even though the baby you were carrying couldn't live."
-- President Clinton, as to why partial birth abortion must remain available.

The Physicians' Ad-hoc Coalition for Truth (PHACT) about partial-birth abortion brings together experts in the fields of obstetrics and gynecology, perinatology and fetal and maternal medicine for one purpose: to bring the medical facts to bear on the public policy debate over partial-birth abortion.

As practitioners and teachers of a medical specialty that must, at all times, be responsible for the well-being of two patients -- mother and child -- we feel compelled to take this course of action in order to counter the very widespread and dangerous misstatements, misperceptions and outright distortions surrounding this procedure.

The most serious such distortion is the claim, now endorsed by President Clinton, that a partial-birth abortion can be *medically necessary* to protect the health of a women carrying a child diagnosed with severe genetic disabilities, and to also protect that woman's future fertility and ability to carry other children.

There is no medical basis for such an assertion. Given the many potential risks the procedure entails for the mother, far from ever being medically indicated, partial-birth abortion is actually *counter*-indicated. Far from ever being a medical necessity, partial-birth abortion is not even a procedure recognized by the medical community, including the American College of Obstetricians and Gynecologists. Statements by practitioners of partial-birth abortion indicate that the vast majority of such procedures are elective in nature. There is only one reason to ever consider the partial-birth abortion procedure "necessary:" to ensure the delivery of a dead child rather than a living one.

Because of the dangers posed to women, the distortions regarding the so-called "medical necessity" of partial-birth abortion must not be allowed to stand. Already we have seen the harm done to women by other false statements made by those who defend partial-birth abortions. Proponents of partial-birth abortion have claimed, for example, that the anesthesia given the woman kills the child in her womb even before the procedure begins. Though leading experts in the field of anesthesiology have repeatedly denounced this claim, the media have repeated it often enough to frighten some pregnant women in need of surgery. The medical community's efforts to dispel this lie have gone largely unreported.

As members of the Physicians' Ad-hoc Coalition for Truth (PHACT) about Partial-Birth Abortion, we will take every opportunity presented to correct the misinformation and educate the public as to the medical facts regarding the partial-birth abortion procedure. We ask our fellow professionals in the field of journalism and communications in particular to give these facts the attention they deserve by reporting them in a clear, evenhanded and objective fashion.

7/24/96

PHACT

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Communications Counsel:
Gene Tarne, Michelle Powers

SCIENCE FACT VS. SCIENCE FICTION:

DOCTORS REPORT THE MEDICAL FACTS ABOUT PARTIAL-BIRTH ABORTION

"People deserve to know that the partial-birth abortion is never medically indicated either to save the health of a woman or preserve her future fertility."
-- Dr. Nancy Romer, FACOG, Chairman, Dept. of Obstetrics and Gynecology, Miami Valley Hospital, Ohio

(Following are highlights from a July 24 Congressional Briefing by the Physicians' Ad-hoc Coalition for Truth (PHACT) about partial-birth abortion):

On the Claimed "Medical Necessity" of this Procedure:

"I am insulted to be told that I am tearing women's bodies apart by not doing this procedure. I am not. ...As physicians, we can no longer stand by while abortion advocates, the President of the United States and newspapers and television shows continue to repeat false medical claims to members of Congress and to the public."
-- Dr. Nancy Romer

"This procedure is currently not an accepted medical procedure. A search of medical literature reveals no mention of this procedure and there is no critically evaluated or peer review journal that describes this procedure. ...There is currently also no peer review or accountability of this procedure. It is currently being performed by a physician with no obstetric training in an outpatient facility behind closed doors and no peer review."
-- Dr. Nancy Romer

On Claims that Unborn Children with Certain Disabilities Must be Aborted by the Partial-Birth Method to Preserve Their Mother's Health or Fertility.

In vetoing the Partial-Birth Abortion Ban, President Clinton showcased the stories of 5 women who, he said "had to make a life-saving -- certainly, health saving -- but still tragic decision" to have partial-birth abortions, given the severe disabilities suffered by the children they carried. He said that "their own lives, their health, and in some cases their capacity to have children in the future were in danger" on account of these children. Six weeks later, the President defended the necessity of partial-birth abortion on the grounds that, without it, these women would be "eviscerated," their bodies "ripped...to shreds and you could never have another baby, even though the baby you were carrying couldn't live." The conditions suffered by the aborted children included: hydrocephalus, polyhydramnios, Trisomy 13, and anencephaly.

Responding to these specific claims, medical experts from PHACT made clear:

1. "[T]hese are honest women who were sadly misinformed and whose decision to have a partial birth abortion was based on a great deal of misinformation."
-- Dr. Joseph DeCook

2. "[T]he presence of *fetal disabilities or fetal anomalies* are not a reason to have a termination of pregnancy to preserve the life of the mother."

-- Dr. Curtis Cook

3. Regarding "a *genetic abnormality* where there is an extra chromosome or a *Trisomy*...These abnormalities do not pose a risk to the mother per se, do not require early delivery, and can be safely delivered vaginally by methods that we use on a regular basis."

-- Dr. Curtis Cook

4. Regarding "*hydrocephalus*...excessive cerebral-spinal fluid... that causes a very large-shaped head in proportion to the rest of the body. ...These patients can be safely delivered by cesarean section. They can even be delivered safely vaginally. We can do that by first decompressing some of the fluid around the baby's head. ...Again, the baby can be delivered safely, without a risk to the mother, and without a risk to her fertility."

-- Dr. Curtis Cook

5. Regarding "*polyhydramnios*...an excessive amount of amniotic fluid around the baby. ...They can be delivered vaginally, safely, and in the need for it in such situations, a cesarean section can be performed."

-- Dr. Curtis Cook

On Claims for the "Safety" of the Partial-Birth Abortion Procedure

-- *"[The procedure] sounds like science fiction. It ought to be science fiction!"*

-- *"It is a maverick medical procedure made up by maverick doctors for the purpose of delivering a dead fetus."*

-- Dr. Joseph DeCook

1. "Dilation [forcible opening] of the cervix" -- the first step -- risks creating the condition of "incompetent cervix," which is "the main cause of subsequent infertility." It also risks "infection of the mother" given that the uterus is a "non-sterile environment" exposed by dilation.

-- Dr. Joseph DeCook

2. "Podalic version" -- reaching into the uterus to pull the baby feet first through the cervix -- the second step-- is a very dangerous procedure," "frightening" because of the chance that it might "rupture" or "tear the uterus." This is the "reason this was abandoned 30 or more years ago."

There is also the danger of "perforating the uterus" with the instrument used to grab the baby's leg.

-- Dr. Joseph DeCook

3. The third step of partial-birth abortion --"putting the scissors through the cortical magnum, spread them and out comes the brain" -- is extremely dangerous given that this step exposes "sharp shards of bone," which, if scraped against the uterus, with its "immense blood supply" would cause "deep shock in 3 or 4 minutes" and would "totally pump out [the mother's] blood supply in ten minutes."

-- Dr. Joseph DeCook

PHACT

Physicians' Ad Hoc Coalition for Truth

DATE: July 24, 1996
CONTACT: 703/683-5004

MEDIA ADVISORY

PHYSICIANS' CONGRESSIONAL BRIEFING TODAY IN ADVANCE OF PARTIAL BIRTH ABORTION VETO OVERRIDE

President Clinton has publicly endorsed the medical conclusion that women carrying children diagnosed with certain severe genetic abnormalities have no medical choice but partial birth abortion. He has stated that without partial birth abortion, a mother of such a child risks having her body ripped "to shreds," with the result that "you can never have another baby even though the baby you were carrying couldn't live."

Women who've been in this situation, yet did not have the partial birth abortion, are concerned about the President's medical misstatements and inaccurate claims, which are potentially dangerous to women and their children. These women will also brief Congressional Members.

WHAT: Leading doctors in the fields of obstetrics and perinatology have formed the Physicians' Ad-hoc Coalition for Truth (PHACT) about Partial Birth Abortion. Physicians from the coalition will brief members of Congress on the medical facts regarding the procedure: that partial birth abortion is *never* medically indicated for women, even in cases of severe fetal abnormality; it is not even a procedure recognized by the medical community or the American College of Obstetricians and Gynecologists (ACOG).

WHO: Members from PHACT who will conduct the briefing are **Dr. Curtis Cook**, Maternal Fetal Medicine, Buttersworth Hospital, Michigan State College of Human Medicine; **Dr. Nancy Romer**, fellow ACOG, clinical professor in Dept. of Ob/Gyn at Wright State University School of Medicine, and Chair, Dept of Ob/Gyn of Miami Valley Hospital (both in Dayton, OH); **Dr. Joseph L. DeCook**, Fellow, American College of Obstetricians and Gynecologists, Grand Rapids, MI.

The physicians will be joined by five women who found they were carrying children with conditions incompatible with life outside the womb, such as anacephaly, Trisomy, encephaloceles and body stalk anomaly. None of these women had an abortion, and none suffered serious health consequences or saw their fertility impaired. They will share their personal experiences, and release correspondence to President Clinton seeking a meeting to correct the President's medical misstatements.

Representatives Charles Canady (R-FL), author of the Partial Birth Abortion Ban Act, and **Tom Coburn (R-OK)**, himself a practicing ob/gyn, will host the briefing.

WHEN: Wednesday, July 24, 1996, 2 - 3 p.m

WHERE: Room 2237 Rayburn House Office Building

CONTACT: Gene Tarne or Michelle Powers (703) 683-5004

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The Washington Times

★ THURSDAY, JULY 25, 1996 /

Doctors deny health value of late abortions

By Julia Duin
THE WASHINGTON TIMES

President Clinton is preaching medical nonsense by claiming that a form of late-term abortion protects a mother's health or fertility, three physicians said yesterday.

"So many physicians like myself watch in disbelief as false medical facts about partial-birth abortions get circulated in the public square," Dr. Nancy Romer, a Dayton, Ohio, obstetrician, said at a briefing to announce the founding of the Physicians Ad-hoc Coalition for Truth (Phact).

"In fact," she said, "there's a lot of evidence they may do harm to women."

Phact, to be based in Alexandria, aims to counteract pro-choice claims about partial-birth abortion, in which a doctor delivers an unborn child feet first up to its neck, punctures the skull and sucks out the brain.

She and two Michigan doctors said they were most incensed by the president's claim that such abortions are medically necessary for mothers of deformed children.

Mr. Clinton made this argument in his April 10 veto statement on the Partial Birth Abortion Ban Act. The ceremony featured five women who said they underwent such abortions for health reasons.

"These were honest women who were sadly misinformed," said Dr. Joseph DeCook, a Grand Rapids, Mich., obstetrician. "There is no literature that testifies to the safety of partial-birth abortion. It's a maverick procedure devised by maverick doctors who wish to deliver a dead fetus."

Instead of protecting a woman's fertility, such abortions endanger it by using methods that could lead to an infection, causing sterility, Dr. DeCook said.

He also said that drawing out the child in a breech position "is a very dangerous procedure, and you could tear the uterus." He said a ruptured uterus could cause the mother to bleed to death in 10 minutes.

The puncturing of the child's skull also produces bone shards that could puncture the uterus.

"It sounds like science fiction," Dr. DeCook said. "It's not taught in any residency program in the country."

Joining the doctors were five women who said they elected not to abort when they discovered they were carrying deformed children.

Among them was Whitney Goin, who was with her husband, Bruce. The Orlando, Fla., couple arrived holding their 10-month-old son, Andrew, whom doctors offered to abort when they learned he would be born with several vital organs outside his body.

The child, who cooed and gurgled while Mrs. Goin spoke, has undergone many painful surgeries and eight blood transfusions, she said, as the organs, one by one, have been inserted into his body.

"The worst-case scenarios that were painted by the doctors did not come to fruition, and we are thankful that our son was allowed the opportunity to fight," she said. "My ability to have more children was not affected at all."

The other four women, who have requested a meeting with the president, displayed photos of children who died.

Several said their conditions were similar to those of the women with whom Mr. Clinton spoke.

NANCY G. ROMER, M.D.
1126 South Main Street
Dayton, Ohio 45409
Telephone 222-0297

Douglas Johnson
National Right to Life

May 28, 1996

Dear Mr. Johnson,

This is in reference to our conversation in regards to the 60 Minutes program on late term abortions. Lisa Binns of 60 Minutes called me on Friday April 26 and we spoke for approximately 45 minutes. I made several points in regard to late term abortions:

1. A handicapped fetus is not a threat to the mother's life. Ms. Binns suggested that a fetus with anencephaly has a higher risk of intrauterine death and this presents a risk to the mother. I told her that intrauterine fetal death under any circumstances is not a medical emergency and can be treated in a few days. Once the fetus dies partial birth abortion ban does not apply.

2. If a mother has a serious medical condition what is required is separation of the fetus from the mother not fetal death. This can be accomplished in several ways, either through induction of labor or cesarean section.

3. There are safe alternatives to partial birth abortion. I FAXed her a copy of Dr. Warren Hearn's article where he described his method of second trimester terminations. He injects the fetal heart with digoxin on day two to allow fetal death. On day three he documents fetal death and again now that the fetus is dead the law no longer applies. I can fax this article to you if you do not have it.

While I was out of the country May 1-10 Ms. Binns called to speak to me. I returned her call on May 14. She said she had a quick question. "Do you personally know of any physicians who would electively terminate a healthy fetus in a healthy mother past viability." I answered yes that I personally had a patient that Dr. Haskell had done an abortion on at 26 weeks. She argued that was not really viable and we debated viability. She then asked "Do you personally know of any physician who terminated a healthy fetus in a healthy mother at term?" I said Dr. McMahon had reported terminating babies with cleft lip and cleft palate. She suggested these were not healthy. I said they were not PERFECT but arguably healthy. Then I said " So what your asking is do I personally know of

any physician who has terminated a PERFECT baby in a PERFECT mother at term? The answer is no."

I hope this is of some help to you and apologize for taking so long to respond. If I can be of further help or answer any questions please don't hesitate to call.

Sincerely,

Nancy G. Romer, M.D.

Partial-Birth Abortion: It's the *Only* Correct Term

By Douglas Johnson
NRLC Federal Legislative Director

You may have read in the paper that President Clinton vetoed a bill "outlawing late-term abortions" or "banning a medical procedure called intact dilation and evacuation." But actually, Congress never passed such a bill.

Rather, Congress passed - - and President Clinton vetoed - - a bill to ban partial-birth abortion (unless necessary to save a mother's life). The bill (HR 1833) defines partial-birth abortion, for purpose of the U.S. criminal code, 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]

The bill does *not* contain any reference to the gestational age of the fetus/baby. From available evidence, it appears that the partial-birth abortion method is generally used after 20 weeks (4½ months) - - often much later. However, there are indications that the method at times has been used earlier - - and the bill bans the practice of partial-birth abortion at any point in pregnancy.

The phrase "outlawing late-term abortions" is doubly misleading, because methods of "late-term" abortion, other than the partial-birth method, would be unaffected by HR 1833.

In the interests of objectivity, the press should use the term that Congress has defined as a matter of law - - partial-birth abortion. That is the practice that the press has followed on other controversial issues. For example, most media outlets refer to the 1993 congressional ban on certain "assault weapons," even though manufacturers of such weapons and opponents of the ban use other terminology to refer to some or all of the firearms affected by that legislation.

Some opponents of HR 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 term "intact dilation and evacuation" was invented by the late Dr. James McMahon. When HR 1833 was introduced in June, 1995, the term did not appear in the standard medical textbooks and databases, nor does it appear anywhere in the standard textbook on abortion methods, *Abortion Practice* by Dr. Warren Hern.

It is clearly inaccurate to equate "intact dilation and evacuation" procedures with the abortions banned by HR 1833. In his writings, Dr. McMahon used the term "intact dilation and evacuation" to cover any procedure that resulted in an intact cadaver. This included partial-birth abortion procedures - - but it also included procedures to remove the bodies of babies who had died *natural* deaths in utero, and procedures to remove the bodies of babies who had been *deliberately* killed in utero, neither of which is a partial-birth abortion as defined by the bill.

[The term "*intact* dilation and evacuation" should not be confused with "dilation and evacuation" (D&E), which is a procedure commonly used to perform second-trimester abortions, involving *dismemberment* of the baby *while still in the uterus*. The bill does not apply to this method at all.]

Because "intact dilation and evacuation" is not a standard, clearly defined medical term, the House Judiciary Constitution Subcommittee legal 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."

The term chosen by Congress, partial-birth abortion, 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 1992 instructional paper that touched off the national 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 breech type of delivery.*" [emphasis added]

Dr. Haskell said that he "coined" the term "dilation and extraction" (D&X) to refer to this method of abortion. However, Dr. Haskell also used the same term to apply to procedures to remove babies already dead - - which are not partial-birth abortions. The term "dilation and extraction" does not appear in medical dictionaries.

Some journalists cite the National Abortion Federation (NAF) as "authority" for the assertion that "intact dilation and evacuation" is the "medical" term for the procedure that HR 1833 would ban. NAF is a lobbying organization for abortionists and abortion clinics that pay their dues.

NAF has a history of disseminating blatant misinformation with respect to partial-birth abortions. In a tape-recorded 1993 interview with *American Medical News*, Dr. Haskell specifically rebutted several of the claims that were being made by NAF officials at that time (e.g., NAF falsely claimed that the fetuses are dead *before* being "extracted;" that the procedures were done mainly in extreme medical cases, etc.). Dr. Haskell explained: "Well, I had heard that they were giving that information.... The people that staff the NAF office are not medical people.... Here they're rabid supporters of abortion. They work in the office there. And... some of them have never seen one performed..."

When questioned about Dr. Haskell's recorded remarks, Barbara Radford, at that time the executive director of NAF, "acknowledged that the information her group was quoted as providing was inaccurate," *American Medical News* reported (July 5, 1993).

In summary, it is a strange kind of "objectivity" that sets aside the term for a criminal offense that has been adopted and explicitly defined by the U.S. Congress, and substitutes a non-equivalent, pseudo-medical term promoted by the very special-interest group that would be "regulated" by the legislation.

The Wall Street Journal, 10/14/96

Letters to the Editor

Abortions of Healthy Babies

Alexander Sanger's Oct. 2 Letter to the Editor in response to our Sept. 19 editorial-page article is a perfect example of why we, as doctors, felt the need to establish the Physician's Ad Hoc Coalition for Truth (PHACT) to correct the many medical distortions surrounding the partial-birth abortion procedure.

Mr. Sanger's charge that the term "partial-birth abortion" is "made up" and appears nowhere in the medical literature is equally true of the term he prefers: "intact dilation and evacuation." Contrary to his assertion, this is not the medical term for partial-birth abortion. Rather, it was coined by the late Dr. James McMahon, until his recent death a leading provider of partial-birth abortions. In contrast, another leading partial-birth abortion provider, Dr. Martin Haskell of Ohio, has his own personal name for this technique—"D&X," for "Dilation and Extraction." What both terms have in common is that neither appear in any standard medical textbook, dictionary or database. Neither do they appear in the nation's standard textbook on abortion methods, "Abortion Practice" by Dr. Warren Hern (in fact, Dr. Hern has expressed reservations as to the safety of the procedure that would be banned by H.R. 1833).

Thus, because the term "intact dilation and evacuation" is not a standard medical term, and because Dr. McMahon's idiosyncratic usage of it was so broad as to cover procedures not affected by the language of H.R. 1833 (e.g. removal of children who have died naturally or been killed in utero), it is inappropriate both to use the term in the legislation and to equate so-called "intact D&E" abortion with "partial-births" abortions. In crafting legislation to ban this particular procedure, it was crucial to employ terminology distinguishing it from techniques that are standard in abortion practice. The term "partial birth-abortion" encompasses both legislative and descriptive concerns.

Mr. Sanger asks, "What would they recommend" if the mid-trimester uterus needs emptying? Every medical school and every training program in America would agree that amniocentesis and/or cephalocentesis followed by induction of labor with prostaglandin or pitocin is the accepted Standard of Care—the most physiologic and safest method of mid-trimester delivery. It is by far preferable to partial-birth abortion, a two-and-a-half-day, potentially dangerous procedure unsupported by any safety data in the medical literature.

In fact, we would ask Mr. Sanger to produce evidence of safety or preference for the "intact D&E" procedure over existing and proven safe procedures. ("Intact D&E" should not be confused with "dilation and evacuation" [D&E], a procedure commonly used in second-trimester abortions involving the dismemberment of the fetus in *utero* and which is, of course, unaffected by H.R. 1833).

As to Mr. Sanger's charge that we "irresponsibly advance the argument" that most partial-birth abortions are "purely elective," we do not: Dr. Haskell does. In an interview with American Medical News, Dr. Haskell volunteered the information that of the partial-birth abortions he performs, "80 percent are purely elective." In materials he submitted to Congress, Dr. McMahon included "indications" such as maternal depression, young age of mother, sickle cell trait, and a host of other conditions associated with the birth of perfectly normal infants. No partial-birth abortion is ever medically indicated, and recent investigative reports by the Washington Post and the Bergen (N.J.) Record confirm what PHACT and other supporters of H.R. 1833 have been saying all along: Most partial-birth abortions are performed on healthy mothers with healthy babies.

Finally, Mr. Sanger's assertion that anencephaly and "400 other types of catastrophic anomalies" cannot be detected prior to 20 weeks is categorically false. Many of us make our living detecting just such anomalies in ultrasound examinations performed between 16 and 20 weeks' gestation.

We again stand by our statement that there is no obstetrical situation that requires the willful destruction of a partially delivered baby to protect the life, health or future fertility of a woman.

NANCY G. ROMER, M.D.,
CURTIS R. COOK, M.D.,
PAMELA E. SMITH, M.D.,
JOSEPH L. DECOOK, M.D.
Physicians' Ad Hoc Coalition for Truth
Alexandria, Va.

* * *

Partial-birth abortion is a moral matter of the most obvious kind. The effort to sterilize it with a technical name is itself reprehensible. The demands of morality are most apparent where the order of nature is clearest and hence most clearly demands respect. It may be that morality has a bad name partly because the natural order has been too long obscured by the pretensions of technology. But deified technology is increasingly becoming recognized for the idol that it really is, and nowhere can the frustrated order and intentions of nature—from the Latin *nascor*, "to be born"—be more manifest than in a human birth brutally cut off in its very moment of accomplishment. This is more true, not less, when the name given to the act betrays studied coldness. (Is this not what we elsewhere refer to as being "cold blooded"?) One should be no more surprised at finding an "emotional charge" in the name used here than with the names of those new highly exalted crimes known as "rape" and "incest."

It should also be noted in reply to Mr. Sanger that this discussion is not, in its most important aspect, about the consequences or circumstances of partial-births abortion, although both friends and foes of abortion often speak as if it were. The essential issue here is the intrinsic character of the procedure itself. If nothing can be weighed, judged and named according to its intrinsic character, then nothing can be weighed, judged or named at all.

SEAN D. COLLINS
Professor of Philosophy, Theology and Liberal Arts
Thomas Aquinas College
Santa Paula, Calif.

The Wall Street Journal, Thursday, September 19, 1996, A22

Partial-Birth Abortion Is Bad Medicine

By Nancy Romer, Pamela Smith, Curtis R. Cook and Joseph L. DeCook

The House of Representatives will vote in the next few days on whether to override President Clinton's veto of the Partial Birth Abortion Ban Act. The debate on the subject has been noisy and rancorous. You've heard from the activists. You've heard from the politicians. Now may we speak?

We are the physicians who, on a daily basis, treat pregnant women and their babies. And we can no longer remain silent while abortion activists, the media and even the president of the United States continue to repeat false medical claims about partial-birth abortion. The appalling lack of medical credibility on the side of those defending this procedure has forced us—for the first time in our professional careers—to leave the sidelines in order to provide some sorely needed facts in a debate that has been dominated by anecdote, emotion and media stunts.

Since the debate on this issue began, those whose real agenda is to keep all types of abortion legal—at any stage of pregnancy, for any reason—have waged what can only be called an orchestrated misinformation campaign.

First the National Abortion Federation and other pro-abortion groups claimed the procedure didn't exist. When a paper written by the doctor who invented the procedure was produced, abortion proponents changed their story, claiming the procedure was only done when a women's life was in danger. Then the same doctor, the nation's main practitioner of the technique, was caught—on tape—admitting that 80% of his partial-birth abortions were "purely elective."

Then there was the anesthesia myth. The American public was told that it wasn't the abortion that killed the baby, but the anesthesia administered to the mother before the procedure. This claim was immediately and thoroughly denounced by the American Society of Anesthesiologists, which called the claim "entirely inaccurate." Yet Planned Parenthood and its allies continued to spread the myth, causing needless concern among our pregnant patients who heard the claims and were terrified that epidurals during labor, or anesthesia during needed surgeries, would kill their babies.

The latest baseless statement was made by President Clinton himself when he said that if the mothers who opted for partial-birth abortions had delivered their children naturally, the women's bodies would have been "eviscerated" or "ripped to shreds" and they "could never have another baby."

That claim is totally and completely false. Contrary to what abortion activists would have us believe, partial-birth abortion is *never* medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility. It seems to have escaped anyone's attention that one of the five women who appeared at Mr. Clinton's veto ceremony had five miscarriages after her partial-birth abortion.

Consider the dangers inherent in partial-birth abortion, which usually occurs after the fifth month of pregnancy. A woman's cervix is forcibly dilated over several days, which risks creating an "incompetent cervix," the leading cause of premature deliveries. It is also an invitation to infection, a major cause of infertility. The abortionist then reaches into the womb to pull a child feet first out of the mother (internal podalic version), but leaves the head inside. Under normal circumstances, physicians avoid breech births whenever possible; in this case, the doctor intentionally causes one—and risks tearing the uterus in the process. He then forces scissors through the base of the baby's skull—which remains lodged just within the birth canal. This is a partially "blind" procedure, done by feel, risking direct scissor injury to the uterus and laceration of the cervix or lower uterine segment, resulting in immediate and massive bleeding and the threat of shock or even death to the mother.

None of this risk is ever necessary for any reason. We and many other doctors across the U.S. regularly treat women whose unborn children suffer the same conditions as those cited by the women who appeared at Mr. Clinton's veto ceremony. Never is the partial-birth procedure necessary. Not for hydrocephaly (excessive cerebrospinal fluid in the head), not for polyhydramnios (an excess of amniotic fluid collecting in the women) and not for trisomy (genetic abnormalities characterized by an extra chromosome). Sometimes, as in the case of hydrocephaly, it is first necessary to drain some of the fluid from the baby's head. And in some cases, when vaginal delivery is not possible, a doctor performs a Caesarean section. But in no case is it necessary to partially deliver an infant through the vagina and then kill the infant.

How telling it is that although Mr. Clinton met with women who claimed to have needed partial-birth abortions on account of these conditions, he has flat-out refused to meet with women who delivered babies with these same conditions, with no damage whatsoever to their health or future fertility!

Former Surgeon General C. Everett Koop was recently asked whether he'd ever operated on children who had any of the disabilities described in this debate. Indeed he had. In fact, one of his patients—"with a huge omphalocele (a sac containing the baby's organs) much bigger than her head"—went on to become the head nurse in his intensive care unit many years later.

Mr. Koop's reaction to the president's veto? "I believe that Mr. Clinton was misled by his medical advisers on what is fact and what is fiction" on the matter, he said. Such a procedure, he added, cannot truthfully be called medically necessary for either the mother or—he scarcely need point out—for the baby.

Considering these medical realities, one can only conclude that the women who thought they underwent partial-birth abortions for "medical" reasons were tragically misled. And those who purport to speak for women don't seem to care.

So whom are you going to believe? The activist-extremists who refuse to allow a little truth to get in the way of their agenda? The politicians who benefit from the activists' political action committees? Or doctors who have the facts?

Dr. Romer is clinical professor of obstetrics and gynecology at Wright State University and chairman of obstetrics and gynecology at Miami Valley Hospital in Ohio. Dr. Smith is director of medical education in the department of obstetrics and gynecology at Chicago's Mt. Sinai Medical Center. Dr. Cook is a specialist in maternal fetal medicine at Butterworth Hospital, Michigan State College of Human Medicine. Dr. DeCook is a fellow of the American College of Obstetricians and Gynecologists. The authors are founding members of the Physicians' Ad Hoc Coalition for Truth, which now has more than 500 members.

The New York Times, Thursday, September 26, 1996, A27

Why Defend Partial-Birth Abortion?

By C. Everett Koop

HANOVER, N.H.

The debate in Congress about the procedure known as partial-birth abortion reveals deep national uneasiness about abortion 23 years after the Supreme Court legalized it. As usual, each side in the debate shades the statistics and distorts the facts. But in this case, it is the abortion-rights advocates who seem inflexible and rigid.

The Senate is expected to vote today on whether to join the House in overriding President Clinton's veto of a bill last April banning partial-birth abortion. In this procedure, a doctor pulls out the baby's feet first, until the baby's head is lodged in the birth canal. Then, the doctor forces scissors through the base of the baby's skull, suctions out the brain, and crushes the skull to make extraction easier. Even some pro-choice advocates wince at this, as when Senator Daniel Patrick Moynihan termed it "close to infanticide."

The anti-abortion forces often imply that this procedure is usually performed late in the third trimester on fully developed babies. Actually, most partial-birth abortions are performed late in the second trimester, around 26 weeks. Some of these would be viable babies.

Pro-choicers twist the medical facts.

But the misinformation campaign conducted by the advocates of partial-birth abortion is much more misleading. At first, abortion-rights activists claimed this procedure hardly ever took place. When pressed for figures, several pro-abortion groups came up with 500 a year, but later investigations revealed that in New Jersey alone 1,500 partial-birth abortions are performed each year. Obviously, the national annual figure is much higher.

The primary reason given for this procedure — that it is often medically necessary to save the mother's life — is a false claim, though many people, including President Clinton, were misled into believing this. With all that modern medicine has to offer, partial-birth abortions are not needed to save the life of the mother, and the procedure's impact on a woman's cervix can put future pregnancies at risk. Recent reports have concluded that a majority of partial-birth abortions are elective, involving a healthy woman and normal fetus.

I'll admit to a personal bias: In my 30 years as a pediatric surgeon, I operated on newborns as tiny as some of these aborted babies, and we corrected congenital defects so they could live long and productive lives.

In their strident effort to protect partial-birth abortion, the pro-choice people remind me of the gun lobby. The gun lobby is so afraid of any effort to limit any guns that it opposes even a ban on assault weapons, though most gun owners think such a ban is justified.

In the same way, the pro-abortion people are so afraid of any limit on abortion that they have twisted the truth to protect partial-birth abortion, even though many pro-choice Americans find it reasonable to ban the procedure. Neither AK-47's nor partial-birth abortions have a place in civil society.

Both sides in the controversy need to straighten out their stance. The pro-life forces have done little to help prevent unwanted pregnancies, even though that is why most abortions are performed. They have also done little to provide for pregnant women in need.

On the other side, the pro-choice forces talk about medical necessity and under-represent abortion's prevalence: each year about 1.5 million babies have been aborted, very few of them for "medical necessity." The current and necessarily graphic debate about partial-birth abortion should remind all of us that what some call a choice, others call a child.

C. Everett Koop was Surgeon General from 1981 to 1989.

Some Second Thoughts on Partial-Birth Abortions

From "A New Look At Late-term Abortion," by syndicated columnist Richard Cohen, September 24, 1996: [In a June, 1995 column] I also was led to believe that these late-term abortions were extremely rare and performed only when the life of the mother was in danger or the fetus irreparably deformed. I was wrong.... my *Washington Post* colleague David Brown looked behind the purported figures and purported rationale for these abortions and found something other than medical crises of one sort or another. After interviewing doctors who performed late-term abortions and surveying the literature, Brown-- a physician himself-- wrote: "These doctors say that while a significant number of their patients have late abortions for medical reasons, many others-- perhaps the majority— do not".... In the latter stages of pregnancy, the word abortion does not quite suffice; we are talking about the killing of the fetus-- and, too often, not for any urgent medical reason....Late-term abortions once seemed to be the choice of women who, really, had no other choice. The facts now are different. If that's the case, then so should be the law.

From a column by Newsweek Senior Editor Jonathan Alter, "The Fight Over Partial-Birth Abortion Illustrates the Practical Limits of Unflinching Principle," October 7, 1996: When the partial-birth-abortion debate took shape last year, pro-choice groups insisted the procedure was extremely rare. The number 500 to 600 was tossed around, with the president and others explaining that it was reserved for heart-wrenching cases involving women whose tests show severely deformed fetuses or whose health was at risk. Not so. When deemed medically appropriate, it is used much more commonly-- perhaps several thousand times a year... The *Washington Post* surveyed physicians and found that most of those patients receiving partial-birth abortions were young, poor, single women without health problems. They simply wanted abortions, and in the second trimester it is sometimes the recommended procedure, though pro-life former surgeon general C. Everett Koop says this type of abortion is never truly medically necessary. If progressives listen raptly to Koop on tobacco, they at least owe him a hearing on obstetrics.

From "Sustaining Partial-Birth Abortion," an editorial in the Wall Street Journal for September 26, 1996: Partial-birth abortion is about pregnancies from the fifth month onward, and as such puts us into a different realm of political, medical and cultural concerns.... When the partial-birth abortion matter first arose in the House, choice advocates such as Planned Parenthood asserted that the procedure-- making an incision or punctured hole in the skull and withdrawing the contents so that the collapsed head can be pulled through the cervix-- was "extremely rare and done only when the woman's life is in danger or in cases of extreme fetal abnormality." That turns out to be untrue. No official records are kept on later-term abortions. But to their credit some newspapers have produced stories on a little-discussed area of the abortion business without the heavy reporter bias that normally attends this subject. Last week Ruth Padawer of the Record newspaper of Bergen County, N.J., reported that a clinic in Englewood said it used the method in about half the 3,000 abortions it did between weeks 20 and 24.... We entirely doubt that most Americans would support abortions past 20 weeks for no better purpose than birth control. Releasing a baby for adoption is always an honored alternative, especially given the disgusting nature of such abortion procedures.

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Partial-Birth Abortions: A Closer Look

By Douglas Johnson
NRLC Federal Legislative Director

September 11, 1996

The final version of the Partial-Birth Abortion Ban Act (HR 1833) was approved by the U.S. Senate by a vote of 54-44 on December 7, 1995, and by the U.S. House of Representatives on March 27, 1996, by a vote of 286-129. On April 10, 1996, President Clinton vetoed the bill. The House is expected to vote on whether to override the veto on or about September 19, 1996. If two-thirds of the House votes to override, the Senate also will vote on whether to override.

Opponents of the bill, including President Clinton and his subordinates, have propagated a number of myths regarding the partial-birth abortion procedure and the bill. These myths include the assertions that partial-birth abortions are very rare and are performed only in extreme circumstances involving serious fetal deformities or threat to the life of the mother; that the bill would jeopardize the lives or health of some women; and that anesthesia given to the mother kills the fetus/baby or renders her pain-free before the procedure is performed. Some of this misinformation -- especially the claim that the procedure is used mostly in cases of severe "fetal deformity" -- has been uncritically adopted as factual by some journalists, columnists, and editorialists.

Yet, these claims are contradicted by the past writings and recorded statements of doctors who have performed thousands of partial-birth abortions, and by other available documentation, including authoritative medical information gathered by the House Judiciary Committee and the Senate Judiciary Committee. This factsheet relies heavily upon such primary sources. For copies of documents cited here, contact the NRLC Federal Legislative Office at (202) 626-8820, fax (202) 347-3668.

Table of Contents

(continued)

PARTIAL-BIRTH ABORTIONS: A CLOSER LOOK, 2

• What is a partial-birth abortion, and what is the Partial-Birth Abortion Ban Act (HR 1833)?

The Partial-Birth Abortion Ban Act (HR 1833) would prohibit performance of a **partial-birth abortion**, except in cases (if there are any) in which the procedure is necessary to save the life of a mother. The complete text of the bill is attached to this factsheet.

The bill 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.

This procedure is generally used ***beginning at*** 20 weeks (4½ months) into pregnancy, and "routinely" to at least 24 weeks (5½ months). It has often been used much later-- even into the ninth month. 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. Martin Haskell of Dayton, Ohio, wrote a paper that described in detail, step-by-step, how to perform the procedure. ["Dilation and Extraction for Late Second Trimester Abortion."] Dr. Haskell is a family practitioner who has performed over 1,000 such procedures in his walk-in abortion clinics. **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 two medical publications, *American Medical News* (the official AMA newspaper) and *Cincinnati Medicine*.** [All are available from NRLC.]

Here is how Dr. Haskell explained a key part of the abortion method:

> With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. The skull lodges at the internal cervical os [the opening to the uterus]. 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 hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down).... [T]he 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.... [T]he 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." ["Dilation and Extraction for Late Second Trimester Abortion," pages 30-31.]

Dr. Haskell also wrote that he "routinely performs this procedure on all patients 20 through 24 weeks LMP [i.e., from 4½ to 5½ months after the last menstrual period] with certain exceptions," 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] He added, "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).

In sworn testimony in an Ohio lawsuit on Nov. 8, 1995, Dr. Haskell 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. [James] McMahon where they internally grab the fetus and rotate it and accomplish-- be ***somewhat equivalent to a breech type of delivery.*** [emphasis added]

Dr. James McMahon, who died in 1995, used essentially the same procedure ***thousands*** of times, and to a much later point in pregnancy-- even into the ninth month. Other abortionists also employ the procedure, as discussed below.

• Aren't "third trimester" abortions rare? At what stage in pregnancy do partial-birth abortions occur? Are these babies "viable"?

It appears that the substantial majority of partial-birth abortions are performed late in the *second* trimester -- that is, before the 27-week mark -- but usually after 20 weeks (4½ months). There is compelling evidence that the overwhelming majority of these pre-week-27 partial-birth abortions are performed for purely "social" reasons.

In an attempt to "filter out" this documentation, many opponents of the bill attempt to narrow the debate to only *third-trimester* partial-birth abortions procedures -- that is, to abortions performed beginning in the 27th week [seventh month] of pregnancy. Some journalists and commentators have readily adopted this "filter." **However, there is really**

no non-ideological justification for adopting this "third trimester" demarcation. It has no basis in the text of the Partial-Birth Abortion Ban Act (HR 1833), which bans partial-birth abortion at *any point* in pregnancy. Nor, contrary to some popular misconceptions, is there any basis in current Supreme Court constitutional doctrine or in neo-natal medical practice for adopting a "third trimester" demarcation.

Under the Supreme Court's doctrine, "viability" is regarded as the constitutionally significant demarcation. In *Planned Parenthood v. Casey* (1992), the Supreme Court explicitly disavowed the "trimester framework" of *Roe v. Wade (1973)*, and reaffirmed that "viability" is (in the Court's view) the constitutionally significant demarcation. "Viability" is the point at which a baby born prematurely can be sustained by good medical assistance. **Currently, many babies are "viable" a full three weeks before the "third trimester." Therefore, most partial-birth abortions kill babies who are already "viable," or who are at most a few days or weeks short of viability.**[1]

(Even at 20 weeks, the baby is seven inches long on average. And, as discussed below, at a March 21 congressional hearing leading medical authorities testified that the baby by this point is very sensitive to painful stimuli.)

At least one partial-birth abortion specialist, the late Dr. James McMahon, regularly performed the procedure *even after* 26 weeks-- even into the ninth month. In 1995, Dr. McMahon submitted to the House Judiciary Constitution Subcommittee a graph and explanation that explicitly showed that he aborted ***healthy*** ("not flawed") babies ***even in the third trimester (after 26 weeks of pregnancy).*** Dr. McMahon's own graph showed, for example, that at 29 or 30 weeks, ***one-fourth*** of the aborted babies had no "flaw" however slight. **Underneath the graph, Dr. McMahon offered this explanation:**

> **After 26 weeks, those pregnancies that are not flawed are still non-elective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications.** [chart and caption reproduced in June 15 hearing record, page 109]

In an interview with Constitution Subcommittee Counsel Keri Harrison, Dr. McMahon

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[1]According to the landmark survey of neonatal units in the National Institute of Child Health and Human Development Neonatal Research Network, conducted in 1987 and 1988 by Dr. Maureen Heck, et al, babies born at 23 weeks had on average a 23% chance of survival, rising to 34% at 24 weeks, and 54% at 25 weeks. See "Very Low Birth Weight Outcomes of the National Institute of Child Health and Human Development Neonatal Network," *Pediatrics*, May 1991.

explained that "pediatric indication" referred to underage mothers, not to any medical condition of the mother or the baby.

- **Is the baby alive when she is pulled feet-first from the womb?**

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 Dr. 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 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. [For further evidence on this issue, see the next section.]

Brenda Pratt Shafer, a registered nurse from Dayton, Ohio, stood at Dr. Haskell's side while he performed three partial-birth abortions in 1993. In testimony before the Senate Judiciary Committee (Nov. 17, 1995), 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 baby was alive and moving as 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.

Under HR 1833, in any case in which a baby dies *before* being partly removed from the uterus -- whether of natural causes or by an action of an abortionist -- the subsequent removal of that baby is *not* a **partial-birth abortion** as defined by the bill.

- **Does anesthesia given to the mother kill the baby?**

Many prominent defenders of partial-birth abortion have publicly 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, 1995, that if you listened to supporters of the ban, "You wouldn't even know that anesthesia ends the life of such a fetus before it comes down the birth canal." NARAL President Kate Michelman said, "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." [KMOX-AM, St. Louis, Nov. 2, 1995]

Likewise, Planned Parenthood distributed to Congress a "fact sheet" signed by Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington, which stated, "The fetus dies of an overdose of anesthesia given to the mother intravenously....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."

However, when this statement was read to Dr. Norig Ellison, the president of the 34,000-member American Society of Anesthesiologists (ASA), he testified, "There is absolutely no basis in scientific fact for that statement....I think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of the fetus is without basis of fact." [Senate Judiciary Committee hearing record J-104-54, Nov. 17, 1995, p. 153]

Subsequently, in attempting to defend their "fetal demise" claims, pro-abortion advocacy groups disseminated new claims that the late Dr. James McMahon had utilized exceptionally massive doses of narcotic anesthesia before performing his abortions, and that these massive doses would indeed kill a fetus. But 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:

> In order to cause fetal demise, it would be necessary to give the mother dangerous and life-threatening doses of anesthesia." [...] 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. [House Judiciary Committee hearing record no. 73, pages 140, 142]

• Since the baby is still alive when "extracted" from the womb, does she feel pain?

Dr. Norig Ellison, president of the American Society of Anesthesiologists (ASA), wrote to the 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 little-to-no analgesia [pain relief] to the fetus. [Senate Judiciary Committee, Nov. 17, 1995 hearing record, page 226]

On March 21, 1996, the House Judiciary Subcommittee on the Constitution conducted a public hearing on "The Effects of Anesthesia During a Partial-Birth Abortion." Four leading experts in the field testified that the fetuses/babies who are old enough to be "candidates" for partial-birth abortion possess the neurological equipment to respond to painful stimuli, whether or not the mother has been anesthetized. Opponents of the bill were unable to produce a single medical witness willing to testify in support of the claims that anesthesia kills the fetus or renders the fetus insensible to pain. [See House Judiciary Committee Hearing Record No. 73, March 21, 1996.)

Dr. Jean A. Wright, associate professor of pediatrics and anesthesia at the Emory University School of Medicine in Atlanta, testified that 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.

Dr. David Birnbach, president-elect of the Society for Obstetric Anesthesia and Perinatology, testified, "Having administered anesthesia for fetal surgery, I know that on occasion we need to administer anesthesia directly to the fetus because even at these early ages the fetus moves away from the pain of the stimulation." [hearing record, page 288]

At a hearing before the same panel on June 15, 1995, Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, testified, "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." [House Judiciary Committee hearing No. 31, June 15, 1995, page 70.]

Prof. Jean Wright concluded, "This procedure, if it were done on an animal in my institution, would not make it through the institutional review process. The animal would be more protected than this child is." [hearing record, page 286]

- **Does the bill contain an exception for life-of-the-mother cases?**

HR 1833 explicitly 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," if "no other medical procedure would suffice for that purpose."

[Some pro-abortion advocacy groups have insisted that exception does not apply to disorders associated with pregnancy, since "pregnancy" per se is not a disorder or disease. House Judiciary Committee Chairman Henry J. Hyde (R-Il.) commented that this reading "is absurdly convoluted, and violates standard principles of statutory construction." In a June 7 letter, even President Clinton has acknowledged that the bill "provides an exception to the ban on this procedure only when a doctor is convinced that a woman's life is at risk."]

Under HR 1833, an abortionist could not be convicted of a violation of the law ***unless the government proved, beyond a reasonable doubt, that the abortion was <u>not</u> 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.)

It is noteworthy that none of the five women who appeared with President Clinton at his April 10 veto ceremony required a partial-birth abortion because of danger to her life. As one of the women, Claudia Crown Ades, said in a tape-recorded April 12 radio interview on WNTM (Mobile, AL):

> "My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary-Dorothy Line and all the other women who were at the White House yesterday. All of our procedures were considered elective." [Complete tape recording available on request.]

[Two of the women said that *if* their babies had died natural deaths within their wombs, it could have placed them at risk. But the removal of a baby who dies a natural death, whether by foot-first extraction or in any other manner, is not an abortion and has nothing to do with the bill. Professor Watson Bowes, Jr., of the University of North Carolina, co-editor of the *Obstetrical and Gynecological Survey*, has stated that weeks would pass between the baby's natural demise and the development of any resulting risk to the mother.]

• What reasons has President Clinton given for vetoing HR 1833?

On December 7, 1995, before the Senate had even voted on final passage of the bill, chief opponent Sen. Barbara Boxer (D-Ca.) took the floor to make an unqualified statement that President Clinton would veto the bill. On December 8, White House Press Secretary Michael McCurry said unequivocally that the President would veto the bill because "it would represent an erosion of a woman's right to choose."

However, when President Clinton next publicly addressed the issue in a February 28 letter to key members of Congress (after a national poll found 71% support for the ban), he took different tone, although the legal bottom line was unchanged. Mr. Clinton wrote of having "studied and prayed about this issue... for many months," of finding the procedure "very disturbing," and of seeking "common ground... that respects the views of those--including myself-- who object to this particular procedure," while defending *Roe v. Wade*. But the "common ground" that Mr. Clinton proposed tracked the language offered by Sen. Boxer on December 7, and endorsed by the National Abortion and Reproductive Rights Action League (NARAL) as a "pro-choice vote." The Boxer/NARAL amendment would have allowed partial-birth abortion to be performed without any limitation whatever until "viability," and also "after viability where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or avert serious adverse health consequences to the woman." (The Senate rejected this gutting amendment.)

The Boxer/Clinton language must be read in the light of *Doe v. Bolton*, the 1973 companion case to *Roe v. Wade*, in which the Supreme Court said that "health" must encompass "all factors-- physical, emotional, psychological, familial and the woman's age-- relevant to the well-being of the patient." Given this expansive definition of "health," adding the word "serious" has no legal effect, since Mr. Clinton proposes to leave entirely up to each abortionist to decide whether "depression" or some other "health" concern is "serious."

In a June 7 letter to leaders of the Southern Baptist Convention, Mr. Clinton said that he favored banning the procedure with an exception for "cases where a woman risks death or serious damage to her health," but not for cases involving "youth" or "emotional stress." But in his formal veto message on the bill, Mr. Clinton referred to a "health" exception as required by *Roe v. Wade*. Mr. Clinton, a former teacher of constitutional law, knows full well that these two positions are inconsistent, because if *Roe/Doe* applies to partial-birth abortions, then even after "viability," the exception must indeed cover "emotional" health.

In his June 7 letter, President Clinton asserted that "the medical community... broadly supports the continued availability of this procedure where a woman's serious health interests are at stake." However, the American Medical Association (AMA) Legislative Council voted *unanimously* to recommend endorsement of the bill, with one member

explaining that the procedure was "not a recognized medical technique." (The full AMA Board of Trustees was divided on the bill and ultimately took "no position.") Of the five medical doctors who serve in Congress, four voted for the bill, including the only family practitioner/gynecologist.

• How often are partial-birth abortions performed?

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. (The Centers for Disease Control reported that in 1993, over *17,000* abortions were performed at *21* weeks and later-- and the CDC acknowledges that the reports that it receives are incomplete.)

No one really knows how many late abortions are done by the partial-birth procedure. The Center for Reproductive Law and Policy told *The New York Times,* "The number of procedures that clearly meet the definition of partial birth abortion is very small, probably only 500 to 1,000 a year." (March 28, 1996) **Even if such figures were accurate, the legislation would be urgently needed. If a new virus swept through neo-natal units and killed 500 or 1,000 premature babies, it would be a top news story -- not dismissed as too "rare" to be of consequence. For each human being at the pointed end of the scissors, a partial-birth abortion is a 100% proposition.**

Moreover, the numbers may be considerably higher-- perhaps thousands per year. Dr. Martin Haskell and the late Dr. James McMahon spent years trying to convince other abortionists of the merits of the procedure -- that was the purpose of Dr. Haskell's 1992 instructional paper (see page 3), which was distributed by the National Abortion Federation, a lobbying group for abortion clinics. For years, Dr. McMahon was director of abortion instruction at the Cedar-Sinai Medical Center in Los Angeles. In addition, he invited other doctors to visit his abortion clinic for a period of days to learn the procedure. Also. *The New York Times* reported on Nov. 6, 1995:

> "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 condition of anonymity. "So do doctors in other cities."

It is not known how many other abortionists have adopted the method, but a few have made themselves known. On March 19, 1996, Dr. William Rashbaum of New York City wrote a letter to Congressman Charles Canady (R-Fl.), stating that he has performed 19,000 late-

term "procedures," and that he has performed the procedure that HR 1833 would ban "routinely since 1979. This procedure is only performed in cases of later gestational age."

In 1995, Dr. Martin Haskell filed a lawsuit challenging a state abortion-regulation law. In that proceeding, two other doctors filed affidavits affirming that they perform the same procedure as Dr. Haskell -- and that's just in Ohio.

• For what reasons are late-term abortions usually performed?

There is no evidence that the reasons for which late-term abortions are performed by the partial-birth abortion method are any different, in general, than the reasons for which late-term abortions are performed by other methods -- and it is well established that the great majority of late-term abortions do not involve any illness of the mother or the baby. They are purely "elective" procedures-- that is, they are performed for purely "social" reasons.

In 1987, the Alan Guttmacher Institute (AGI), an affiliate of the Planned Parenthood Federation of America (PPFA), collected questionnaires from 1,900 women who were at abortion clinics procuring abortions. Of the 1,900, "420 had been pregnant for 16 or more weeks." These 420 women were asked to choose among a menu of reasons why they had not obtained the abortions earlier in their pregnancies. Only two percent (2%) said "a fetal problem was diagnosed late in pregnancy," compared to 71% who responded "did not recognize that she was pregnant or misjudged gestation," 48% who said "found it hard to make arrangements," and 33% who said "was afraid to tell her partner or parents." The report did not indicate that any of the 420 late abortions were performed because of maternal health problems. ["Why Do Women Have Abortions?," *Family Planning Perspectives,* July/August 1988.]

Also illuminating is an 1993 internal memo by Barbara Radford, then the executive director of the National Abortion Federation, a "trade association" for abortion clinics:

> There are many reasons why women have late abortions: life endangerment, fetal indications, *lack of money or health insurance*, *social-psychological crises, lack of knowledge about human reproduction, etc.*" [emphasis added]

Likewise, a June 12, 1995, National Abortion Federation letter 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."

In her article about late-term abortions, based in part on extensive interviews with Dr. McMahon and on direct observation of his practice (*Los Angeles Times Magazine*, January 7, 1990), reporter Karen Tumulty 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.

According to Peggy Jarman, spokeswoman for Dr. George Tiller, who specializes in late-term abortions in Wichita, Kansas:

> About three-fourths of Tiller's late-term patients, Jarman said, are teen-agers who have denied to themselves or their families they were pregnant until it was too late to hide it. [*Kansas City Star*]

• For what reasons are *partial-birth* abortions usually performed?

Some opponents of HR 1833, such as NARAL and the Planned Parenthood Federation of America (PPFA), have persistently disseminated claims that the partial-birth abortion procedure is employed only in cases involving extraordinary threats to the mother or grave fetal disorders. For example, NARAL President Kate Michelman wrote in a Scripps Howard News Service op ed published June 16, 1996, "Late-term abortions are only used under the most compelling of circumstances-- to protect a woman's health or life or because of grave fetal abnormality....nearly all abortions are performed in the first trimester." PPFA said in a press release that the partial-birth abortion procedure is "done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." (Nov. 1, 1995)

However, claims such as these are inconsistent with the writings and recorded statements of the three doctors who are most closely identified with the procedure: Dr. Martin Haskell, Dr. James McMahon, and Dr. David Grundmann.

Reasons for Partial-Birth Abortions: Dr. Martin Haskell

In his 1992 paper, Dr. Martin Haskell, who has performed over 1,000 partial-birth abortions, described the procedure as "a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia." Dr. Haskell, a family practitioner who operates three abortion clinics, 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.

For information on why Dr. Haskell adopted the method, the 1993 interview in *Cincinnati Medicine* is very instructive. Dr. Haskell explained that he had been performing dismemberment abortions (D&Es) to 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 up 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. . . . 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.

In 1993, 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 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.]

Reasons for Partial-Birth Abortions: Dr. James McMahon

The late Dr. James McMahon performed thousands of partial-birth abortions, including the third-trimester abortions performed on the five women who appeared with President Clinton

at his April 10 veto ceremony. Dr. McMahon's general approach is illustrated by this illuminating statement in the July 5, 1993 edition of *American Medical News*:

> "[A]fter 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.'"

In June, 1995, Dr. McMahon submitted to Congress a detailed breakdown of a "series" of over 2,000 of these abortions that he had performed. He classified only 9% (175 cases) as involving "maternal [health] indications," of which the most common was "depression."

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 175 "maternal indication" cases. 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 to the mother.

Of Dr. McMahon's series, another 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders, such as cleft palate and Down Syndrome. In an op ed piece written for the *Los Angeles Times,* Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws" group. She wrote:

> Twenty-four were done for cystic hydroma (a benign lymphatic mass, usually treatable in a child of normal intelligence). Nine were done for cleft lip-palate syndrome (a friend of mine, mother of five, and a colleague who is a pulmonary specialist were born with this problem). Other reasons included cystic fibrosis (my daughter went through high school with a classmate with cystic fibrosis) and duodenal atresia (surgically correctable, but many children with this problem are moderately mentally retarded). Guess they can't enjoy life, can they? In fact, most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting. ["What Constitutes A Quality Life?," *Los Angeles Times*, Aug. 28, 1996]

Over one-third of McMahon's 2,000-abortion "series" involved neither fetal nor maternal health problems, however trivial.

In Dr. McMahon's interviews with *American Medical News* and with Keri Harrison, counsel to the House Judiciary Subcommittee on the Constitution, Dr. McMahon freely acknowledged that he performed **late second trimester** procedures that were "elective" even by *his* definition ("elective" meaning without fetal or maternal medical justification).

After 26 weeks, Dr. McMahon claimed that all of his abortions were "non-elective" -- but his definition of "non-elective" was very expansive. His written submission stated:

> ***"After 26 weeks [six months],*** those pregnancies that are not flawed are still non-elective. 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.]

Reasons for Partial-Birth Abortions: Dr. David Grundmann

Dr. David Grundmann, the medical director for Planned Parenthood of Australia, has written a paper in which he explicitly states that he uses the partial-birth abortion procedure (he calls it "dilatation and extraction") as his "method of choice" for abortions done after 20 weeks (4½ months), and that he performs such abortions for a broad variety of social reasons. [This paper, "Abortion After Twenty Weeks in Clinical Practice: Practical, Ethical and Legal Issues," and associated documentation. is available from NRLC.]

Dr. Grundmann himself described the procedure in a television interview as "essentially a breech delivery where the fetus is delivered feet first and then when the head of the fetus is brought down into the top of the cervical canal. it is decompressed with a puncturing instrument so that it fits through the cervical opening."

In the 1994 paper, Dr. Grundmann listed several "advantages" of this method, such as that it "can be performed under local and/or twi-light anesthetic" with "no need for narcotic analgesics," "can be performed as an ambulatory out-patient procedure," and there is "no chance of delivering a live fetus." Among the "disadvantages," Dr. Grundmann wrote, is "the aesthetics of the procedure are difficult for some people; and therefore it may be difficult to get staff." (Dr. Grundmann also wrote that "abortion is an integral part of family planning. Theoretically this means abortions at any stage of gestation. Therefore I favor the availability of abortion beyond 20 weeks.")

Dr. Grundmann wrote that in Australia, late-second-trimester abortion is available "in many

major hospitals, in most capital cities and large provincial centres" in cases of "lethal fetal abnormalities" or "gross fetal abnormalities," or "risk to maternal life," including "psychotic/suicidal behavior." **However, Dr. Grundmann said, his Planned Parenthood clinic *also* offers the procedure after 20 weeks for women who fall into five additional "categories": (1) "minor or doubtful fetal abnormalities," (2) "extreme maternal immaturity i.e. girls in the 11 to 14 year age group," (3) women "who do not know they are pregnant," for example because of amenorrhea [irregular menstruation] "in women who are very active such as athletes or those under extreme forms of stress i.e. exam stress, relationship breakup...," (4) "intellectually impaired women, who are unaware of basic biology...," (5) "major life crises or major changes in socio-economic circumstances. The most common example of this is a planned or wanted pregnancy followed by the sudden death or desertion of the partner who is in all probability the bread winner."**

• Is a partial-birth abortion ever the only way to preserve a mother's physical health?

President Clinton and pro-abortion advocacy groups have made strenuous efforts to persuade the public that partial-birth abortions are necessary to protect the lives or health of pregnant women, and many journalists have uncritically accepted this claim at face value. However, these claims are coming under increasingly sharp challenge from prestigious medical experts, and from women who have given birth to babies in circumstances such as those cited by President Clinton.

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

In an interview published in the August 19 edition of *American Medical News,* former Surgeon General C. Everett Koop said, "I believe that Mr. Clinton was misled by his medical advisors on what is fact and what is fiction in reference to late-term abortions. Because in no way can I twist my mind to see that the late-term abortions as described-- you know, partial birth, and then destruction of the unborn child before the head is born-- is a medical necessity for the mother. It certainly can't be a necessity for the baby."

Dr. Koop, a world-renown pediatric surgeon, was asked by the *American Medical News*

reporters whether he had ever "treated children with any of the disabilities cited in this debate? For example, have you operated on children born with organs outside of their bodies?" Dr. Koop replied, "Oh, yes indeed. I've done that many times. The prognosis usually is good. There are two common ways that children are born with organs outside of their body. One is an omphalocele, where the organs are out but still contained in the sac... the first child I ever did, with a huge omphalocele much bigger than her head, went on to develop well and become the head nurse in my intensive care unit many years later."

In addition, in the summer of 1996, an organization called Physicians' Ad Hoc Coalition for Truth (PHACT) began circulating material directly challenging President Clinton's claims. As of early September, PHACT reportedly consisted of over 230 physicians, mostly professors and other specialists in obstetrics, gynecology, and fetal medicine. In an advertisement published in August, the PHACT physicians said:

> Congress, the public-- but most importantly women-- need to know that partial-birth abortion is never medically indicated to protect a mother's health or her future fertility.

The PHACT doctors also referred directly to the specific medical conditions that affected some of the women who appeared with President Clinton at his April 10 veto ceremony, such as hydrocephalus (excessive fluid in the head), and commented:

> We, and many other doctors across the United States, regularly treat women whose unborn children suffer these and other serious conditions. Never is the partial-birth procedure medically indicated. Rather, such infants are regularly and safely delivered live, vaginally, with no threat to the mother's health or fertility.

At a July 24 briefing on Capitol Hill, PHACT member Dr. Curtis Cook, an ob/gyn perinatologist with the West Michigan Perinatal and Genetic Diagnostic Center (616-391-3681), said that partial-birth abortion

> is never necessary to preserve the life or the fertility of the mother, and may in fact threaten her health or well-being or future fertility. In my practice, I see these rare, unusual cases that come to most generalists' offices once in a lifetime-- they all come into our office. We see these every day....The presence of fetal disabilities or fetal anomalies are not a reason to have a termination of pregnancy to preserve the life of the mother-- they do not threaten the life of the mother in any way....[and] where these rare instances do occur, they do not require the death of the baby or the fetus prior to the completion of the delivery.

Also present at the July 24 briefing were several women who, while pregnant, had learned

that their unborn babies were afflicted with conditions similar or identical to those cited by President Clinton, but who gave birth to their babies alive. One of the women, Jeannie French of Oak Park, Illinois, distributed a July 17 letter that she and several other women sent to President Clinton, asking for a meeting so that he could learn about the medical alternatives to partial-birth abortion. Ms. French wrote:

> In recent months, I have had the opportunity to get to know many women who've carried and given birth to children with fatal conditions from anacephaly, encepaloceles, Trisomy 18, hydrocephaly, and even a rare disease called body stalk anomaly, in which internal organs develop outside a baby's body. We gave birth to our children knowing that their serious physical disabilities might not allow them to live long.... You say that partial-birth abortion has to be legal for cases *like ours*, because women's bodies would be 'ripped to shreds' by carrying their very sick children to term. By your repeated statements, you imply that partial-birth abortion is the *only or the most desirable response to children suffering severe disabilities* like our children... This message is so wrong!... Will you meet with us personally, and hear our stories?

Ms. French got a brief letter of response from two White House scheduling aides, who said that "the tremendous demands on the President will not give him the opportunity to speak with you and your group.... Your continued interest and support are deeply appreciated."

• What about President Clinton's statement that for some women, the only alternative to partial-birth abortion is to "rip your body to shreds"?

President Clinton has repeatedly justified his veto by referring to cases in which the baby suffers from advanced hydrocephaly (head enlargement). Speaking in Milwaukee on May 23, President Clinton suggested that Bob Dole or others who would deny a partial-birth abortion in such cases are saying "it's okay with me if they ripped your body to shreds and you could never have another baby."

But this is medical nonsense. Medical specialists commonly deal with cases of severe hydrocephaly by a procedure called cephalocentesis, in which a needle is used to withdraw the excess fluid (but *not* the brain), reducing the head size so that normal delivery of a live baby can occur. 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 Charles 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.

(Note: Cases of hydrocephaly accounted for less than 4% of Dr. McMahon's partial-birth abortions, according to his submission to the House Judiciary Committee.)

• What about the small minority of cases that *do* involve "serious fetal deformity"?

It is true that *some* partial-birth abortions -- a small minority -- 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.

Dr. Harlan 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." However, in sworn testimony in the U.S. Federal District Court for the Southern District of Ohio (Nov. 13, 1995), Prof. Giles said:

> [After 23 weeks] I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent. . . But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt. [transcript, page 240]

In a partial-birth abortion, the abortionist dilates a woman's cervix for three days, until it is open enough to deliver the entire baby breech, except for the head. When *American Medical News* asked Dr. Martin Haskell why he could not simply dilate the woman a little more and remove the baby without killing him, Dr. Haskell responded:

> The point here is you're attempting to do an abortion... not to see how do I manipulate the situation so that I get a live birth instead. [*American Medical News* transcript]

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

Viki Wilson, whose daughter Abigail died at the hands of Dr. McMahon at *38 weeks*, said:

> I knew that I could go ahead and carry the baby until full term, but knowing, you know, that this was futile, you know, that she was going to die... I felt like I needed to be a little more in control in terms of her life and my life, instead of just sort of leaving it up to nature, because look where nature had gotten me up to this point. [NAF video transcript, page 4.]

Tammy Watts, whose baby was aborted by Dr. McMahon in the 7th month, said:

> I had a choice. I could have carried this pregnancy to term, knowing everything that was wrong. [Testimony before Senate Judiciary Committee, Nov. 17. 1995]

Claudia Crown Ades, who appeared with President Clinton at the April 10 veto, said:

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

In a letter opposing HR 1833, one of Dr. McMahon's colleagues at Cedar-Sinai Medical Center, Dr. Jeffrey S. Greenspoon, wrote:

> As a volunteer speaker to the National Spina Bifida Association of America and the Canadian National Spina Bifida Organization, I am familiar with the burden of raising a significantly handicapped child. . . . The burden of raising one or two abnormal children is realistically unbearable. [Letter to Rep. Hyde, July 19, 1995]

• Is there a more "objective" term for the procedure than "partial-birth abortion"?

Some opponents of the Partial-Birth Abortion Ban Act (HR 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 appeared in no standard medical textbook or database, nor anywhere in the standard textbook on abortion methods, *Abortion Practice* by Dr. Warren Hern. Because "intact dilation and evacuation"[2] 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 "intact dilation and evacuation" 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, at least one 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."

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[2]The term "*intact* dilation and evacuation" should not be confused with "dilation and evacuation," which is a procedure commonly used in second-trimester abortions, involving *dismemberment* of the fetus/baby *while still in the uterus.* The bill does not apply to "dilation and evacuation" abortions at all.

[In his 1992 instructional paper, Dr. Haskell referred to the method as "dilation and extraction" or "D&X"-- noting that he "coined the term." When the bill was drafted, the term "dilation and extraction" did not appear in medical dictionaries or databases.]

The term chosen by Congress, **partial-birth abortion**, 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 breech type of delivery.*** [emphasis added]

• Are the five line drawings of the procedure circulated by NRLC accurate, or misleading?

The AMA newspaper *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."

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?**

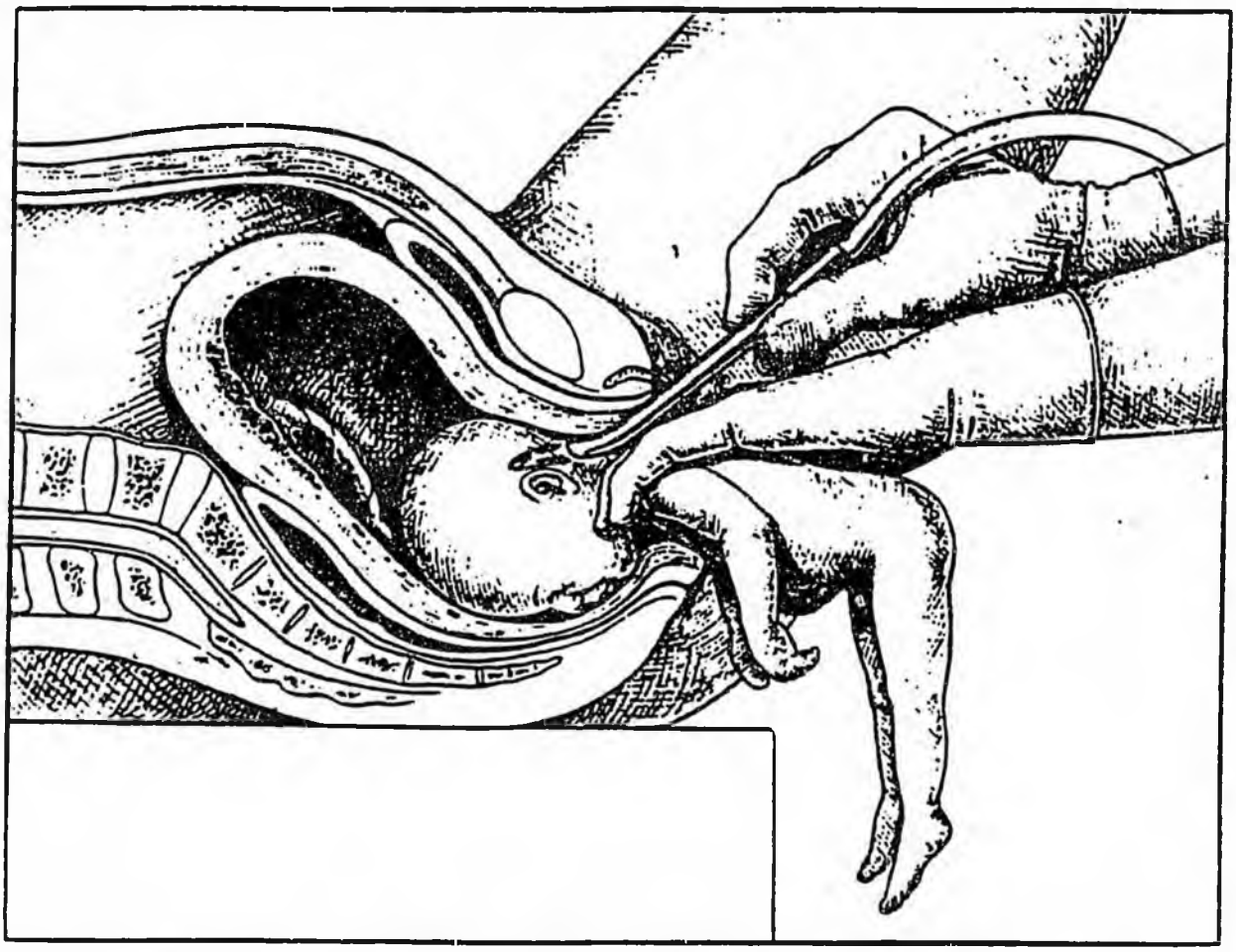
The Supreme Court has never said that there is a constitutional right to kill human beings who are mostly born.

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*.

STEP 5



"[T]he surgeon then forces the scissors into the base of the skull... [H]e 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."

Text from Martin Haskell, M.D.
Dilation and Extraction for Late Second Trimester Abortion

Regarding House Bill No.65 Partial Birth Abortion

February 6, 1997

My name is Sharylee Zachary.

My husband, Dan, our three daughters, and I hold life very dearly.

Every conceived baby, whether two cells old or full term, has a God given right to life.

It is not right that they should receive the 'death penalty' as the result of someone who does not want to live up to the consequences of their irresponsibility.

It is not right that they should receive the 'death penalty' as the result of someone else's abusive behavior on the mother, - which created that little life.

It is particularly horrifying and horrible that someone would ever perform a partial-birth abortion on a beautiful, vital baby. Or even on a baby that is not "perfect". All life is sacred.

Mostly, partial-birth abortions are done for the 'convenience' of the aborting mother who does not want the child. It is extremely rare that a medical situation exists to preserve the life of the mother through the partial-birth abortion procedure. If the mother's life were truly in danger, than having her go through the doctors manipulations to 'turn' the baby into the abnormal and undesirable position of 'feet first' birth presentation, having the mother go through all the labor that is involved to get all of the baby out except it's head, and then the horrible procedure of jabbing a scissors into the viable infants skull, sucking its brains out, having the head collapse and then giving birth to what's left of the head, - if all that didn't kill her or cause severe physical and/or emotional problems, then delivering just 'the head' is not going to kill her or cause other problems, - but it will give the baby a chance at life.

We, and thousands of other people, are against any kinda of abortion, - but we are especially AGAINST PARTIAL BIRTH ABORTION.

And we VOTE accordingly. We DO NOT vote for anyone who is pro-choice because that is the same as 'pro-death'. And we know many, many, many people who feel the same way even though they do not express it in this manner, they do express it at the voters booth. And more and more voters are gaining this conviction all the time.

I thank you for all the hard work you go through in evaluating all the things you need to in making our Alaska state laws.

Alaska has made many wise pro-family, pro-nation choices in it's laws and I am very proud of that.

Alaska has to stand strong, not to go the route of many of the lower-48 states that are falling apart because of their unwise, anti-family choices in their living styles and laws.

Alaska needs to be the North Star state pointing the way to strong families, strong communities, strong states, and a strong nation founded and built on absolute values and taking responsibility for personal actions and the consequences thereof so that the innocent no longer suffer.

Very Sincerely and Respectfully,

Sharylee Zachary
Box 1531
Petersburg,AK 99833
(907)772-3681

PHACT

Physicians' Ad Hoc Coalition for Truth

FOR IMMEDIATE RELEASE

FOR INFORMATION CONTACT:
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FORMER SURGEON GENERAL KOOP SEPARATES MEDICAL FACT FROM FICTION ON PARTIAL-BIRTH ABORTIONS

KOOP: THE PARTIAL-BIRTH ABORTION IS "IN NO WAY...A MEDICAL NECESSITY"

ALEXANDRIA, VA -- In a wide ranging interview with the American Medical News, former Surgeon General C. Everett Koop expressed his opposition to partial-birth abortions and declared that they are not medically necessary.

The former Surgeon General was asked about President Clinton's recent veto of a bill to ban partial-birth abortions and claims regarding the medical need for them. Following is Dr. Koop's response, reported in the August 19th issue of American Medical News:

> **"I believe that Mr. Clinton was misled by his medical advisers on what is fact and what is fiction in reference to late-term abortions. *Because in no way can I twist my mind to see that the late-term abortion as described -- you know, partial-birth, and then destruction of the unborn child before the head is born -- is a medical necessity for the mother.* It certainly can't be a necessity for the baby. So I am opposed to ... partial birth abortions."**

Asked "have you ever treated children with any of the disabilities cited in the debate? For example, have you operated on children with organs outside of their bodies," Koop responded:

> **"Oh, yes indeed. I've done that many times. The prognosis is usually good. [With an] omphalocele...organs are out but still contained in the sac composed of the tissues of the umbilical cord. I have been repairing those since 1946...In fact, the first child I ever did, with a huge omphalocele much bigger than her head, went on to develop well and become the head nurse in my intensive care unit many years later."**

Dr. Koop's remarks echo over three hundred other medical professionals -- leaders in the fields of obstetrics, gynecology and perinatology -- who have joined the Physicians' Ad-hoc Coalition for Truth to help Americans and Congress understand that partial-birth abortion is never medically necessary, and in fact can threaten a mother's health and safety.

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The Physicians' Ad-hoc Coalition for Truth (PHACT), with over three hundred members drawn from the medical community nationwide, exists to bring the medical facts to bear on the public policy debate regarding partial birth abortions. Members of the coalition are available to speak to public policy makers and the media. If you would like to speak with a member of PHACT, please contact Gene Tarne or Michelle Powers at 703-683-5004.

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Why are Partial-Birth Abortions Performed?

On the *ABC* television show *This Week* on November 24, columnist George Will suggested that there is a close relationship between reported cases involving the murder of newborns, such as a case in Delaware that recently received national media coverage, and society's tolerance of practices such as partial-birth abortion.

In response, *ABC News* correspondent Sam Donaldson asserted:

> *First of all, there's no evidence that this couple [in Delaware] would have been able to have a partial-birth abortion. That is an operation, George, as you may know, that's used very rarely because of the life of the mother being jeopardized or some other rare circumstance.*

Unfortunately, Mr. Donaldson's assertion - - like similar statements by many other journalists - - cannot be reconciled with the statements of doctors who have themselves performed thousands of partial-birth abortions.

For example, the *Record* of Bergen County, New Jersey, on September 15 published an investigative report by "women's issues" staff writer (and Columbia journalism professor) Ruth Padawer, who found that at a single abortion clinic in Englewood, New Jersey - - only a few miles away from the homes of the young couple in question - - doctors acknowledged that they perform ***over 1,500 partial-birth abortions a year.*** Moreover, the story quotes doctors at the clinic as stating that "only a 'minuscule amount' are for medical reasons." The *Record* reported:

> *"We have an occasional amnio abnormality, but it's a minuscule amount," said one of the doctors at Metropolitan Medical, an assessment confirmed by another doctor there.* ***"Most are Medicaid patients, black and white, and most are for elective, not medical, reasons: people who didn't realize, or didn't care, how far along they were.*** *Most are teenagers."*

The September 17 edition of the *Washington Post* contained the results of an investigation conducted by staff writers Barbara Vobejda and David M. Brown, M.D., who interviewed several abortionists (*not* those in New Jersey), and concluded:

> *It is possible - - and maybe even likely - - that the majority of these [partial-birth] abortions are performed on normal fetuses, not on fetuses suffering genetic or other developmental abnormalities. Furthermore, in most cases where the procedure is used, the physical health of the woman whose pregnancy is being terminated is not in jeopardy.... Instead, the "typical" patients tend to be young, low-income women, often poorly educated or naive, whose reasons for waiting so long to end their pregnancies - are rarely medical.*

Dr. Martin Haskell of Dayton, Ohio, has performed over 1,000 partial-birth abortions. In a tape-recorded interview, Dr. Haskell told *American Medical News*, **"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."**

Dr. Haskell also wrote a paper in which he said he uses the method "routinely" in his walk-in abortion clinic, adding, "Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia."

The late Dr. James McMahon of Los Angeles developed the partial-birth technique, and used it thousands of times. **In a written submission to the House Judiciary Committee in 1995, he admitted using the method *even during the final three months of pregnancy* on babies with no "flaw," for such reasons as mere youth of the mother, or "psychiatric" difficulties.**

In an interview with *American Medical News*, Dr. McMahon explained that "after 20 weeks where it frankly is a child to me, I really agonize over it," but added, "Who owns the child? It's got to be the mother."

In short, anyone who will set aside wishful thinking and the manufactured claims of abortion-industry lobbyists, and examine documentation such as that cited above - - and there is much more of the same sort - - can only conclude that the overwhelming majority of these late-term procedures are performed for entirely non-medical, "personal" reasons.

A small subset of partial-birth abortions involve babies with severe abnormalities, but medical specialists regularly deliver such babies alive, usually vaginally, without jeopardy to their mothers. **In September over 300 physician-specialists - - including former Surgeon General C. Everett Koop - - issued a statement "partial-birth abortion is never medically necessary to protect a mother's health or her future fertility."**

For copies of the documents cited above or additional information, please contact the Federal Legislative Office of the National Right to Life Committee, (202) 626-8820, fax (202) 347-3668.

file
HB 65

Despite abortion lies, doublespeak goes on

CAL THOMAS

Also last year, pro-abortion groups claimed that anesthesia takes the life of the unborn child before the procedure in which its brains are sucked out.

The admission by a prominent abortion advocate that he lied about the number of babies killed during the procedure called "partial-birth abortion" is surprising only in its candor. Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, said he misled the public because he feared the truth would damage the abortion rights cause.

Recalling a November 1995 appearance on ABC's "Nightline," Fitzsimmons said, "I lied through my teeth" when claiming the procedure was rarely used and that only women who sought such abortions were those whose lives were in danger, or whose unborn children were severely damaged. President Clinton used nearly identical language in explaining his veto of a bill that would have outlawed the procedure.

The White House says it will take another look at the matter in light of Fitzsimmons's comments. But the administration is lock-step with the abortion rights movement, so look for more doublespeak. President Clinton frequently says he wants to make abortions "safe, legal and rare," but has done nothing to limit the procedure even in the most extreme of circumstances, such as partial-birth abortion.

Legal abortion was conceived in a lie. Norma McCorvey, "Jane Roe," claimed to have been raped. She later admitted lying in order to make her case more compelling to the Supreme Court. The justices who made abortion legal believed testimony that thousands of women were dying from illegal abortions, a "fact" asserted by the National Abortion Rights Action League (NARAL), but later acknowledged to be false by top NARAL official Dr. Bernard Nathanson, who was at the time operating the nation's largest abortion clinic in New York.

To maintain a policy of abortion on demand, proponents have had to continue telling lies. Planned Parenthood, which consistently argues for maintaining the abortion status quo, once told a different story. In 1965, a Planned Parenthood pamphlet called "Plan Your Children" said of family planning: "Is it abortion? Definitely not. An abortion kills the life of a baby after it has begun. It is dangerous to your life and health. It may make you sterile so that when you want a child you cannot have it. Birth control merely postpones the beginning of life." Was Planned Parenthood lying then, or is it lying now?

On Dec. 11, 1993, NARAL's Kate Michelman was quoted in the Philadelphia Inquirer as saying, "We think abortion is a bad thing. No woman wants to have an abortion." Five days later a NARAL statement claimed that Michelman "has never said — and would never say — that 'abortion is a bad thing.'" But reporter Jodi Enda taped the interview and stood by the quote.

Sandra Cano, the "Mary Doe" in Roe's companion case, Doe vs. Bolton, stated that she never wanted an abortion and signed paperwork she thought was related to a divorce she sought from an abusive husband. The American Civil Liberties Union lawyer that Cano believed was helping with her divorce claimed that her client applied for an abortion but was turned down. Cano says she was lied to and that the lawyers handling the case did not explain to her what was happening and why.

During the partial-birth abortion debate last year, in which proponents claimed it is rarely done, the Bergen County Record reported that doctors in one New Jersey clinic perform 3,000 abortions annually, half of them the partial birth variety. Rather than admit the truth, abortion proponents attacked the professionalism of the reporter.

Also last year, pro-abortion groups claimed that anesthesia takes the life of the unborn child before the procedure in which its brains are sucked out. Though many physicians denied the claim, the media continued to spread the falsehood as if it were true, as if that would somehow make the procedure more ethically tolerable.

Then there are the daily lies told to women that their unborn child is not a baby, just tissue, and that having an abortion will solve the problems that lead them to seek one. And let's not forget the lie about no one being available to care for the child or the woman after birth.

Another bill needs to be introduced immediately that would outlaw partial-birth abortions before the public forgets that Fitzsimmons has added his name to a growing list of pro-abortion liars.

Cal Thomas is a nationally syndicated columnist.

Second Trimester Abortion: From Every Angle

Fall Risk Management Seminar

September 13-14, 1992

Dallas, Texas

Dr. Martin Haskell's paper on how to do the partial-birth abortion, with interviews attached.

Presentations, Bibliography & Related Materials

NATIONAL ABORTION FEDERATION

1436 U Street, NW Suite 103 Washington, DC 20009

Table of Contents
Presentations, Bibliography, and Related Materials

Dilation and Extraction for Late Second Trimester Abortion

Martin Haskell, M.D.

Presented at the National Abortion Federation
Risk Management Seminar, September 13, 1992

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. 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 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 place 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, anesthesized 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 - More Dilation

The patient returns to the operating room where the previous day's Dilapan are removed. The cervix is scrubbed and anesthesized. 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, anesthesized 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 tranducer 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 analgesia 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, 100mgm by mouth twice daily for six additional days.

Patients allergic to tetracyclines are not given proplylactic 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 intramuscalarly 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 her.. globin 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 laminaria 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.

REFERENCES

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., Elygdeman, 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 Hem, W.M., *Abortion Practice*, Philadelphia, J.B. Lippincott, 1990, p. 127, 144-6.

10 McMahon, J., personal communications, 1992.

NATIONAL ASSOCIATION OF SOCIAL WORKERS
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Testimony Regarding

HB 65 - LATE TERM ABORTION

Before the
STATE AFFAIRS COMMITTEE
ALASKA HOUSE OF REPRESENTATIVES
February 6, 1997

Presented by
Angela M. Salerno, ACSW
Executive Director,
National Association of Social Workers Alaska Chapter

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

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The National Association of Social Workers (NASW) is the world's largest organization of professional social workers. NASW's 155,000 members nationwide and 460 in Alaska work in a wide range of settings at all levels in the public and private sectors. Professional social workers focus on vulnerable populations and promote state and federal policies which enhance the lives of the people we serve.

Thank you for the opportunity to address the Committee on HB 65 - Late Term Abortion.

NASW strongly opposes HB 65 and does not recommend its passage.

Abortion late in pregnancy is rare. 99% of all abortions are performed in the first half of pregnancy and only four one-hundredths of one percent (.04%) of abortions are performed after 26 weeks. Opponents of choice are exploiting a rare and tragic occurrence to further their goal of making all abortion illegal.

Abortion late in pregnancy is needed when a woman's life or health is endangered, and in cases of severe fetal abnormality. The bill as written would allow late-term abortion if it were necessary to save the life of a mother endangered by a physical disorder, illness, or injury and no other medical procedure would suffice for that purpose. We suggest late term abortion is needed when severe abnormality makes the fetus incompatible with life. Such cases include fetus that have developed without a spinal cord, brain, or with underdeveloped and non functional organs, or who have devastating genetic or chromosomal disorders.

A ban on late-term abortion will jeopardize women's health and future fertility. The D&X (dilation and extraction) method is the safest late-term abortion method for many women. An Ohio court compared the D&X procedure to other procedures such as C-section and induced labor and found that these methods constitute "major, traumatic surgeries," are more likely to result in uterine and cervical lacerations and pose risks inherent in undergoing labor. Moreover, late term abortion preserves the mother's body and therefore her future fertility. By prohibiting a physician form using the procedure except in some cases in which a woman's life is endangered, this bill will prevent physicians' exercise of discretion in determining the best course of treatment for their patients.

A ban on late-term abortion would be an unacceptable intrusion into the life of the family. Families and their physicians, not legislatures, must be permitted to make the difficult decisions posed by the rare and heartbreaking circumstances of wanted pregnancies gone tragically wrong.

The debate highlights an extreme situation and uses it opportunistically to further curtail a woman's right to choose. Professional social workers who believe in access to safe and legal abortion are looking for ways to end the standoff advocates find themselves in, and work toward our common goal - prevention. This legislation works to cloud the issue, and ultimately complicates the real problem of unwanted pregnancies. This legislation forces us to continue skirmishing, instead of learning to work collaboratively.

Thank you for the opportunity to testify. I'm available at any time for questions.

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FACTS ON ABORTION

Safety of Abortion

- 97% of women who obtain abortions before 13 weeks of pregnancy report no complications. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- Abortion is 11 times safer than carrying a pregnancy to term. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

- **Teenage girls are more than 24 times more likely to die from childbirth that from a first trimester, legal abortion.** (Ory, H W, "Mortality Associated with Fertility and Fertility Control," *Family Planning Perspectives,* vol. 15, no. 2).

- Of the 3.4 million woman who become pregnant unintentionally in the U.S. each year, approximately 1.6 million terminate their pregnancies by medically safe, legal abortion. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

Health Risks to Women

- Legislation mandating parental involvement in decisions about abortion does **increase the risk of harm to the adolescent** by delaying access to appropriate medical care. (American Academy of Pediatrics, Committee on Adolescence, "The Adolescent's Right to Confidential Care When Considering Abortion," *Pediatrics*, vol. 97, no 3).

- Complication rates increase for abortions performed between 13 and 24 weeks. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- The American Medical Association noted that "because the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a "back alley" abortion, or resort to self-induced abortion. The desire to maintain secrecy has been **one of the leading reasons for illegal abortion deaths since...1973**. (AMA, "Mandatory Parental Consent," 83.).

Possible Links Between Abortion and Breast Cancer

- Only about 20 studies have examined the risk of developing breast cancer for women who have has abortions. (National Women's Health Network Fact Sheet: "*Abortion and Breast Cancer: The Unproven Link.*" January, 1994).

- Cancer researchers at the **National Cancer Institute,** the **American Cancer Society,** and major universities say that the most reliable studies show no increased risk, and they call the entire body of research inconclusive.

- **Harvard School of Public Health** researchers concluded in the January issue of *Cancer Causes and Control,* that abortion does not appreciably increase or decrease a woman's risk for breast cancer.

Long-Term Effects of Abortion

- Anti-choice groups are circulating unfounded claims that a majority of American women who choose to terminate their pregnancies suffer severe and long-lasting emotional trauma as a result. They call this largely nonexistent phenomenon "post-abortion trauma," or "post-abortion syndrome." They hope that terms like these will gain wide currency and credibility despite the fact that **neither the American Psychological Association nor the American Psychiatric Association recognizes their existence.**

- For most women who have had abortions, the procedure represents a maturing experience, a successful coping with a personal crisis situation. In fact, **the most prominent emotional response of most women to first-trimester abortion is relief.** (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6), Nov/Dec 1989; Adler, N. et al. "Psychological Responses After Abortion." *Science*, April 6, 1990; Lazarus, A. "Psychiatric Sequelae of Legalized Elective First Trimester Abortion." *Journal of Psychosomatic Obstetrics & Gynecology,* 43(3), September 1985; Russo, N.F. and Zierk, K.L. "Abortion, Childbearing, and Women's Well-Being." *Professional Psychology: Research and Practice,* 23(4), 1992; Armsworth, M.W. "Psychological Response to Abortion." *Journal of Counseling and Development*, 69, March/April 1991.).

- A study of a group of teenage black women who obtained pregnancy tests at one of two Baltimore clinics found that the young women who choose to have abortions were **are more likely to graduate from high school** than those of similar socioeconomic status who carried their pregnancies to term or who were not pregnant. They showed no greater levels of stress at the time of the pregnancy and abortion and no greater rate of psychological problems two years after the abortion that did the other women. (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6)).

- Up to 98% of the women who have abortions **have no regrets and would make the same choice again** in similar circumstances. (Dagg, P.K.B., MD "The Psychological Sequelae of Therapeutic Abortion - Denied and Completed." *American Journal of Psychiatry*, 148(5), May 1991).

- In July 1987, President Ronald Regan directed Surgeon General C. Everett Koop to provide the administration with a report on the health effects of induced abortion. In a letter to the president dated January 8, 1989, Dr. Koop stated that he could not form a conclusion with the available data. (Koop, C. Everett, letter to President Regan, January 9, 1989. Reproduced in "A Measured Response: Koop on Abortion," *Family Planning Perspectives,* 21(1), Jan/Feb, 1989.

- In a 1988 closed meeting, Surgeon General Koop told representatives from several anti-abortion organizations that the risk of **significant emotional problems following abortion was "minuscule"** from a public health perspective. (House Committee on Government Operations. "*The Federal Role*

in Determining the Medical and Psychological Impact of Abortions on Women, H.R. Rep. No. 329, 101st Congress, 2d Sess. 14 (1989)).

- In 1989, a panel of experts assembled by the **American Psychological Association** concluded unanimously that legal abortion "**does not create psychological hazards for most women undergoing the procedure.**" The panel noted that, since approximately 21% of all U.S. women have had an abortion, if severe emotional reactions were common there would be an epidemic of women seeking psychological treatment. There is no evidence of such an epidemic. (Adler, N., University of California at San Francisco, statement on behalf of the American Psychological Association before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, March 16, 1989.)

February 3, 1997

Representative Jeanette James
716 West 4th Avenue
Anchorage, Alaska 99501

Dear Representative James:

I wanted to take a few minutes to give you my views on House Bill 65, banning the so-called partial birth abortions. I have been doing abortions in Alaska for approximately 13 years, and am quite familiar with the abortion process and the controversy surrounding abortions.

Please read the text of the bill. Since the term "partial birth abortion" is a term which is not defined in the medical literature, a definition had to be adopted to write this bill. The text of the bill has one sentence which describes what the term "partial birth abortion" would mean. Please notice that in this case the legislature is defining "partial birth abortion", not medical literature. As such, when the legislature defines this procedure, it may have far reaching consequences in the field of medicine than was originally intended.

First, gestational age is not included in the description of the partial birth abortion. If literally interpreted, partial birth abortion can be interpreted to include the first, second and third trimester abortions. There is nothing in the bill that speaks of viability of the fetus. Again, broad interpretation of the bill could allow to apply to first, second and third trimesters.

The procedure that this bill would eliminate is actually a procedure referred to as dilation and evacuation. In Alaska, I am often called upon to do a dilation and evacuation for a number of medical indications. For instance, in a mother who is carrying an anencephalic fetus, which is a fetus with no brain, the D&E procedure is one that is most commonly used to terminate the pregnancy. In fetuses with genetic abnormalities, such as trisomy-11, 13, and a host of other genetic disorders, the D&E is the procedure that is used to terminate these pregnancies. Unfortunately, the women who are most often at risk for genetic abnormalities, are women who have chosen to become educated and establish work careers prior to establishing a family. Thus, many of the women who are in their 30's and have been in the work force for some time, find themselves in the unfortunate position of having a genetically abnormal child and dealing with this issue. These are not elective abortions, they are often family tragedies inflicted upon couples who want very much to have children. The D&E process has been used for years in Alaska as the most humane way to terminate

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these pregnancies. The CDC has actually run a study looking at different methods of pregnancy termination and has been able to demonstrate that the dilation and evacuation procedure, when applied prior to certain points in gestation, is actually the safest procedure to the mother.

We do not have laws governing how gall bladder surgery might be performed, or how prostatic cancer surgery might be performed, and it seems unreasonable to pass a law to address how pregnancy terminations are performed. The CDC data clearly shows that at certain points in gestation the D&E procedure, or dilation and evacuation, is the safest procedure to the mother. Medical science should guide us on how to do specific procedures, not the legislature.

Thank you for taking time to read this letter.

Sincerely,

Jan Whitefield, M.D.
Alaska Women's Health Services

JW:FasType,jlb

THE LEAGUE OF WOMEN VOTERS

2806 John Street #2
Juneau, Alaska 99801
February 14, 1997

Representative Jeannette James
Alaska State Legislature
Juneau, Alaska 99801-1182

Dear Representative James:

Last week I sent a letter via FAX to members of the House State Affairs Committee relating to House Bill 37. I made the mistake of using the FAX machine at my place of employment, Catholic Community Service (CCS), which has created some confusion. Since the FAX received indicates "Catholic Community Service" at the top, some folks wondered if my message reflected the opinion of CCS. I wish to emphasize that **the contents of the faxed material in no way was related to or reflected the views of CCS**. Should this issue come up among your colleagues, please let them know that.

I apologize for any confusion my FAX may have caused.

Sincerely,

Marianne Mills

Marianne Mills

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name.

committee on HB 65 bill/subject, dated Mar. 3-97.

Relating to ban on "Partial Birth Abortion"

After the television coverage in late Feb. of this year relative to the untruthful testimony of a top ACLU officer; I think it is evermore clear to all of us that partial birth abortions are not rare and they are performed on otherwise healthy fetuses.

We can not allow our culture to become jaded into thinking that since abortion is legal, then it necessarily follows that any procedure developed by any doctor is perfectly acceptable as long as it gets rid of the fetus.

Stop this kind of thinking. There has to be a limit on your tolerance. Ban the Partial Birth Abortions in Alaska.

Signed: Mary E. Hughes
Testifier

Representing (Optional)

P.O. Box 912 Sitka AK 99835
Address

(907) 747-3962
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name.

committee on HB 65 Partial Birth Abortion bill/subject, dated Mar 5 1997.

Please put ban on Partial Birth abortions. Please bring back the important family values, respect for life. Lets not murder our alaska children Our future. We should all be responsible to care & help each other & that includes the preborn children.

Signed: Georgia L. Rogers
Testifier

Mr & Mrs Frank A Rogers Sr.
Representing (Optional)

P.O. BX 1022 Sitka AK 99835
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9/88 Legislative Information Office

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AMA's *American Medical News* and Public Broadcasting's *Media Matters* Independently Report that Pro-Abortion Groups Have Badly Misled the Press and the Public About Partial-Birth Abortions

> ***"The pro-choice movement has lost a lot of credibility during this debate, not just with the general public, but with our pro-choice friends in Congress. Even the White House is now questioning the accuracy of some of the information given to it on this issue. . . I think we should tell them the truth, let them vote and move on."***
> ***-- Ron Fitzsimmons, executive director, National Coalition of Abortion Providers***

Leaders of prominent abortion industry associations and other pro-abortion groups have badly misled the press and the public regarding the key issues surrounding partial-birth abortions, according to new investigative reports by the AMA newspaper *American Medical News* and by *Media Matters*, a media-review program funded in part by the Corporation for Public Broadcasting.

The report in this week's (March 3) edition of *American Medical News* contains quotations -- startling in their candor -- by Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers (NCAP), a major "trade association" of abortion providers. NCAP represents about 220 independently owned abortion clinics. Fitzsimmons says that leaders of the "abortion-rights" movement tried to defeat the Partial-Birth Abortion Ban Act by telling the press and the public that the procedures were done very rarely and only in extreme circumstances, even though he and some others in the pro-abortion movement knew that these claims were untrue.

Pro-abortion spokespersons should drop their "spins" and "half-truths," and stop apologizing for partial-birth abortions, says Fitzsimmons -- who now believes that the disinformation has hurt the very abortionists whom he represents.

"When you're a doctor who does these abortions and the leaders of your movement appear before Congress and go on network news and say these procedures are done in only the most tragic of circumstances, how do you think it makes you feel? You know they're primarily done on healthy women and healthy fetuses, and it makes you feel like a dirty little abortionist with a dirty little secret," Fitzsimmons said. "I think we should tell them the truth, let them vote and move on."

PRO-ABORTION GROUPS MISLED PRESS, PUBLIC, 2

New Reports Validate Early Statements by Ban Supporters

Since introduction of the Partial-Birth Abortion Ban Act in June, 1995, bill author Rep. Charles Canady (R-Fl.) and NRLC have emphasized that partial-birth abortions are performed routinely on healthy babies of healthy mothers during the fifth and sixth months of pregnancy. These abortions are also performed more rarely in the seventh month and later; these "third-trimester" cases sometimes involve women or babies with medical difficulties, sometimes not. [Press releases and factsheets issued by NRLC and by Mr. Canady's office from June, 1995 onward are available on request.]

Also from the start, abortion-industry groups such as the National Abortion Federation (NAF) and the Planned Parenthood Federation of America (PPFA) insisted that the method was used very rarely, and only or nearly only in cases where the mother's life was endangered or the baby had lethal anomalies. As the *American Medical News* report concludes, "Abortion rights activists. . . have consistently claimed it is done only when the woman's life is at risk or the fetus has a condition incompatible with life. And the numbers are small, they said, only 500 to 600 a year."

[Typical of many such claims was a Nov. 1, 1995 PPFA press release: "The procedure, dilation and extraction (D&X), is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." **Even *today*, the home page of the National Abortion Federation, a "trade association" of abortion clinics, informs journalists and other web visitors, "This particular procedure is used only in about 500 cases per year, generally after 20 weeks of pregnancy, and most often when there is a severe fetal anomaly or maternal health problem detected late in pregnancy."]**

Some on Pro-Abortion Side Knew Their Claims Were Untrue

These assertions by the pro-abortion advocates were adopted as simple fact by many journalists. They have been repeatedly transmitted as fact or as information from authoritative sources by major television networks, wire services, and newspapers. Yet, at least some prominent pro-abortion leaders knew all along that these claims were untrue.

Fitzsimmons admits that when he was interviewed in November, 1995, for a *Nightline* program on partial-birth abortion, he (in his own words) "lied" by saying women have these abortions only in the most extreme circumstances of life endangerment or fetal anomaly. Fitzsimmons told *American Medical News* that he knew this was untrue, because when the Partial-Birth Abortion Ban Act was first introduced (in June, 1995), he called doctors who use the method, and "I learned right away that this was being done for the most part in cases that did not involve those extreme circumstances."

Kathryn Kolbert Counsels Strategy of Evasion

The *American Medical News* story also quotes from a 1996 meeting of the National Abortion Federation, at which a public relations strategy for dealing with the bill was laid out by Kathryn Kolbert, vice-president of the New York-based Center for Reproductive Law and Policy, who is described as "one of the chief architects of the movement's opposition to the bill." At the session,

Kolbert "urged those attending the session not to get 'sidetracked' by their opponents' efforts to get them to discuss the specifics of the procedure," *American Medical News* reports.

"I urge incredible restraint here, to focus on your message and stick to it, because otherwise we'll get creamed," Kolbert told the group. "If the debate is whether the fetus feels pain, we lose. If the debate in the public arena is what's the effect of anesthesia, we'll lose. If the debate is whether or not women ought to be entitled to late abortion, we probably will lose. But if the debate is on the circumstances of individual women... then I think we can win these fights."

CPB *Media Matters* Investigation Finds Press Adopted Pro-abortion Misinformation

The *American Medical News* report says that Fitzsimmons agrees that the vast majority of partial-birth abortion are performed in the 20-plus-week range [late second trimester] on healthy fetuses and healthy mothers. Fitzsimmons comments, "The abortion rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else."

In NRLC's judgment, however, "everyone else" clearly does *not* know that partial-birth abortions are performed thousands of times annually on healthy babies of healthy mothers in the fifth and sixth months of pregnancy. They have repeatedly been told just the opposite by reporters and editors for many of the top broadcast and print outlets.

That assessment by NRLC is confirmed by the findings of an investigative report by journalists for *Media Matters*, a quarterly TV magazine funded in part by the Corporation for Public Broadcasting. In an edition now airing on some PBS affiliates, the *Media Matters* journalists concluded that much of the major media coverage of the Partial-Birth Abortion Ban Act has been riddled with misinformation that journalists uncritically adopted from pro-abortion organizations.

The 20-minute report, titled "Partial Truth," is part of a one-hour *Media Matters* edition that was released to PBS affiliates beginning January 24. *Media Matters* describes itself as "a series that looks critically at news media performance." The program is hosted by executive editor Alex Jones, a Pulitzer Prize-winning journalist who also hosts National Public Radio's weekly show *On the Media*. The investigation of partial-birth abortion coverage was reported by Terry Eastland, editor of *Forbes MediaCritic Online*, and produced by two-time Emmy documentary nominee Joseph Dorman.

The *Media Matters* team's investigation on the partial-birth abortion story found that many journalists "did little original reporting and willingly accepted information from pro-choice sources -- which turned out to be inaccurate," say the producers. **From the time the Partial-Birth Abortion Ban Act was introduced in June, 1995, until the final votes on President Clinton's veto in September, 1996, most "reporters tended to accept as true the assertions of the abortion-rights side, despite evidence calling into question their claims."**

The program focused on three specific disputed issues. From the beginning, Eastland states, "Abortion opponents claimed that the procedure was used thousands of times a year, mainly in the second trimester of pregnancy, and mostly on the healthy fetuses of healthy mothers. Countering their campaign, abortion-rights groups said that the procedure was used only several hundred times a

year, mainly in the third trimester, and almost always in cases of severe fetal deformity and to protect the health or the life of the mother." After displaying press releases in which NAR, NARAL and PPFA that made just such claims regarding the number and circumstances of the procedures, the program shows how the pro-abortion side's assertions were adopted as fact by the *Washington Post*, the *Los Angeles Times*, and many others.

"In reporting these claims, journalists tended to accept as fact assertions provided by abortion-rights groups," Eastland concludes, noting that the mainstream press did no independent checking on the pro-abortion claims for 14 months after the bill was introduced. "I think that the coverage of the partial-birth abortion debate has been abysmal," *Time* magazine's Karen Tumulty told *Media Matters*. "By and large, most news organizations have been far more willing to accept what facts, figures and examples are offered by the abortion-rights side, and to discount the other side's argument."

A June 2, 1996 *60 Minutes* program on partial-birth abortion receives particularly sharp criticism. "The piece that *60 Minutes* did really fell into all the traps that this whole debate presented," commented *Time*'s Tumulty. "They used these incredibly tragic examples, but examples that only portrayed basically one side of the debate." Eastland adds that *60 Minutes* "made little effort to convey the view of abortion opponents that the procedure is most often used on healthy fetuses in the second trimester." [A detailed critique of the *60 Minutes* program is available from NRLC.]

Bergen *Record* and *Washington Post* Belatedly Investigate Claims

Finally, in September, 1996, the Bergen *Record* and then the *Washington Post* published articles, based in part on interviews with multiple abortion doctors who regularly perform partial-birth abortions. On each of the three key disputed issues examined by *Media Matters*-- how often the procedure is performed, at what point in pregnancy, and for what typical reasons-- the *Post* and *Record* reports offered support for the assertions of NRLC and other key bill supporters.

Media Matters interviewed Ruth Padawer, a Bergen *Record* reporter who interviewed two different doctors at a single New Jersey clinic. The doctors independently told her that over 1,500 partial-birth abortions are performed annually at that single clinic -- "close to three times the number that abortion-rights advocates had claimed for the entire country-- and the procedure was mainly done in the second trimester on healthy fetuses," Eastland notes. The abortion doctors at the clinic "say only a 'minuscule amount' are for medical reasons " the *Record* reported. One abortion doctor told Padawer, "Most are Medicaid patients, black and white, and most are for elective, not medical, reasons: people who didn't realize, or didn't care, how far along they were. Most are teenagers." "One of the unsettling things of what I found of the reporting, was the discovery that the pro-choice side was playing fast and loose with the facts, and there's a credibility gap there that there wasn't before for me," Padawer told *Media Matters*.

Media Matters also interviewed *Washington Post* medical writer David Brown, M.D., who was assigned to do an in-depth report on the subject "after complaints from anti-abortion groups" about the paper's repeated adoption of the pro-abortion line in news stories. Brown wrote two lengthy articles on the subject, published September 17, which included information from five doctors who perform partial-birth abortions (not those interviewed by the *Record*). **"Cases in which the**

mother's life were at risk were extremely rare," Brown told *Media Matters*. "Most people who got this procedure were really not very different from most people who got abortions."

Misinformation Persists in the Press

Despite these reports, and similar information available in much earlier interviews with partial-birth abortionists in *American Medical News*, the pro-abortion disinformation has continued to be presented to the American people as fact by many journalists. For example: CBS's *This Morning*, Sept. 20, correspondent Linda Douglass, "[The bill would ban] rare, late-term abortions, usually done only in cases where the fetus is severely deformed." *Time*, Sept. 30, "Experts estimate that partial-birth abortion accounts for perhaps 600 of the 1.5 million abortions performed in the U.S. each year," and, "In many such abortions, the fetus is so severely deformed or the pregnancy so complicated that carrying the child to term would threaten the life or health of the mother." *Los Angeles Times*, Sept. 27: "The [partial-birth abortion] procedure is generally used when the fetuses have fatal birth defects or when the mother's health is in jeopardy."

Media Distortions Regarding the Clinton-Daschle Proposal

The *American Medical News* report observes that the "abortion rights" side's strategy is "to try to narrow the focus of the debate to third-trimester abortions, which are far fewer in number than those done in the late second trimester and more frequently done for reasons of fetal anomaly." But this diversionary strategy depends heavily on the continuation of careless and gullible coverage of the issue by the news media, which persists to this day.

In recent months, we at NRLC have seen many highly misleading press reports, suggesting that President Clinton and Senate Democratic Leader Tom Daschle have indicated a willingness to accept a ban on partial-birth abortions if a "narrow" exception were added for various "serious health" circumstances. In fact, however, the Clinton-Daschle proposal hardly overlaps at all with the Partial-Birth Abortion Ban Act, which would prohibit partial-birth abortions (except to save the life of the mother) regardless of the exact age of the baby. The substantial majority of partial-birth abortions -- thousands annually -- are performed on healthy babies of healthy mothers in the fifth and sixth months of pregnancy, but the Clinton-Daschle proposal would apply ***absolutely no restrictions whatever*** until the ***seventh month***.

Furthermore, the Clinton-Daschle proposal would allow partial-birth abortions ***even in the seventh month and later*** if an abortionist asserts that the procedure will somehow protect a mother's future fertility -- medical nonsense, but elastic enough to allow any abortion at all. The Physicians' Ad Hoc Coalition for Truth (PHACT) -- made up of over 400 physician-specialists, including former Surgeon General C. Everett Koop -- says that "partial-birth abortion is never medically necessary to protect a mother's health or future fertility. On the contrary, this procedure... can pose a significant threat to both her immediate health and future fertility."

NRLC has published a number of detailed critiques of media-amplified misinformation regarding partial-birth abortions, which are available on request from the NRLC Federal Legislative Office, (202) 626-8820, fax (202) 347-3668, e-mail: Douglas51@aol.com.

AFFIDAVIT

I, John W. Scanlon, M.D., do hereby swear and affirm the following:

1. I am a physician licensed to practice in the state of Maryland. My medical training and qualifications are contained in my Curriculum Vitae, which is attached hereto and made a part of this affidavit.

2. In 1991 an article written by me was published in the medical journal, Advances in Pediatrics, 38:317-33. The article is titled "Appreciating Neonatal Pain" and addresses indepth the fact that, contrary to earlier beliefs, it has now been proven and is widely accepted that premature neonates are capable of feeling pain from at or before the 24th gestational week.

3. As written in the above referenced article, it was and still is my considered medical judgment that there numerous situations in which neonates will regularly feel pain including but not limited to surgical procedures, chest tube insertion, lumbar puncture, venous or arterial puncture, removal of supernumerary digits, intramuscular injection, dressing or electrode removal, heel sticks, and endotracheal intubation. In addition, excessive handling, environmental noise or light, and various diseases may produce noxious, at times painful, stimuli. (at page 327.) The article discusses each of the above in detail and also explains the anatomy and physiology of pain, how pain can be measured in neonates, other sources of acute pain for some neonates, chronic pain in neonates, and inappropriate infant stimulation. I concluded in 1991 and continue to believe that "It should no longer be controversial that newborns, in manner similar to other infants, have the ability to recognize painful (i.e., tissue damaging) insults and respond to them. Further, such responses may be physiologically deleterious and impede recovery. ...one of the physician's preeminent tasks, to alleviate suffering, can now be accomplished safely, humanely, and with precision in the neonatal period." (at 330.)

4. Extensive research has been undertaken by the medical and nursing community on neonatal pain since my 1991 article was published. The overwhelming weight of medical evidence continues to support the understanding that neonates, even extremely premature infants, can and do feel pain and suffer. Sophisticated tools are available to determine whether the patient is in pain and pharmaceutical and nursing interventions are routinely recommended and utilized to alleviate the infant's suffering.

5. It is my expert medical opinion that the understanding that premature infants can and do feel pain is no longer considered controversial in the medical community.

The article described above in numbers 2-4 is also attached hereto and made part of this affidavit.

I swear that the foregoing is true and correct to the best of my knowledge and belief.

2/13/96
date

John W. Scanlon, M.D.

State of Maryland)
) ss:
City of CAMBRIDGE)

I, HEREBY CERTIFY that before me, a Notary Public in and for the State and County aforesaid, personally appeared, **John W. Scanlon, M.D.**, known to me to be the person whose name is subscribed to within instrument, who, after being sworn, made oath in due form of law that the matters and facts set forth in the foregoing affidavit are true and correct to the best of his knowledge.

I WITNESS my hand and official seal this 13 day of FEB, 1996.

Notary Public
My Commission Expires: 2-13-98

An Abortion Rights Advocate Says He Lied About Procedure
DAVID STOUT
New York Times, Late Edition - Final ED, COL 01, P 12
Wednesday February 26 1997

WASHINGTON, Feb. 25 - A prominent member of the abortion rights movement said today that he lied in earlier statements when he said a controversial form of late-term abortion is rare and performed primarily to save the lives or fertility of women bearing severely malformed babies.

He now says the procedure is performed far more often than his colleagues have acknowledged, and on healthy women bearing healthy fetuses.

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said he intentionally misled in previous remarks about the procedure, called intact dilation and evacuation by those who believe it should remain legal and "partial-birth abortion" by those who believe it should be outlawed, because he feared that the truth would damage the cause of abortion rights.

But he is now convinced, he said, that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

In an article in American Medical News, to be published March 3, and an interview today, Mr. Fitzsimmons recalled the night in November 1995, when he appeared on "Nightline" on ABC and "lied through my teeth" when he said the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged.

"It made me physically ill," Mr. Fitzsimmons said in an interview. "I told my wife the next day, 'I can't do this again.' "

Mr. Fitzsmmons said that after that interview he stayed on the sidelines of the debate for a while, but with growing unease. As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common.

In the procedure, a fetus is partly extracted from the birth canal, feet first, and the brain is then suctioned out.

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist borders on infanticide and some abortion rights advocates also believe should be outlawed as particularly gruesome. Polls have shown that such a ban has popular support.

Senator Tom Daschle of South Dakota, the Democratic leader, has

suggested a compromise that would prohibit all third-trimester abortions, except in cases involving the "life of the mother and severe impairment of her health."

The Right to Life Committee and its allies have complained repeatedly that abortion-rights supporters have misled politicians, journalists and the general public about the frequency and the usual circumstances of the procedure.

"The abortion lobby manufactures disinformation," Douglas Johnson, the committee's legislative director, said today. He said Mr. Fitzsimmon's account would clarify the debate on this procedure, which is expected to be renewed in Congress.

Mr. Fitzsimmons predicted today that the controversial procedure would be considered by the courts no matter what lawmakers decide.

Last April, President Clinton vetoed a bill that would have outlawed the controversial procedure. There were enough opponents in the House to override his veto but not in the Senate. In explaining the veto, Mr. Clinton echoed the argument of Mr. Fitzsimmons and his colleagues.

"There are a few hundred women every year who have personally agonizing situations where their children are born or are about to be born with terrible deformities, which will cause them to die either just before, during or just after childbirth," the President said. "And these women, among other things, cannot preserve the ability to have further children unless the enormity -- the enormous size of the baby's head -- is reduced before being extracted from their bodies." A spokeswoman for Mr. Clinton said tonight that the White House knew nothing of Mr. Fitzsimmons's announcement and would not comment further.

In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said. "The abortion-rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," he said in the article in the Medical News, an American Medical Association publication.

Mr. Fitzsimmons, whose Alexandria, Va., coalition represents about 200 independently owned clinics, said coalition members were being notified of his announcement.

One of the facts of abortion, he said, is that women enter abortion clinics to kill their fetuses. "It is a form of killing," he said. "You're ending a life."

And while he said that troubled him, Mr. Fitzsimmons said he continued to support this procedure and abortion rights in general.

PHACT

Physicians' Ad Hoc Coalition for Truth

FOR IMMEDIATE RELEASE CONTACT: Gene Tarne/Michelle Powers
703/683-5004

THE CASE OF COREEN COSTELLO

Partial-birth abortion was not a medical necessity *for the most visible "personal case" proponent of procedure.*

Coreen Costello is one of five women who appeared with President Clinton when he vetoed the Partial-Birth Abortion Ban Act (4/10/96). She has probably been the most active and the most visible of those women who have chosen to share with the public the very tragic circumstances of their pregnancies which, they say, made the partial-birth abortion procedure their only medical option to protect their health and future fertility.

But based on what Ms. Costello has publicly said so far, her abortion was not, in fact, medically necessary.

In addition to appearing with the President at the veto ceremony, Ms. Costello has twice recounted her story in testimony before both the House and Senate; the *New York Times* published an op-ed by Ms. Costello based on this testimony; she was featured in a full page ad in the *Washington Post* sponsored by several abortion advocacy groups; and, most recently (7/29/96) she has recounted her story for a "Dear Colleague" letter being circulated to House members by Rep. Peter Deutsch (FL).

Unless she were to decide otherwise, Ms. Costello's full medical records remain, of course, unavailable to the public, being a matter between her and her doctors. However, Ms. Costello has voluntarily chosen to share significant parts of her very tragic story with the general public and in very highly visible venues. Based on what Ms. Costello *has* revealed of her medical history -- of her own accord and for the stated purpose of defeating the Partial-Birth Abortion Ban Act -- doctors with PHACT can only conclude that Ms. Costello and others who have publicly acknowledged undergoing this procedure "are honest women who were sadly misinformed and whose decision to have a partial-birth abortion was based on a great deal of misinformation" (Dr. Joseph DeCook, Ob/Gyn, PHACT Congressional Briefing, 7/24/96). Ms. Costello's experience does not change the reality that a partial birth abortion is never medically indicated -- in fact, there are available several alternative, *standard* medical procedures to treat women confronting unfortunate situations like Ms. Costello had to face.

The following analysis is based on Ms. Costello's public statements regarding events leading up to her abortion performed by the late Dr. James McMahon. This analysis was done by Dr. Curtis Cook, a perinatologist with the Michigan State College of Human Medicine and member of PHACT.

"Ms. Costello's child suffered from 'polyhydramnios secondary to fetal swallowing defect.' In other words, the child could not swallow the amniotic fluid, and an excess of the fluid therefore collected in the mother's uterus. Because of the swallowing defect, the child's lungs were not properly stimulated, and an underdevelopment of the

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lungs would likely be the cause of death if abortion had not intervened. The child had no significant chance of survival,.but also would not likely die as soon as the umbilical cord was cut.

"The usual approach in such a case would be to reduce the amount of amniotic fluid collecting in the mother's uterus by serial amniocentesis. Excess fluid in the fetal ventricles could also be drained. Ordinarily, the draining would occur 'transabdominally.' Then the child would be vaginally delivered, after attempts were made to move the child into the usual, head-down position. Dr. McMahon, who performed the draining of cerebral fluid on Ms. Costello's child, did so 'transvaginally,' most likely because he had no significant expertise in obstetrics/gynecology. In other words, he would not be able to do it well transabdominally -- the standard method used by ob/gyns -- because that takes a degree of expertise he did not possess.

Ms. Costello's statement that she was unable to have a vaginal delivery, or, as she called it, 'natural birth or an induced labor,' is contradicted by the fact that she did indeed have a vaginal delivery, conducted by Dr. McMahon. What Ms. Costello had was a breech vaginal delivery for purposes of aborting the child, however, as opposed to a vaginal delivery intended to result in a live birth. A cesarean section in this case would not be medically indicated -- not because of any inherent danger -- but because the baby could be safely delivered vaginally."

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The Physicians' Ad-hoc Coalition for Truth (PHACT), with over three hundred members drawn from the medical community nationwide, exists to bring the medical facts to bear on the public policy debate regarding partial birth abortions. Members of the coalition are available to speak to public policy makers and the media. If you would like to speak with a member of PHACT, please contact Gene Tarne or Michelle Powers at 703-683-5004.

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PHACT

Physicians' Ad Hoc Coalition for Truth

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Gene Tarne, Michelle Powers

September 18, 1996

Dear Member of Congress:

We write to you as founding members of the Physicians' Ad-hoc Coalition for Truth (PHACT), an organization of over three hundred members drawn from the medical community nationwide -- most ob/gyns, perinatologist and pediatricians -- concerned and disturbed over the medical misinformation driving the partial-birth abortion debate. As doctors, we cannot remember another issue of public policy so directly related to the medical community that has been subject to such distortions and outright falsehoods.

The most damaging piece of medical disinformation that seems to be driving this debate is that the partial-birth abortion procedure may be necessary to protect the lives, health and future fertility of women. You have heard this claim most dramatically not from doctors, but from a handful of women who chose to have a partial-birth abortion when their children were diagnosed with some form of fetal abnormality.

As physicians who specialize in the care of pregnant women and their children, we have all treated women confronting the same tragic circumstances as the women who have publicly shared their experiences to justify this abortion procedure. So as doctors intimately familiar with such cases, let us be very clear: *the partial-birth abortion procedure, as described by Dr. Martin Haskell (the nation's leading practitioner of the procedure) and defined in the Partial-Birth Abortion Ban Act, is never medically indicated and can itself pose serious risks to the health and future fertility of women.*

There are simply no obstetrical situations encountered in this country which require a partially-delivered human fetus to be destroyed to preserve the life, health or future fertility of the mother. Not for hydrocephaly (excessive cerebrospinal fluid in the head); not for polyhydramnios (an excess of amniotic fluid collecting in the woman); and not for trisomy (genetic abnormalities characterized by an extra chromosome).

Our members concur with former Surgeon General C. Everett Koop's recent statement that "in no way can I twist my mind to see that [partial-birth abortion] is a medical necessity for the mother."

As case in point would be that of Ms. Coreen Costello, who has appeared several times before Congress to recount her personal experience in defense of this procedure . Her unborn child suffered from at least two conditions: "polyhydramnios secondary to abnormal fetal swallowing," which causes amniotic fluid to collect in the uterus, and "hydrocephalus", a condition that causes an excessive amount of fluid to accumulate in the fetal head.

The usual treatment for removing the large amount of fluid in the uterus is a procedure called amniocentesis. The usual treatment for draining excess fluid from the fetal head is a procedure called cephalocentesis. In both cases the excess fluid is drained by using a thin needle that can be placed inside the womb through the abdomen ("transabdominally"--the preferred route) or through the vagina ("transvaginally.") The transvaginal approach however, as performed by Dr. McMahon on Ms. Costello, puts the woman at an increased risk of infection because of the non-sterile environment of

the vagina. Dr. McMahon used this approach most likely because he had no significant expertise in obstetrics and gynecology.' After the fluid has been drained, and the head decreased in size, labor would be induced and attempts made to deliver the child vaginally. Given these medical realities, the partial-birth abortion procedure can in no way be considered the standard, medically necessary or appropriate procedure appropriate to address the medical complications described by Ms. Costello or any of the other women who were tragically misled into believing they had no other options.

Indeed, the partial-birth abortion procedure *itself* can pose both an immediate and significant risk to a woman's health and future fertility. To take just one example, to forcibly dilate a woman's cervix over the course of several days, as this procedure requires, risks creating an "incompetent cervix," a leading cause of future premature deliveries. It seems to have escaped anyone's attention that one of the five women who appeared at President Clinton's veto ceremony who had a partial-birth abortion subsequently had five miscarriages.

The medical evidence is clear and argues overwhelmingly against the partial-birth abortion procedure. Given the medical realities, a truly pro-woman vote would be to end the availability of a procedure that is so potentially dangerous to women. The health status of women and children in this country can only be enhanced by your unequivocal support of H.R. 1833.

Thank you for your consideration.

Sincerely,

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James C. Glenn, M.D.
OB/GYN
Amarillo, TX

K. Michael Kearns, M.D.
Gynecologic Oncology
Hartford, CT

Frank Wilson, M.D.[LMO1]
OB/GYN
Natick, MA

W.A. Krotoski, M.D., PhD., MPH
Medical Director, USPHS (Ret)
Baton Rouge, LA

Richard M. Thorne, M.D., P.C.
OB/GYN
Salem, OR

Richard G. Moutvic, M.D.
OB/GYN
Clinical Professor, Loyola University School of Medicine
Chicago Heights, IL

Anthony Culotta, DDS
Washington, DC

Margaret Culotta Norton, DDS
Washington, DC

Mark G. Campbell, M.D., MHA
Grand Rapits, MI

Karyn Grimm Herndon, M.D.
OB/GYN
Director, Medical Education, Dept. of OB/GYN, Evanston Hospital; Instructor, Northwestern Medical School
Evanston, IL

James W. Stough, M.D.
Gynecologist
Winfield, IL

Carl Christman, M.D
OB/GYN
Assistant Professor, University of Kansas School of Medicine, Wichita, KS

James M. Burkhead III, M.D.
OB/GYN
Houston, TX

Harold Chotiner, M.D.
FACOG
Reno, NV

Dr. James P. Hartley, M.D.
OB/GYN
Bethesda, MD

William J. Hogan, M.D.
OB/GYN
Rockville, MD

Patrick Marmion, M.D.
OB/GYN
Fellow, American College of Preventive Medicine;
Director, OH/KY/IN Perinatal Program
Cincinatti, OH

Steve Nickisch, M.D.
JFACOG
Clinical Faculty, University of North Carolina
Asheville, NC

David Kawasaki, M.D.
OB/GYN
Mission Viejo, CA

Laurie Scott, M.D.
FACOG
Assistant Professor, Dept. of OB/GYN, Southwestern Medical Center, Dallas
Boca Raton, FL

Lawrence C. Cairns, M.D.
FACOG
Stevensville, MI

Mark Harrison, M.D.
FACOG
Fairfax Station, VA

J. Michael Rollins, M.D.
FACOG
Clinical Assistant Professor, Dept. of OB/GYN, West Virginia University
Morgantown, WV

Ronald P. Blake, M.D.
Family Practice
Stevensville, MI

Marc G. Meininger, M.D.
OB/GYN
Sunnyside, WA

Jonathan P. Daniels, M.D.
OG/GYN
Yankton, SD

Mark Neerhof, D.O.
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Member, American Colleg of Osteopathic OB/GYN;
Society of Perinatal Obstetricians
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FACOG
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linical Medicine.
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Herbert Reese. M.D.
FACS
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John H. Chain. M.D.
NE

Dennis Weisenberger. M.D.
Omaha. NE

Michael G. Skoch. M.D.
A ct Assistant Professor.
amily Medicine. U. of
ebraska Medical center
Omaha. NE

Peter R. DeMarco. M.D.
Omaha. NE

Thomas W. Hilgers. M.D.
Omaha. NE

J. Thomas Fitch. M.D., P.A.
San Antonio. TX

John G. Saint. M.D.
Springfield. IL

Ann J. Yadusky. M.D.
OB/GYN
Raleigh. NC

Philip Horner. M.D.
ABFP
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Professor. University of
Kentucky. Dept of
OB/GYN. College of
Medicine
Lexington. KY

Terrence A. Pheifer. M.D.
FACOG
Clinical Associate
Professor. OB/GYN
University of Washington
Kirkland. WA

May 17, 1996

TO: Ms Lisa Binns

FROM: Dr. Pamela E. Smith

RE: Medical Articles on the short and long term consequences of induced abortion

Number of pages: 13

Pursuant to our telephone conversation yesterday I am forwarding to you a partial list of the medical references that substantiate my statements that the partial birth abortion procedure is dangerous to women and that there is no need to do any research to document this as we have at least 3 decades of research reports, conducted in countries where abortion is legal, that have clearly demonstrated the fact that abortion methods utilizing forceful cervical dilatation are associated with poor pregnancy performance in subsequent pregnancies, ectopic pregnancy (including a rare type of ectopic pregnancy which requires hysterectomy as its treatment), infertility, infection and maternal death from uterine hemorrhage. Also, as was stated in our discussion, Drs. McMahon and Haskell are both Family Practitioners who only do abortions for a living, are not trained to do high risk obstetrics and who have not supplied any longitudinal data substantiating their claims that the partial birth abortion procedures they performed had no negative impact on the thousands of women they treated. From the evidence that has been presented in standard obstetrical textbooks as well as in the annals of research in OBGYN there is absolutely no medical necessity for this abortion technique portions of which have been clearly documented to be causal factors in the death and reproductive morbidity of women.

Furthermore, as we also discussed, a person interested in doing a genetic analysis of a malformed child would be better off with living tissue obtained from an induced labor than with freshly killed tissue obtained from an abortion. The baby would also, truly, be completely intact and could be held and normally mourned for by the parents.

Finally, I also mentioned to you my interest in public health and the problems this procedure amply illustrates of how the public's safety has been jeopardized by the abortion industry. In chapters 14, 15 and 18 of a book entitled **Public Health and Law** by Tom Christoffel we are reminded of why institutional review boards, informed consent and

waiting periods were necessary to establish in this country as American citizens were intentionally medically misinformed, sterilized and experimented upon as recently as the 1970's by medical personnel. As it is still a government function to maintain the public's safety it is clearly a responsibility and obligation to investigate and, in this case, ban a medical technique that is a documented threat to the health of women and children. Particularly when there are safer, cheaper and more expeditious means presently available to deal with complex medical, social and emotional problems that are occasionally encountered in the late stages of pregnancy.

If I can be of any further assistance in your research of this matter do not hesitate to contact me.

1. **Wright, C etal Lancet June 10, 1972**
Documents a ten fold increase in second trimester spontaneous abortion following a pregnancy terminated electively. Discussion section noted this effect was probably the result of forceful cervical dilatation

2. **Dicker, D etal The Journal of Reproductive Medicine Vol 30 No 1 Jan 1985**
Case reports of women who needed hysterectomy for the treatment of cervical-ectopic pregnancy. Authors warn that induced abortion was associated with this rare type of ectopic pregnancy.

3. **Koller, O and Eikhom, S Acta OBGYN Scandanavia Vol56 311-317 1977**
Documents a decline in future reproductive performance by women who have had induced abortions when compared with women who have had miscarriages and those who had a normal delivery. The discussion section in this paper clearly states that case control studies have confirmed an association between ectopic pregnancy and previous induced abortion. It also states that women have poorer pregnancy outcomes in the future if they elect to have an abortion rather than carrying the baby to term.

4. **Mittal, S and Misra, S Int J Gyn Obset 1985 Vol 23 pages 45-50**
Documents uterine perforation in 9344 elective abortions but also notes in the discussion section that unrecognized perforation is not uncommon

5. **Moberg, P Int J Gyn Obset Vol 14 pages 77-80 1976**

Documents that perforation at the cervical-isthmic junction(the most vascular part of the uterus) occurred in 22% of the cases analyzed. Suggested that prostaglandins, a compound that induces labor, be used instead to avoid this type of potentially fatal complication.

6. **Grimes, D etal Surgery, Gynecology and Obstetrics November 1983 Vol 157 pages 461-466**
An article reviewing fatal hemorrhage from legal abortion in the United States. Authors start out saying that deaths should not occur but still do. End the article by saying women who have had a uterine perforation are over 1000 times more likely to die from hemorrhage than those who do not.

7. **Lanska, M etal Letter to Editor JAMA July 15, 1983 Vol 250 No 3**
Authors point out that when comparing mortality statistics of abortion to childbirth that one should stratify based on type of delivery (ie vaginal delivery vs C/Section vs vaginal abortion) rather than linking all delivery types together. When one does this vaginal birth is far safer than abortion.

8. **Pritchard, J (editor) Williams Obstetrics 17th edition**
In chapter 21 pages 416-417 there is a discussion of amniotic fluid embolism...a condition that has over a 90% maternal mortality rate. Dr. Warren Hearn, the author of **Abortion Practice**, has acknowleged that this complication can be associated with the partial birth abortion technique(PBA). Chapter 44, which deals with breech extraction, ends on page 866 where internal podalic version is discussed (putting a hand inside of the uterus, turning the baby around and doing a breech extraction). It is clearly stated that this procedure is rarely indicated. And that when it is done the cervix should be fully dilated(something that can not be accomplished by mechanical techniques alone),the membranes are intact (something that is specifically avoided in partial birth abortion)and the baby is small or dead. Partial birth abortion has been performed on term infants as well as on 24-27 week babies who can weigh up to 2 pounds. The chapter ends by saying serious trauma to the mother is possible particularly if a baby is flipped around from a head first position.

TOM A. COBURN, M.D.
2d District, Oklahoma
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Telecommunications and Finance
Health and Environment
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(918) 341-8407 (Fax)
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(918) 542-6287 (Fax)

Congress of the United States
House of Representatives
Washington, DC 20515-3602

June 7, 1996

60 Minutes
524 West 57 Street
New York, NY 10019

Dear 60 Minutes,

I was disappointed when I watched the "60 Minutes" piece on partial-birth abortion to note that there was only one physician interviewed on the segment, and one who has a long history of advocacy for unrestricted abortion even during the final months of pregnancy. That was stacking the deck.

As I discussed with your producer during a lengthy telephone conversation, I was prepared to give an on-camera interview to discuss the issue. I am qualified to discuss both the medical and legislative aspects of the Partial-Birth Abortion Ban Act because I am a practicing obstetrician and a member of Congress who was actively involved in passing the bill.

From my experience as a physician and having delivered more than 3000 babies in my lifetime, I know that it is never necessary to take the life of a child in the process of being born. Partial-birth abortion is a procedure tantamount to infanticide.

I understand that you also spoke with Dr. Nancy Romer of Dayton, Ohio, and Dr. Pamela Smith of Chicago. They too provided you with information on the various reasons why partial-birth abortion is never necessary.

Clearly there are many physicians who – unlike Dr. Hern, who specializes in late-term abortion -- are vehemently opposed to this procedure. I believe "60 Minutes" did a disservice to its viewing audience by declining to interview any doctor who opposed the use of partial-birth abortion.

Sincerely,

Tom A. Coburn

Tom Coburn, M.D.
Member of Congress

cc:Mail for: Representative Pete Kott

Subject: Info to support legitimacy/necessity of HB65

From: fchapel@polarnet.com at CC2MHS1 2/20/97 9:58 AM

To: Representative Pete Kott at LAA_TRANS

Dear Representative Kott:
I listened in on a portion of the teleconference on HB65 on Tuesday, Feb. 18. I am sorry I was not able to listen in on the debate this morning (2/20). I am a pastor in Tok and am very much in favor of your bill. I'm not sure what data you have on the issue or who your sources for information have been. I have contacted the organization Focus on the Family, which is an excellent resource, and they are sending me a packet of articles on partial birth abortion. I will forward these to you, if you think they can be of value. These may give you more ammunition for defending the legitimacy and necessity of HB65. If you would like this info, please have your office drop me a quick note.
Keep up the good and important work you're doing.

Terry Pruett, Pastor
Faith Chapel
P.O. Box 57
Tok, AK 99780
907-883-4771
E-mail: fchapel@polarnet.com

Faxed 2-20-97

Thank you Pete Kott for Sponsoring this!

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House State Affairs committee on HB65 "An Act relating to partial-birth abortions." A listen-only teleconference was held on 2-20-97.

My name is Ruth Ewig and I reside at 2325-30th Avenue. I am in complete support of HB65 and there were at least 600 of us up here in the Tanana Valley, one year and a half ago, and probably more at this time.

Thank you for caring enough about human life to have written this bill which bans partial-birth abortions. I am hopeful that bills such as this which are traveling through the legislative process represent the cutting edge of a swing in the state and hopefully the nation toward morality, thus reversing the "decay of a nation."

Representative James, thank you for your courageous stand in preventing supporters of these deaths of pre-born babies from badgering our witnesses. Those who continue to insist that it is the woman's choice need to be required to state just what choice we are talking about. It would be too embarrassing to verbalize protecting the medical procedure of killing the baby after most of it has been delivered.

Thank you to legislators who have the discernment and foresight to get us off this "slippery slope" to destruction that we are on with our different killing procedures such as partial birth abortions. Partial birth abortion represents destruction of the helpless and the weak.

I support this bill also because of the attitudes that develop in the hearts and souls of physicians who repeatedly destroy human life. Surely, they become quite insensitive to what they are doing after repeatedly killing babies. Each step makes the next step a little easier and we are already moving into euthanasia, "medically assisted suicides" and the next phase, attacks on the elderly.

Vote YES to ban partial birth abortions. It is long overdue. Please contact me if there is more that I can do to help.

Sincerely yours,

Ruth Ewig

Ruth Ewig

2/20/97

452-5538 phone/fax

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name

committee on Post-Birth Abortion HB65 bill/subject, dated 3/5/97.

I oppose HB65. While I do not encourage unnecessary abortions, I do not feel the legislature ought to involve itself in medical decisions affecting women's reproductive rights + freedoms. ~~While~~ ~~this particular bill~~ moreover, Leave those decisions to the woman + her physician. From a ~~another~~ legal standpoint, I am concerned at the breadth of this particular bill as well. In the absence of any time restrictions or guidelines, I am concerned that this bill will impact legal abortions performed in the 1st or 2nd trimester.

Signed: Lisa Fitzpatrick
Testifier

self
Representing (Optional)

2822 Iliamna Ave. Anch. 99517
Address

248 1206
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee committee name committee on HB 65 / HB 37 bill/ subject, dated 3/5/97.

KINDLY PASS HB 65 & HB 37.

PARENTAL CONSENT

THOUGH THERE ARE SOME DIFFICULT SITUATIONS FOR WHICH SOME MINORS WILL HAVE DIFFICULTY DISCUSSING LIFE/DEATH ISSUES WITH THEIR PARENTS I BELIEVE AS A STATE WE SHOULD NOT BE LEGISLATING SITUATIONS OR ENCOURAGING MINORS TO AVOID TALKING WITH THEIR PARENTS.

PARTICAL BIRTH ABORTIONS:

A VOTE FOR LIFE PLEASE

ENOUGH ALREADY SAID BY OTHER PRO-LIFE SPEAKERS.

Signed: D. Koehler NS / D. KOEHLER MD.
Testifier

SELF
Representing (Optional)

PO BOX 1539 DELTA JCT AK 99737
Address

895-1903
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name committee on HB37 HB65 bill/ subject, dated 2/19/97.

Please support both of these bills for the following reasons:

HB 37 Parents, in most cases, have the greatest interest in the minor daughter and any pre-born children. Parents bear children not the State of Alaska or any other state or government entity.

Unwanted pregnancies occur because of irresponsibility on the part of the minor. Bringing the parent(s) into the situation brings about responsibility and accountability needed to deal with the current dilemma and also open the lines of communication to prevent/minimize future irresponsible sexual behavior.

Keeping unwanted pregnancies secret only increases the guilt that the minor experiences and can eventually overwhelm some causing depression or worse problems. Few minors can make mature decisions in situations of unwanted ~~baby~~ pregnancies let alone S.T.D.'s.

Strengthen the family and parental rights.

Signed: Daniel E Davis

Testifier

self Dist 35

Representing (Optional)

P.O. Box 1285 D.J.

Address

675-4190

Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name

committee on H.B.65 PARTIAL BIRTH ABORTION, dated MARCH 5, ~~1996~~ 1997.
bill/subject

Thank you for this opportunity. My thoughts on the disgusting D&X procedure are this:

Why outlaw it? Whether you put a man in a dark room before mutilating and murdering him or drag him half-way out of the room before killing him matters little.

I seriously doubt that ending partial birth abortions will save lives. In fact, by our outrage over this method of murder we lend credence to the ridiculous idea that a baby is miraculously transformed from a lump of tissue into a human being as it passes through the birth canal.

Abortion is a dark deed and it should be brought to light. I wish that you would write a bill requiring that the D&X and all abortion procedures be filmed and studied in health classes beginning with 4th grade sex ed.

Signed: Sally A. Oppokedak
Testifier

self
Representing (Optional)

HC 33 BOX 3180, WASILLA, AK. 99654
Address

(907) 373-7845
Phone No.

RECEIVED
MAR 10 1997

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name
committee on HB65/HB37, dated 3-5-97.
bill/ subject

I urge passage of both HB37 and HB65.

As a parent of 2 girls I am greatly concerned that a life-altering, life-ending procedure as abortion could be performed without my consent.

I refer you to the article from the Wall Street Journal ~~article~~ about partial birth abortion which I read to the House State Affairs Committee during their teleconference on HB65. The Committee requested a copy of this article and should be able to make it available to you.

Signed: Debra J. Parker
Testifier

RPA, District 35 Chairman
Representing (Optional)

PO Box 377, Delta Jct, AK 99737
Address

(907) 895-4565
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Comm. committee name on HB 37 + 65, dated Mar. 5, 1997.
bill/ subject

HB 37 - I would like to go on record as a supporter of the HB 37. I have always been in agreement with the parent involvement in all the decisions of their children.

HB 65 - I go on record stating I am in agreement w/ HB 65. I am not in agreement w/ partial-birth abortion. I am against abortion.

Signed: Jo E McBride
Testifier

Representing (Optional)

P.O. Box 779
Address

Delta Jct. Ak 99737

Phone No. 907-895-4009

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY committee name

committee on 37 AND 65 bill/ subject, dated 1/19/97 AND 1/13/97

37 - relating to a requirement that a parent guardian or Custodian consent before certain minors receive an abortion,
65 - an act relating to partial-birth abortions;
It is in my opinion
I think the Government from Fed. to the local street
(37) sweeper has no business meddling in the affairs of the family. These situations should be resolved by the parents who should have complete authority over their minor children, however a minor should not be forced to have an abortion against her will.
(65) I am 100% against Partial birth abortions. If the mothers life was in danger, it would certainly be known before the baby is 99% born! Partial birth abortions is evil, against all factors of morality and it is murder in my opinion, and against the laws and nature of almighty God! I believe that anyone with a healthy conscience could never do or allow such a thing to be done. Where does personal responsibility come in? Does it matter what God thinks anymore?

Signed: _____
Testifier
Robert L Hollibee
Representing (Optional)
Self
Address
Mile 1378 Alaska Hwy.
Phone No. NONE

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY Comm.
committee name
committee on HB 65 , dated 5 MAR 97 .
bill/ subject

I urge passage of this partial-birth abortion bill.

Surely the new statement by a Dr. Fitzsimmons should change the tone of this debate. He is the oft-quoted pro-choice dr. cited by many, including Pres. Clinton, as supporting both the rarity & the necessity of this procedure. His admission last week that his previous statements were a lie, was a bombshell that should give new clarity to this question. On CBS news, he now stated that this procedure is not rare – done not on a few hundred women, as previously stated, but on 309000-500,000 women per year. And as to necessity, he stated that this procedure was not limited to hopelessly deformed babies, as previously stated, but that most of these procedures were performed on healthy babies.

I urge you to vote YES to stop this barbarous procedure.

Signed: BARBARA RAUALT
Testifier
RPA – DIST 35 – FINANCE CHR
Representing (Optional)
PO BOX 823 – DELTA
Address
895-1946
Phone No.

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
January 12, 1997

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, DC 20090-6920 Telephone 202 638 5577

907-465-4276

Alaska Legislature
Joe Green, Chair
District 10

Marty Haber
432 E. 15th Terrace
Anchorage, AK 99501
907-343-4757

Dear Mr. Green

I was an active supporter in your campaign and it has come to my attention that you will participating in the voting of HB 37 and HB 65. My concern is that you hear the voices of your people and then, make the **best** decision. It will be hard to know what that is. You must listen to your heart, your head and your inner gut feeling.

Imagine yourself a woman, a young teenage female, or a pregnant woman whose health is in danger due to the pregnancy. Would you like to have had someone, through law, not allow you a **choice** of what your options are. That is the fundamental question here. **CHOICE,** keep it alive. Perhaps someday you might want a choice to make. Please vote **NO, against HB 37 and HB 65.**

My prayers are with you.

Sincerely,

Marty Haber

Marty Haber

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB 65 & HB 37, dated 3/5/97
bill/subject

HB 65: Partial birth abortion is child abuse in its most extreme form. I believe the destruction of human life (albeit in the womb) chips away at society as a whole.

HB 37: Laws prevent minors from buying cigarettes and alcohol. It does not make sense a major decision of a young girl to have an abortion can be made without parental knowledge or consent.

Signed: A. Vivian Mackie
Testifier

Representing (Optional)

P. O. Box 2095
Address

907-747-7816
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name committee on HB 165 bill/subject, dated 3-5-97.

A woman & her doctor must make these difficult decisions without government interferance.

Women must be trusted to make their own decisions regarding their own health.

Signed: Dawn Taisanen
Testifier

Representing (Optional)

35985 Homer Dr. Soldotna AK 99669
Address

262-9833
Phone No.

Geo. Dozier @ KOTS
HB65

Telecon
FBKS
Anch
Kenai
Soldotna
Sitka

Mister Chairman, and members of the House Judiciary Committee, for the record my name is George Dozier, and I am an aide in the Office of Representative Pete Kott, the prime sponsor of HB 65

At the outset, I would like to discuss, just briefly, federal constitutional requirements in the abortion context. As everyone knows, the seminal case addressing the constitutionality of abortion in the United States is Roe v Wade, 410 US 113. Generally, the Court held as follows:

1. The fourteenth amendment includes a right to privacy, and this right is broad enough to include the right to obtain an abortion. Roe, 410 US, at 177.

2. This right is not absolute and may be limited by states' legitimate interest in safeguarding women's health, maintaining proper medical standards, and protecting potential human life. Roe, 410 US, at 177.

3. Applying these principles, the Court arrived at the following conclusions. During the first trimester, the state, essentially, may not interfere in a woman's decision to obtain an abortion. Roe, 410 US, at 183. From the end of the first trimester, the state may regulate abortion to safeguard the health of the mother. From the point of viability, the state may proscribe abortions, except where necessary to preserve the life and health of the mother. Roe, 410 US, at 183.

4. It may be noted that the Roe Court specifically and expressly rejected an argument that a pregnant woman is "...entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she chooses." Roe, 410 US, at 177.

The most recent Supreme Court opinion discussing abortion is Planned Parenthood v. Casey, which can be found at 505 U.S. 833; 120 L Ed 2d 674 (1992). In Casey, the Court found that states have a substantial interest in potential human life, and that this extends throughout the pregnancy. Casey, 120 L Ed 2d, at 714. Indeed, this interest is characterized as "profound". Casey, 120 L. Ed 2d, at 715. The Court found that its opinions subsequent to Roe had undervalued this interest of states in potential human life, 120 L Ed 2d, at 711, and as a consequence, it rejected the rigid trimester system first articulated in Roe. Casey, 120 L Ed 2d, at 710. Instead, it divided pregnancies into two periods---previability and viability.

According to the Casey Court, during that first period, in which the baby is not viable, states may not place an "undue burden" on a woman's right to decide whether to terminate a pregnancy. It defined "undue burden" as regulations that have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. 120 L Ed 2d, at 715.

During the second period, in which the baby is viable, the constitutional standard is different. As stated by the court, in quoting from Roe: "...subsequent to viability, the State in promoting its interest in the

potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Casey, 120 L Ed 2d, at 716.

To summarize: First, the state has a substantial interest in potential human life which extends throughout the pregnancy. Second, prior to viability, the state can not place an undue burden on the right to pregnancy, which means placing a substantial obstacle in the path of a woman seeking an abortion. Third, after viability, the state may regulate abortion, and even prohibit them, except where necessary to protect the life or health of the mother.

Since partial birth abortions span the last part of the previability stage and into the viability stage, HB 65 is specifically designed to cover both. Hence, it must be analyzed with respect to both standards. HB 65 more than meets these standards.

First, with respect to previability abortions, HB 65 does not place an undue burden on the right to chose an abortion. That is to say, it does not place a substantial obstacle, either by intent or in effect, in the path of a woman seeking an abortion. After all, it does not proscribe abortions per se. It merely makes one particular form of abortion, and a particularly egregious form at that, illegal. All other forms of abortion remain open to pregnant women. The fact that this does not place a substantial obstacle in the path of women seeking abortion is clear. The Director of Public Health in Alaska testified that partial birth abortions, as defined by the bill, have not been

performed in Alaska. Thus, the question must be asked: Does HB 65, which proscribes a procedure which, thus far, is not done in Alaska, place a substantial obstacle in the path of a woman seeking an abortion? The answer, by definition, is clearly no. The procedure is not available anyway.

In that regard, can it really be a substantial obstacle to require abortionists to conform to the standards of abortion practice already present and accepted by practitioners in Alaska. That, to my mind, is no obstacle at all, let alone a substantial one.

In short, all options presently available to women to obtain abortions remain unaffected. There is no obstacle, and thus, the first standard---that which applies to previability pregnancies---is clearly satisfied.

The second standard, which applies to viable babies, is also satisfied. As I previously indicated, during the period of viability, the Supreme Court recognizes that the state may regulate or even proscribe abortions, except where necessary to preserve the life or health of the mother. HB 65 does not ban abortions during this period; it merely bans a particular procedure. Thus, it is more of a regulation of abortion than a proscription. And, the state is free to regulate, except where necessary to preserve the life and health of the mother. HB 65 contains an express exception applicable to the life of the mother. It does not mention health. However, it does not need to expressly mention health for the following reasons:

First, all forms of abortion present in Alaska remain in effect. If the mother's health requires an abortion, she continues to have recourse to those procedures. Her health is protected.

Second, even when partial birth abortions become available in Alaska, their ban would not adversely impact maternal health. The Committee was provided with voluminous material clearly establishing that fact. For instance, as Dr. Pamela Smith, who is the Director of Medical Education, Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago, testified before the US Senate: "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". Similarly, Dr. James Jones, who is chairman of the Department of Obstetrics and Gynecology at the New York Medical College, stated, regarding partial-birth abortions, that he "can't imagine that being an indicated procedure for the saving of a life or well-being of the mother." Although the AMA has remained neutral on the issue, its Legislative Council voted unanimously to recommend that the AMA endorse the federal partial birth ban. In so doing, it stated that the procedure is basically repulsive and is not a recognized medical technique. Again, the former Surgeon General of the United States, Dr. C. Everett Koop stated: "...In no way can I twist my mind to see that the late-term abortion as described---you know, partial-birth, and then destruction of the unborn child before the head is born---is a medical necessity for the mother." Similarly, Dr. Warren Hern who wrote the Horn Book on late term abortions, stated in an article in American Medical News: "You really can't defend it... I would dispute any statement that this is the safest procedure to use." He stated

further: "You have to be concerned about causing amniotic fluid embolism or placental abruption if you do that."

I won't bore you with more opinions. There are plenty in the materials. The point is that partial-birth abortions are not necessary for the health of the mother.

In summary: The Legislature can conclude that partial birth abortions are not necessary to preserve the health of the mother, and indeed may even be inimical to the health of the mother. No express exception is needed, since all other procedures remain available.

Thus, both the previability and the postviability standards required by Casey are satisfied. That being the case, all that is required is that there be some rational basis for HB 65. And, there are several permissible state interests that are advanced by HB 65. Indeed, the State has compelling interests in preventing such procedures. Let me suggest but a few.

First, delivering a baby just to the very cusp of constitutional personhood and then killing it, just inches away from being completely born, is cruel. Indeed, Dr. Isada, who spoke against HB 65 before the House State Affairs Committee, described one aspect of partial birth abortion---sticking scissors into the baby's skull---as gruesome. The state has a very strong interest in protecting human life from such cruel and gruesome actions. If the state can prevent cruelty to animals, it certainly can do the same thing for human life.

Second, partially delivering a baby ---or, I should say almost entirely delivering a baby---and then killing it tends to mix the roles of obstetrician and abortionist. The former are healers, and they are perceived as such by the general public. Abortionists, in the overwhelming number of cases, ---for instance I refer you to Dr. Haskill's statement that 80% of his partial birth abortions are elective---are not healers. They perform some other function. By mixing these two opposing roles, there is great danger that public confidence in the medical profession will be undermined.

Third, bringing a baby right to the very edge of complete birth and then sucking its brains out is inherently disrespectful of human dignity.

Fourth, the state has a legitimate and compelling interest in drawing a clear distinction between legal abortion and infanticide. Partial birth abortions blur that distinction. Furthermore, it may be noted that the difference between a viable baby who has just emerged from the womb and a viable baby who is almost out of the womb is negligible. But for a few inches they are the same. To permit the killing of one and forbid the killing of the other is ludicrous and will breed disrespect for the law. So fine a distinction, carrying such dire consequences, can not but be scoffed at by Alaska's people.

Hence, in my opinion, partial birth abortions are fully constitutional under the guidelines established by the United States Supreme Court. I would like to turn now to some of the specific arguments that have been made against the constitutionality of HB 65.

First, it has been argued that HB 65 creates an undue burden because partial birth abortions are the safest alternative. This, of course, is an assertion of fact, and the alleged fact is extremely dubious. This Committee has been provided with an abundance of materials indicating that partial birth abortions are not necessary for maternal health and further indicating that partial birth abortions, *in themselves*, present a risk to maternal health.

It also has been argued that the Supreme Court, in Planned Parenthood v. Danforth, held unconstitutional an abortion statute which proscribes the use saline amniocentesis, in part because such a prohibition would force women to use more dangerous methods. On the surface, this argument has a certain appeal. After all, HB 65, like Danforth, involves the proscription of a defined abortion procedure. However, Danforth is clearly distinguishable, on at least three grounds. First, HB 65, unlike the Danforth statute, does not force women to use procedures which are less safe than partial birth abortions. Second, the Danforth court emphasized that the proscribed method was the most prevalent available, and that another safe method was not yet available. Here, with HB 65, the proscribed method is not yet used in Alaska and other, safe, methods *are* available. Third, Danforth predates Casey and thus its analysis focused on whether the statute advanced maternal health. This was during the period in which states' interest in protecting potential human life was undervalued. Casey changed all of that. Now, unlike when Danforth was decided, it is recognized that the state's interest in human life may be asserted throughout pregnancy. HB 65 does just that, and it may be expected that the right to assert that interest would be weighed in any constitutional challenge. Danforth, quite simply, is distinguishable.

It also has been argued that the only Court to review a ban similar to HB 65 invalidated it, because for some women the prohibited procedure would be safer than other available techniques. The case is Women's Medical Professional Corp v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995). The Court in that case, within the context of deciding whether to issue a preliminary injunction and prior to a full trial, held that D&X was safer than other methods; and, because D&X was more available than induction methods, which require hospitalization, a proscription on D&X was a substantial burden. The Court was certainly entitled to make its findings. This Committee has an equal right to make findings of fact, and ample evidence has been presented to it to base a contrary finding concerning safety. Moreover, this Committee reasonably can not find, given the testimony of the Public Health Director, that partial birth abortions are more prevalent than any other methods. In Alaska, partial birth abortions, thus far have not been performed. Our state, fortunately, seems to lag behind the rest of the United States in adopting undesirable conduct.

It also has been argued that the definition of partial-birth abortions is overbroad because it could encompass procedures other than partial birth abortions. It is true that statutes which are so broad as to sweep within their coverage not only properly proscribed acts but also constitutionally protected acts are unconstitutional. The definition employed in HB 65, however, is not of that nature. It does not overlap other alternative methods. They are clearly distinct and clearly outside the coverage of HB 65. It is also argued that the definition is vague. Vague statutes, particularly those that impose criminal liabilities, are unconstitutional. However, HB 65's definition is not vague. It is clear and precise. It establishes definitively what is proscribed.

Persons of common intelligence easily can understand what is prohibited and thus there will not be a chilling effect. Proponents of this argument may have in mind the definition used in the statute examined by the court in Voinovich. There, the court---and I think quite rightly--- concluded that there was an overlap and that the statute was vague. But, the definition of D&X employed in that case does not in the slightest resemble HB 65's definition. I can quote the Ohio definition for you. "The termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. 'Dilation and extraction procedure' does not include either the suction curettage procedure of abortion or the suction aspiration procedure of abortion." The court found that this definition overlaps normal D&E procedure (because both may involve inserting a suction device into the skull) and because D&E is not excluded as suction curettage or suction aspiration. Further, the Voinovich Court noted that in analyzing statutes for vagueness, the absence of a mens rea requirement is somewhat persuasive. In fact, it relied on this concept in finding another portion of the Ohio law unconstitutionally vague. In HB 65, it may be noted that there is an express mens rea.

Concerns regarding vagueness are misplaced. This bill does not resemble, in any respect, the statute considered by the Voinovich court. It is clear and precise, and it does not overlap any other abortion procedure. It is such as to apprise people of common intelligence what is being prohibited, and there is no reason to believe that it will have a chilling effect on constitutionally protected acts. Finally, since it is clear, there is no danger of arbitrary or discriminatory enforcement.

Finally, it is argued that the privacy clause of the Alaska Constitution would be violated by HB 65. The Alaska Supreme Court has not yet decided an abortion case using this constitutional provision. What we do know is that, although the right is broader than the privacy right found by the US Supreme Court in the US Constitution, *it is not absolute.* And, certainly, the right to privacy is not violated when an alleged infringement is justified by a legitimate and compelling governmental interest.

Although the Alaska Constitution's right of privacy is deemed to be broader than that of the United States Constitution, it does not reach everywhere and cover all things. Essentially there is a two step analysis that is required. First, it must be determined if the conduct in question is within the scope of the amendment. Then, and only then, it must be determined if the alleged infringement bears a fair and substantial relation to a compelling governmental interest.

First, does partial-birth abortions fall within the scope of the amendment? The Alaska Supreme Court has determined that this issue is resolved by answering two questions: (1) Does the person have an actual (that is, subjective) expectation of privacy concerning the conduct? (2) Is the expectation one that society is prepared to recognize as reasonable? If both questions are answered in the affirmative, the conduct falls within the scope of the privacy amendment. Hilbers v Muni. of Anchorage, 611 P. 2d 31 (1980).

In Alaska, as with the rest of the United States over the last quarter century, many people have been conditioned to perceive abortion as part of the culture. Indeed, the Casey Court made much of that fact in discussing

whether or not it would be appropriate to abandon the central tenants of Roe. Given this state of affairs, it would not surprise me that some would have a subjective expectation a privacy right to engage in even this gruesome procedure. But, is subjective expectation something that we as a society are prepared to recognize as reasonable? I think not. In my opinion, for the reasons I have discussed at length in this testimony, society is not even close to recognizing as reasonable any such assertion of a privacy right to obtain a partial-birth abortion. Hence, this procedure falls outside the scope of the amendment.

Even assuming, arguendo, that partial-birth abortions are within the scope of Alaska's constitutional right to privacy, society's hands are not tied. As previously stated, the right is not absolute. An alleged "infringement" is permissible if it bears a fair and substantial relationship to a compelling governmental interest.

I respectfully submit to you that Alaska has a compelling state interest in protecting babies, who are almost born, who are mostly outside the bodies of their mothers, from having their brains sucked out. I also submit that the government has a compelling interest in protecting public confidence in the medical profession by not blurring the roles of healer and abortionist. I also suggest to you that the government has a compelling interest in protecting the almost born from this cruel, gruesome, and undignified death. Accordingly, HB 65 does not run afoul Alaska's right to privacy.

In conclusion, HB 65 will pass constitutional muster.

AMENDMENT #1 CROFT

fails
3/10/97

OFFERED IN HOUSE JUDICIARY

TO: CS HB 65 ( ) work draft dated 3/4/97

Page 2, line 8 following "save the life":

Insert "or health"

Page 2, line 8 following "mother":

Delete "whose life"

Insert "who"

CROFT

AMENDMENT #2

OFFERED IN HOUSE JUDICIARY

TO: CSHB 65 ( ) work draft dated 3/4/97

fails
3/10/97

Page 2, line 13 following "means":

Delete "an"

Insert "a third trimester"

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: February 21, 1997 **FURTHER REFERRALS:**

Date of Committee Action: 3/10/97

The JUDICIARY Committee considered: **HB 65**

HOUSE BILL NO. 65 **PARTIAL-BIRTH ABORTIONS**

"An Act relating to partial-birth abortions."

recommends it be replaced with the following committee substitute _____ [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [X] fiscal note(s) (1) ADMIN. (INDETERMINATE)

[ ] zero fiscal note(s) _____ [X] zero fiscal note(s) (1) HSS

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
CROFT			✓	
ROKEBERG			✓	
PORTER			✓	
GREEN	✓			
JAMES	✓			
BERKOWITZ		✓		

CHAIR'S SIGNATURE _____

Official Business

COMMITTEE: HOUSE JUDICIARY

DATE: March 5, 1997 - Wednesday

Subject of meeting: HB 65 - Partial-Birth Abortions

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS (MAILING) & (ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
Amy Skilbred	4477 Abby Way Juneau 9980	780-4649	ACLU	Yes
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nikki Sullivan	P.O Box 20572 Juneau 99801	789-2000	self	Yes
JOSEPH HEIDENER	4600 NO DOUGLAS/ JUNEAU 99801	586-2900	SELF	YES
DAVID ROGERS	BOX 33932 JUNEAU	586-1107	WARDEN'S (IBB)	YES
Pat Denny	526 Seward Juneau 99801	586-3925	self	yes
SID HEIDERSDORF	Box 020658 JUNEAU	789-9858	SELF	YES
John Mongle	POBox 210527 Auke Bay	789-5910	Alaska Right to Life	Y
Sandy King	PO Box 22953 Juneau	790-3522	Self	Y
Peter Nakamura	DHSS / Juneau	465 3090	DHSS	Yes
Tom Gerday	PO Bx 34832 Juneau 99803	389-3953	Juneau Christian Coalition	Yes

STATE OF MICHIGAN
88TH LEGISLATURE
REGULAR SESSION OF 1996

Introduced by Reps. Ryan, Horton, Cropsey, Hill, Green, Middleton, Nye, Llewellyn, Walberg, Lowe, Kaza, Porreca, Griffin, London, Olshove, Palamara, Geiger, DeMars, Mathieu, Baade, Harder, Owen, Alley, Ciaramitaro, LeTarte, McNutt, Randall, Gustafson, Perricone, Voorhees, McManus and Rocca
Reps. Goschka and McBryde named co-sponsors

ENROLLED HOUSE BILL No. 5889

AN ACT to amend sections 16221 and 16226 of Act No. 368 of the Public Acts of 1978, entitled as amended "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," section 16221 as amended by Act No. 196 of the Public Acts of 1995 and section 16226 as amended by Act No. 133 of the Public Acts of 1993, being sections 333.16221 and 333.16226 of the Michigan Compiled Laws; and to add sections 17016 and 17516.

The People of the State of Michigan enact:

Section 1. Sections 16221 and 16226 of Act No. 368 of the Public Acts of 1978, section 16221 as amended by Act No. 196 of the Public Acts of 1995 and section 16226 as amended by Act No. 133 of the Public Acts of 1993, being sections 333.16221 and 333.16226 of the Michigan Compiled Laws, are amended and sections 17016 and 17516 are added to read as follows:

Sec. 16221. The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:

(a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession.

(b) Personal disqualifications, consisting of 1 or more of the following:

(i) Incompetence.

(ii) Subject to sections 16165 to 16170a, substance abuse as defined in section 6107.

(iii) Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

(iv) Declaration of mental incompetence by a court of competent jurisdiction.

(v) Conviction of a misdemeanor punishable by imprisonment for a maximum term of 2 years; a misdemeanor involving the illegal delivery, possession, or use of a controlled substance; or a felony. A certified copy of the court record is conclusive evidence of the conviction.

(vi) Lack of good moral character.

(vii) Conviction of a criminal offense under sections 520a to 520l of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being sections 750.520a to 750.520l of the Michigan Compiled Laws. A certified copy of the court record is conclusive evidence of the conviction.

(viii) Conviction of a violation of section 492a of the Michigan penal code Act No. 328 of the Public Acts of 1931, being section 750.492a of the Michigan Compiled Laws. A certified copy of the court record is conclusive evidence of the conviction.

(ix) Conviction of a misdemeanor or felony involving fraud in obtaining or attempting to obtain fees related to the practice of a health profession. A certified copy of the court record is conclusive evidence of the conviction.

(x) Final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States. A certified copy of the record of the board is conclusive evidence of the final action.

(xi) Conviction of a misdemeanor that is reasonably related to or that adversely affects the licensee's ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence of the conviction.

(c) Prohibited acts, consisting of 1 or more of the following:

(i) Fraud or deceit in obtaining or renewing a license or registration.

(ii) Permitting the license or registration to be used by an unauthorized person.

(iii) Practice outside the scope of a license.

(iv) Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 or a drug as defined in section 7105 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.

(d) Unethical business practices, consisting of 1 or more of the following:

(i) False or misleading advertising.

(ii) Dividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or in behalf of patients.

(iii) Fraud or deceit in obtaining or attempting to obtain third party reimbursement.

(e) Unprofessional conduct, consisting of 1 or more of the following:

(i) Misrepresentation to a consumer or patient or in obtaining or attempting to obtain third party reimbursement in the course of professional practice.

(ii) Betrayal of a professional confidence.

(iii) Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service.

(iv) Directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest.

(f) Failure to report a change of name or mailing address within 30 days after the change occurs.

(g) A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.

(h) Failure to comply with a subpoena issued pursuant to this part, failure to respond to a complaint issued under this article or article 7, failure to appear at a compliance conference or an administrative hearing, or failure to report under section 16222 or 16223.

(i) Failure to pay an installment of an assessment levied pursuant to section 2504 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.2504 of the Michigan Compiled Laws, within 60 days after notice by the appropriate board.

(j) A violation of section 17013 or 17513.

(k) Failure to meet 1 or more of the requirements for licensure or registration under section 16174.

(l) A violation of section 17015 or 17515.

(m) A violation of section 17016 or 17516.

Sec. 16226. (1) After finding the existence of 1 or more of the grounds for disciplinary subcommittee action listed in section 16221, a disciplinary subcommittee shall impose 1 or more of the following sanctions for each violation:

Violations of Section 16221	Sanctions
Subdivision (a), (b)(ii), (b)(iv), (b)(vi), or (b)(viii)	Probation, limitation, denial, suspension, revocation, restitution, community service, or fine.
Subdivision (b)(vii)	Revocation or denial.
Subdivision (b)(i), (b)(iii), (b)(v), (b)(ix), (b)(x), or (b)(xi)	Limitation, suspension, revocation, denial, probation, restitution, community service, or fine.
Subdivision (c)(i)	Denial, revocation, suspension, probation, limitation, community service, or fine.
Subdivision (c)(ii)	Denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)(iii)	Probation, denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)(iv) or (d)(iii)	Fine, probation, denial, suspension, revocation community service, or restitution.
Subdivision (d)(i) or (d)(ii)	Reprimand, fine, probation, community service, denial, or restitution.
Subdivision (e)(i)	Reprimand, fine, probation, limitation, suspension, community service, denial, or restitution.
Subdivision (e)(ii) or (h)	Reprimand, probation, suspension, restitution, community service, denial, or fine.
Subdivision (e)(iii) or (e)(iv)	Reprimand, fine, probation, suspension, revocation, limitation, community service, denial, or restitution.
Subdivision (f)	Reprimand or fine.
Subdivision (g)	Reprimand, probation, denial, suspension, revocation, limitation, restitution, community service, or fine.
Subdivision (i)	Suspension or fine.
Subdivision (j)	Reprimand or fine.
Subdivision (k)	Reprimand, denial, or limitation.
Subdivision (l)	Denial, revocation, restitution, probation, suspension, limitation, reprimand, or fine.
Subdivision (m)	Revocation or denial.

(2) Determination of sanctions for violations under this section shall be made by a disciplinary subcommittee. If, during judicial review, the court of appeals determines that a final decision or order of a disciplinary subcommittee prejudices substantial rights of the petitioner for 1 or more of the grounds listed in section 106 of the administrative procedures act of 1969, being section 24.306 of Michigan Compiled Laws, and holds that the final decision or order is unlawful and is to be set aside, the court shall state on the record the reasons for the holding and may remand the case to the disciplinary subcommittee for further consideration.

(3) A disciplinary subcommittee may impose a fine of up to, but not exceeding, $250,000.00 for a violation of section 16221(a) or (b).

(4) A disciplinary subcommittee may require a licensee or registrant or an applicant for licensure or registration who has violated this article or article 7 or a rule promulgated under this article or article 7 to satisfactorily complete an educational program, a training program, or a treatment program, a mental, physical, or professional competence examination, or a combination of those programs and examinations.

Sec. 17016. (1) Except as otherwise provided in subsection (2), a physician or an individual performing an act, task, or function under the delegatory authority of a physician shall not perform a partial-birth abortion, even if the abortion is otherwise permitted by law.

(2) A physician or an individual described in subsection (1) may perform a partial-birth abortion if the physician or other individual reasonably believes that performing the partial-birth abortion is necessary to save the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury and that no other medical procedure will accomplish that purpose.

(3) This section does not create a right to abortion.

(4) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

(5) As used in this section:

(a) "Abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus. Abortion does not include a procedure to complete a spontaneous abortion or the use or prescription of a drug or device intended as a contraceptive.

(b) "Fetus" means an individual organism of the species homo sapiens at any time before complete delivery from a pregnant woman.

(c) "Partial-birth abortion" means an abortion in which the physician or individual acting under the delegatory authority of the physician performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

Sec. 17516. (1) Except as otherwise provided in subsection (2), a physician or an individual performing an act, task, or function under the delegatory authority of a physician shall not perform a partial-birth abortion, even if the abortion is otherwise permitted by law.

(2) A physician or an individual described in subsection (1) may perform a partial-birth abortion if the physician or other individual reasonably believes that performing the partial-birth abortion is necessary to save the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury and that no other medical procedure will accomplish that purpose.

(3) This section does not create a right to abortion.

(4) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

(5) As used in this section:

(a) "Abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus. Abortion does not include a procedure to complete a spontaneous abortion or the use or prescription of a drug or device intended as a contraceptive.

(b) "Fetus" means an individual organism of the species homo sapiens at any time before complete delivery from a pregnant woman.

(c) "Partial-birth abortion" means an abortion in which the physician or individual acting under the delegatory authority of the physician performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

Section 2. This amendatory act shall take effect October 1, 1996.

Civil Action ?

Clerk of the House of Representatives.

Carol Morey Viventi

Secretary of the Senate.

Approved 1:17 p.m. 6/14/96

John Engler

Governor.

4

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Ashcroft 462 US 476

Ohio v Akron 497 US 502

Hodgson 497 US 417

Bellotti 443 US 645

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IN THE HOUSE COMMITTEE ON
STATE AFFAIRS

TESTIMONY OF JANET CREPPS
THE CENTER FOR REPRODUCTIVE LAW AND POLICY
IN OPPOSITION TO HOUSE BILL 65

FEBRUARY 18, 1997

Good morning Madame Chair and members of the Committee. My name is Janet Crepps. I am a staff attorney and director of the state legislative program with the Center for Reproductive Law and Policy. I am here to speak in opposition to the proposal to ban so-called "partial-birth abortions." I have been a member of the Alaska bar since 1983. Along with other attorneys at the Center, I currently represent the plaintiffs in *Mat-Su Coalition for Choice v. Valley Hospital*, a case involving the obligation of a community hospital to provide abortions, which is currently pending before the Alaska Supreme Court. The Center also represents abortion providers in Ohio in a challenge to that state's 1995 law banning dilation and extraction abortions, a case which deals with many of the same legal issues raised by HB 65.

House Bill 65 would ban the performance of "partial-birth abortions" unless the procedure is performed to "save the life of a woman" "if no other medical procedure" would suffice. This bill is based on an unconstitutional premise -- namely that the government may prohibit a method of abortion that for some women is the safest and most appropriate medical care. In other words -- in the balance that has been struck by the U.S. Supreme Court between a woman's right to terminate a pregnancy and state interests, the government may not make its interests in the fetus paramount to women's health.[1]

Since the Supreme Court's 1992 decision in *Planned Parenthood v. Casey*, courts evaluate statutes restricting pre-viability abortions using the "undue burden" test. A statute imposes an undue burden if it has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion."[2]

House bill 65 creates an undue burden because in some circumstances, the intact dilatation and evacuation method, which would clearly be prohibited under the bill, is the safest alternative to all other methods of terminating the pregnancy.

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[1] In an unbroken line of cases beginning with *Roe v. Wade*, the Supreme Court has recognized that the State cannot "interfer[e] with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992) *citing Roe v. Wade*, 410 U.S. 113, 164 (1973).

[2] *Id.* at 877.

The Supreme Court has already held unconstitutional a ban on the use of an abortion procedure known as saline amniocentesis in part because the ban "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed."[3] Under this reasoning, HB 65 is clearly invalid, because it too would require women to terminate pregnancies by methods that pose a greater risk to their lives and health.

The only court to review a ban similar to HB 65, a 1995 Ohio law prohibiting dilation and extraction abortions, invalidated the statute because for some women the prohibited procedure would be safer than other available techniques.[4]

Even when the government exercises its authority to ban abortions after viability, the Supreme Court has made clear that the state may not make its interest in the fetus paramount to women's health or require a "'trade-off' between a woman's health and fetal survival."[5]

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[3] *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 78-79 (1976).

[4] *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051, 1071 (S.D. Ohio 1995). The court also found that the prohibition would force women seeking pre-viability abortions to undergo procedures requiring hospitalization, while the banned method could be performed in an out-patient setting. *Id.* at 1071.

[5] *Thornburgh v. Amer. Coll. of Obst. & Gyn.* 476 U.S. 747, 768-70 (1986) *overruled in part, Planned Parenthood v. Casey*, 112 S. Ct. at 2823, *citing Colautti v. Franklin*, 439 U.S. 379, 400 (1979) (holding unconstitutional a law requiring post-viability abortions to be performed using the method "which would provide the best opportunity for fetal survival," unless it "would present a significantly greater medical risk to the life or

Restrictions on abortion are also subject to review under the explicit right of privacy contained in the Alaska constitution.[6] The Alaska Supreme Court has consistently held that this guarantee provides more protection of individual rights than the Federal Constitution. While the Court has not yet ruled on a case involving the right to privacy in the context of abortion, it has held that the Alaska Constitution protects an individual's autonomy to make choices affecting his or her body and personal life, and has recognized that the right to privacy provides protection for personal decisions about childbearing.[7] Thus, even if the federal courts should stray from the strong protection provided thus far to ensure the health of women seeking abortions, HB 65 would still be likely to fail under the Alaska Constitution.

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health of the pregnant women"); *see also*, *Jane L. v. Bangerter*, 61 F.3d 1493, 1503-04 (10th Cir. 1995) (a law requiring physicians to use the method that would best ensure fetal survival, unless it "would gravely damage a woman's medical health," "unconstitutionally devalue[s] a woman's privacy rights").

[6] Alaska Const. Article 1 § 22 provides in part that "[t]he right of the people to privacy is recognized and shall not be infringed. . . ."

[7] *See, e.g., Breese v. Smith*, 501 P.2d 159, 168 (Alaska 1972) (recognizing that at the core of Alaska's constitutional heritage is the "notion of total immunity from governmental control: the right to be let alone"); *Falcon v. Alaska Public Offices Comm'n*, 570 P.2d 469, 479 n. 42 (Alaska 1977) ("decisions whether to accomplish or prevent contraception are among the most private and sensitive"); *Ravin v. State*, 537 P.2d 494, 502 (Alaska 1975) (noting that decisions involving contraception are "significantly personal areas").

In addition to the problems I have outlined, HB 65 would also be subject to constitutional challenge on vagueness grounds, which was an additional reason why the law in Ohio was permanently enjoined.[8]

Physicians performing abortions must be permitted to provide the safest and most appropriate care to their patients. Women seeking legal reproductive health care cannot and should not be made to sacrifice their health. I urge you not to support this patently unconstitutional bill.

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[8] The *Voinovich* court held that the definition of dilation and evacuation used in the Ohio bill was impermissibly vague because "that the statutory definition . . . could be construed to include the more widespread Dilation and Evacuation ("D&E") procedure." 911 F. Supp at 1064. Thus, "it does not provide physicians with fair warning as to what conduct is permitted, and as to what conduct will expose them to criminal and civil liability." *Id.* at 1067.

JOSEPH D. RIEDERER, M.D.
4500 NO. DOUGLAS
JUNEAU, ALASKA 99801
TELEPHONE 907 - 586-2900

March 6, 1997

Representative Pete Kott
State of Alaska
FAX#465-2819

RE: House Bill #65

Dear Representative Kott:

I had hoped to testify on House Bill #65 but I will be out of Juneau at the next hearing. I was present on March 5.

My name is Joseph Riederer. I have been a Juneau physician since 1961. I am not a specialist in OB-GYN; however, a major part of my practice was obstetrics from 1961-77 and I attended perhaps 2000 deliveries, and from that time, have continued to do some C-section and laparoscopic OB and GYN care from 1977-96. I am writing in support of House Bill #65. I would have like to have testified against the use of partial birth abortion as a medical procedure. I believe it is unspeakably inhumane to carry this procedure out on what is frequently a viable infant.

This type of medical procedure, that is, a partial birth abortion, is not even listed or discussed or described as a medical procedure in any of the current OB-GYN references that I can find. For instance, the seven volume authoritative reference on Gynecology and Obstetrics by Sciarra, does not even discuss surgical intervention for late term abortions in this manner.

It has been argued that this is a necessary option for the health and safety of the mother. This is not verified by any respected medical authority that I can find. There are multiple procedural complications to the mother in any abortion procedure. That includes certainly uterine perforation, or rupture, sepsis, bleeding after the procedure, and incompetent cervix, sterility, andpsychological trauma, etc. All of this is in addition to the fetal death. People certainly need to figure out before the 2nd or 3rd trimester if abortion is an option or not if you believe an abortion is a necessity.

The proposed definition of this Bill is specific and no other medical procedure

would be restricted or affected by banning partial birth abortion. The language is clear and specific.

I hope that House Bill #65 will be enacted. Thank you for this consideration.

Sincerely,

Joseph D. Riederer, M.D.

Alaska Perinatology Associates

FEB 27 1997

February 17, 1997

Representative Ethan Burkowitz
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Re: Senate Bills #'s 12 & 14

Honorable Representative Ethan Burkowitz:

I would like to take this opportunity to express my concern as a provider of medical services to pregnant women and their fetuses. As a brief introduction, my name is Sherrie Richey, and I am a board-certified Obstetrician/Gynecologist with sub-specialty training in Maternal Fetal Medicine (Perinatology). This sub-specialty deals with high-risk and medically complicated pregnancy, prenatal diagnosis, including high resolution ultrasound to diagnose fetal abnormalities, and intrauterine fetal therapy, such as fetal blood sampling and fetal blood transfusions. As the first, and now one of only three perinatologists in the State of Alaska, I am in a unique position to comment on the effect that Senate Bills 12 & 24, if enacted, would have on health care for women in our state.

My partners and I spend hundred of hours a week attempting to diagnose and treat genetic and structural abnormalities in unborn children. We do this for several reasons: We firmly believe that knowledge of these abnormalities will provide for opportunities to prepare the parents to care for a child with an abnormality, to provide for optimal early newborn care including informing the sub-specialists required to be present at the birth of a child with an abnormality, and in some cases, to perform life-saving intrauterine therapy. Unfortunately, several times a month we have the tragic responsibility of informing a couple that their child has a lethal abnormality, and that there is nothing that we can do to change that outcome. We attempt to provide the best support possible, both medically and emotionally, during this most difficult time.

There is a wealth of scientific data supporting the fact that termination of pregnancy at any gestational age is safer for the mother than being pregnant. In many cases, if the mother's affected fetus is allowed to continue gestation, it will be born only to add the horror of watching the child die in the first few hours of life; often a painful death for the infant, the parents, and the health care providers. From a medical standpoint, it makes no sense to allow a pregnancy to continue, increasing the mother's risk of hemorrhage, pre-eclampsia (toxemia), anemia, and other complications which occur more commonly in later gestation, when a fetus has no chance of living. Additionally, the emotional trauma of carrying a child that will not live, having to endure the comments of well-meaning, but uninformed friends, acquaintances, and even strangers on the street, is no trivial matter.

There are many different methods of terminating a pregnancy, with advantages and disadvantages, indications and complications of each one. Obstetricians/gynecologists are uniquely trained to individualize each patient's case to determine the safest method for her as a individual. It appears that Senate Bill No. 12, banning so-called "partial-birth " abortions, was intended to prohibit a type of pregnancy termination which actually takes place very infrequently in the United States, and one that is virtually always chosen because it is the safest way to terminate a pregnancy complicated by a lethal fetal abnormality or a life threatening maternal medical complication. Specific examples of such cases are available if desired. To deprive even one grieving mother and family of the safest

option available to her in these circumstances is unethical and immoral. I cannot, for this reason support Senate Bill No. 12.

Senate Bill No. 24 would seek to require that the legal parents or guardians of minors give consent prior to abortion. I wish to add my voice to that of The American Academy of Pediatrics, The American Academy of Family Physicians, and the American College of Obstetrics and Gynecology, of which I am a member, opposition to this bill. The majority of teenage women voluntarily seek the counsel of a trusted adult when faced with an unwanted pregnancy. Those who do not generally have experienced violence in their family and fear that it will recur. Others believe that parental knowledge would damage their relationship, escalate conflict of coercion in their family, or subject a vulnerable parent to stress and disappointment. The fact that I have to face as a perinatologist, is that regardless of the law, the vast majority of these young women will terminate their pregnancies, many under desperate circumstances. Enactment of this bill will only ensure that more of them will have the pregnancy terminated at a later gestational age, in an unsterile, unsafe, and unregulated environment, and some will lose their fertility, and even their lives in the process.

All it takes is one telephone call to any of my mentors at the University of Texas Southwestern Medical School in Dallas, several of whom are co-authors of the leading obstetrical textbook "Williams Obstetrics", who will recount the days prior to the legal termination of pregnancy, when wards of women were gravely ill and dying, or rendered incapable of bearing children due to complications of "back-alley" abortions. Regardless of one's personal moral beliefs about abortion, no physician who remembers those days would choose to relive them.

As a physician who spends many of my waking hours fighting to preserve and improve the lives of unborn children and save the lives of women with complicated pregnancies, I must in all good conscience, strongly urge you to oppose these dangerous pieces of legislation, as I believe they will do nothing but jeopardize the lives and well-being of a particularly vulnerable and unfortunate group of women.

Thank you for allowing me to express my professional views on bills no. 12 & 24 and I will be looking forward to talking with you in Washington on March 18th regarding these and other health care issues.

Sincerely,

Sherrie D. Richey MD
Alaska Perinatology Associates

cc: Cynthia Brooke MD
Jan Whitefield MD
Susan Lemagie MD
Ethan Burkowitz MD

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on #37 / STA , dated 3/6/97 .
bill/subject

Please oppose Bill #37. I have no doubt in my mind that the parents of my girlfriends would not hesitate to hit them when faced with their daughters pregnancy. This among many other reasons frightens me to think, that they will have to tell their parents, about having an Abortion.

Signed: Robert Calvin
Testifier

Representing (Optional)

P.O. Box 713 Sitka Ak 99835
Address

907-747-6134
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name

committee on #37 / STA bill/subject, dated 3/5/97.

Please oppose Bill no. 37!

Signed: Elizabeth M Casanovas
Testifier

Representing (Optional)
Self Malaspina S. St. AK 99835

Address
907 747-3796

Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee
committee name

committee on HB 37/STA, dated 3/5/97.
bill/subject

Please oppose #37/STA

thank you

Joyce

Signed: Joyce A. Thomas
Testifier

self
Representing (Optional)

PO Box 6433 Sitka AK 99835
Address

907-966-2554
Phone No.

LIO FAX # 747-5807

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB65 / Partial Birth, dated March 5, 1997.
bill/subject Abortion

I am opposed to the passage of this bill - contrary to anti-choice propaganda, this is a procedure which occurs rarely + with great agony to parents who want their child but become aware there is something terribly wrong with the fetus. This is an opportunistic way to further the anti-choice agenda.

Signed: Jeanette M Rutherford
Testifier

Representing (Optional)

301 Moller Ave Sitka
Address

907 747-5379
Phone No.

9/88 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the Judiciary
committee name

committee on Parental Consent before minor's abortion dated 3-5-97
bill/subject

Signed: Corrine Z Eagle
Testifier

Representing (Optional)

909 HPR #39, Sitka
Address

(907) 747-3595
Phone No.

HB 37 would protect my parental rights. As a parent it is my right and duty to protect, care for, and nurture my child. The passing of HB 37 would ensure that these rights are safe guarded.

HB 37 would also protect minors from making uninformed decisions. The decision to have an abortion is a serious one, and should be researched fully before the procedure is performed. Most minors lack the maturity to make this decision on their own. HB 37 would be a shield to minors, protecting them from a potentially harmful procedure. A procedure that could leave emotional scars for the rest of their lives.

I have been in the position of a pregnant minor. It is a frightening and confusing time. During this time abortion crossed my mind as an alternative. Without my parents I would have chosen this route, not having even the faintest idea about the consequences of such an operation. I am eternally thankful that my parents had an opportunity to help me make the right decision. Every parent should have that opportunity.

I give my full support to HB 37. Passing the bill in is the best interests of families, parents, and children.

Alaska State Legislature

Please enter into the record my testimony to the Judiciary committee name

committee on Partial-Birth abortion bill/subject, dated 3-5-97.

Signed: Don S Eagle
Testifier

Representing (Optional)
909 HPR #39, Sitka

Address
747-3595

Phone No.

I strongly support HB65. Partial-birth abortion is a shocking reversal of what is right and what is wrong. We are now being told that it is "wrong" to restrict in any way what a woman would do with "her" baby. We are told it is "right" to allow physicians to kill what would otherwise likely be a healthy baby. This is a travesty of justice. The blood of those undefended victims will be on all of our hands if we allow this institutional homicide to continue. We must immediately rid our state of this procedure and set an example for the rest of the country as a state that will actively protect and defend those who cannot defend themselves.

Consider the procedure itself. Word cannot adequately describe the horror of partial-birth abortion. Can those who support it really call it "good" and "necessary" without shuddering at the realities of the procedure, considering it a "necessary evil" in their hearts? Is evil really necessary? At one time, early-term abortions were shocking and then became more or less accepted. At this time, partial birth abortion is shocking; do we make it illegal, as it should be, or do we let it become more or less accepted? What then? Why not pull the baby all the way out before jabbing the scissors into its skull? Better yet, let there be a one month trial period after birth to decide if the baby will cause unresolvable difficulties. If there is a problem, let the baby be brought back before the month is over, and then it may be killed. We'll call it "post-birth abortion." Shocking? Not if we continue to close our eyes to this present horror, thereby allowing the continuing encroachment on the rights of our undefended child.

I support HB65 because it will end this horror in Alaska. There should be no basis in the law for partial-birth abortion. It is nothing short of murder. It is wrong. We Alaskans can take the lead in the Nation by ridding our state of this horror and making the clear statement that partial-birth abortion will never be acceptable.

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY
committee name

committee on HOUSE BILL 37, dated MARCH 6, 1997.
bill/subject

PLEASE VOTE AGAINST H.B. 37.
GOVERNMENTAL MICROMANAGEMENT
CAN ONLY LEAD TO FURTHER BREAKDOWN
OF THE FAMILY UNIT.

WARD M. ELDIDGE

Signed: Ward M. Eldridge
Testifier

Representing (Optional)

PO BOX 6245, SITKA, AK 99835
Address

907-747-8278
Phone No.

STATE OF ALASKA

LEGISLATIVE AFFAIRS AGENCY

DIVISION OF PUBLIC SERVICES

DATE: 3/7/97

Please accept the enclosed original(s) of written testimony for the House Judiciary teleconference hearing that was scheduled on 3/7/97.

A copy of this testimony was transmitted to your committee via fax on 3/7/97.

Thank you,

LEGISLATIVE AFFAIRS AGENCY
Sitka Legislative Office
210 Lake Street
Sitka, Alaska 99835
747-6276

STATE of ALASKA

Delta Junction Legislative Information Office

P.O. Box 1189
Room 210, Jarvis Office Center
Delta Junction, AK 99737
(907) 895-4236
Fax: (907) 895-5017

March 5, 1997

TO: House Judiciary

Please accept the enclosed originals of written testimony for the House Judiciary hearing that was scheduled on 3/5/97.

Copies of this testimony were transmitted by fax on 3/5/97.

Thank you,

Tammy Renee' Hall
Information Assistant

Enclosures: 7

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY Comm.
committee name

committee on HB 65 , dated 5 MAR 97 .
bill/ subject

I urge passage of this partial-birth abortion bill.

Surely the new statement by a Dr. Fitzsimmons should change the tone of this debate. He is the oft-quoted pro-choice dr. cited by many, including Pres. Clinton, as supporting both the rarity & the necessity of this procedure. His admission last week that his previous statements were a lie, was a bombshell that should give new clarity to this question. On CBS news, he now stated that this procedure is not rare – done not on a few hundred women, as previously stated, but on 309000-500,000 women per year. And as to necessity, he stated that this procedure was not limited to hopelessly deformed babies, as previously stated, but that most of these procedures were performed on healthy babies.

I urge you to vote YES to stop this barbarous procedure.

Signed: BARBARA RAWALT
Testifier

RPA – DIST 35 - FINANCE CHR.
Representing (Optional)

PO BOX 823 – DELTA
Address

895-1946
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY Comm.
committee name

committee on HB 37, dated 5 MAR 97.
bill/ subject

I urge passage of this bill to require parental consent for a minor to have an abortion. Parents have the responsibility to guide their children, + are required to give their consent on many more mundane matters, that have been cited earlier; ~~s~~ surely they should be needing to give their consent in this ~~context~~, potentially life-threatening surgical procedure. To exempt this procedure from the requirement for parental consent makes no sense at all, + further erodes parental rights. I strongly urge passage of this bill.

Signed: BARBARA RAWALT
Testifier

RPA - DIST 35 - FINANCE CHR.
Representing (Optional)

PO BOX 823 - DELTA
Address

895-1946
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name

committee on 37 AND 65 bill/ subject, dated 2/19/97 AND 1/13/97

37 - relating to a requirement that a parent guardian or custodian consent before certain minors receive an abortion,
65 - an act relating to partial-birth abortions;
This is my opinion;

(37) I think the Government from Fed, to the local street sweeper has no business meddling in the affairs of the family. These situations should be resolved by the parents who should have complete authority over their minor children, however a minor should not be forced to have an abortion against her will.

(65) I am 100% against Partial birth abortions. If the mothers life was in danger, it would certainly be known before the baby is 99% born! Partial birth abortion is evil, against all factors of morality and it is murder in my opinion, and against the laws and nature of almighty God! I believe that anyone with a healthy conscience could never do or allow such a thing to be done. Where does personal responsibility come in? Does it matter what God thinks anymore?

Signed: _____

Testifier

Robert L Wallace

Representing (Optional)

Self

Address

Mile 1378 Alaska Hwy.

Phone No. NONE

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Comm.
committee name

committee on HB 37 & 65, dated Mar. 5, 1997.
bill/ subject

HB 37 - I would like to go on record as a supporter of the HB 37. I have always been in agreement with the parent involvement in all the decisions of their children.

HB 65 - I go on record stating I am in agreement w/ HB 65. I am not in agreement w/ partial-birth abortion. I am against abortion.

Signed: Jo E. McBride
Testifier

Representing (Optional)

P.O. Box 779
Address

Dell, Jct. Ak 99737

Phone No. 907-895-4009

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name
committee on HB65/HB37, dated 3-5-97.
bill/ subject

I urge passage of both HB37 and HB65.

As a parent of 2 girls I am greatly concerned that a life-altering, life-ending procedure as abortion could be performed without my consent.

I refer you to the article from the Wall Street Journal ~~a title~~ about partial birth abortion which I read to the House State Affairs Committee during their teleconference on HB65. The Committee requested a copy of this article and should be able to make it available to you.

Signed: Debra A. Davis

Testifier

RPA District 35 Chairman

Representing (Optional)

POBox 377 Delta Jct. AK 99737

Address

(907) 895-4565

Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HOUSE JUDICIARY COMMITTEE committee name committee on HB 65 / HB 37 bill/ subject, dated 3/15/93.

KINDLY PASS HB 65 & HB 37.

PARENTAL CONSENT

THOUGH THERE ARE SOME DIFFICULT SITUATIONS FOR WHICH SOME MINORS WILL HAVE DIFFICULTY DISCUSSING LIFE/DEATH ISSUES WITH THEIR PARENTS I BELIEVE AS A STATE WE SHOULD NOT BE LEGISLATING ABORTIONS OR ENCOURAGING MINORS TO AVOID TALKING WITH THEIR PARENTS.

PARTICAL BIRTH ABORTIONS:

A VOTE FOR LIFE PLEASE

ENOUGH ALREADY SAID BY OTHER PRO-LIFE SPEAKERS.

Signed: D. Koehler MD / D. KOEHLER MD
Testifier

SELF
Representing (Optional)

PO BOX 1539 DELTA JCT AK 99737
Address

895-1903
Phone No.

My name is Kay Scott my address is 7400 E 17th 99504.
I could have sworn I was born in America not Holland
I am against abortion in any way.
When this all started it was to happen with in a few weeks now these abortion are done in any month right up to the 9th month.
I checked the paper from front to back and no where did I find where God had died and left us in charge to pick who lives or dies.
Or are we talking out of both sides of our mouth.
Maybe if this abortion was made legal 20 to 30 years ago you would not be here today
America says they don't believe in capital punishment and were not allowed to spank our children, but in the next breath were going to kill these little babies so humanely
What happen to adoption?

With Today Medical
Advances known as an option

There are so many people who would give anything to have a baby.
What's happen to America?
For Christ, for Christ don't these little babies have a Choice to.
You know if we don't watch out our country is going to become like Hallond.
When we go into the Doctor for something he may decide we are not important enough or maybe live long enough and just wipe us out.
You people in Juneau better start thinking long term on some of these decision you make because they will effect you at some time in your life.
By the way I'm a mother of 4 and Grandmother of 4½ and I love each of you more with all my heart. There a part of me that I can give to my Country.

Alaska State Legislature

Please enter into the record my testimony to the House
committee name

committee on #65 , dated 3/7/97 .
bill/subject

I believe that Partial Birth Abortion is nothing short of murder, I can't imagine why or how a Doctor can do something so cruel to a little baby.

There are alot of myths vs truth and like Ron Finkelstein. We are being misled.

I think this is awful. and don't want it in our city or State.

Signed: Debra Margrill
Testifier

Representing (Optional)

873 Norman St
Address

907 333-4894
Phone No.

My name is Tesha Sandy. I am twenty years old and a mother of two beautiful children. So you all probably know how sick this issue makes me feel. I cant even imagine someone thinking about this even being an option in our society. This type of stuff is beginning in our country and now may be a possibility in our state and I am supposed to be proud to be an American?

On April 10, 1996, President Clinton vetoed the partial birth abortion ban act. On April 15, the bill was refered back to the House Judiciary Committee. President Clinton defended his veto of this legislation by saying that he wanted to protect the "health" of the mothers involved. However, "Health" is so broadly defined in the context of U.S. abortion law as to include all factors - pysical, emotional, psychological, familial, and the womans age - relevent to the well being of the patient". The health position Clinton has taken makes abortion legal for whatever reason.

Have you ever sat down and thought about how it would feel to have surgical scissors stabbed into your head and the life just sucked right out of you and not have any control over it. These babies are in a completely warm, safe, happy wonderful place and then all of a sudden, its over. If the abortionist made a mistake and the babys head slipped out of the mother before he got the scissors in, this baby would then legally be a person. This baby is only seconds away from life.

My sister just lost her first baby. This precious little baby was my first neice. She was only three weeks old. My sister feels so much guilt as would almost any mother who lost a baby. But I cant even imagine the guilt of a mother that let someone suck the brains out of her baby.

The only positive outcome of this entire situation is that the baby that this happens to is immediatly in heaven and will not ever have to suffer [redacted]

through the disgusting tragedies in this world such as this. Nor will the baby ever have to know the sick type of people who are wanting partial birth abortions to happen.

Tesha Sanchez.
5630 South Tahiti
Anchorage, AK 99507

(907) 563-9894

Arthur Bobyn

Henry Hyde's Plea to Override the President's Veto of the Partial Birth Abortion Ban

Basic Right to Life

Taken from the Congressional Record

September 19, 1996

Mr. HYDE. Mr. Speaker, I beg the indulgence of my colleagues not to ask me to yield because I cannot and will not and I would appreciate their courtesy. I also want to say briefly that those who have charged us with politics, invidious politics, for delaying this debate ought to understand that Americans cannot believe this practice exists and it has taken months to educate the American people and it will take many more months to educate them as to the nature and extent of this horrible practice. That is one reason it has taken so long.

The law exists to protect the weak from the strong. That is why we are here.

Mr. Speaker, in his classic novel `Crime and Punishment,' Dostoyevsky has his murderous protagonist Raskolnikov complain that `Man can get used to anything, the beast!'

That we are even debating this issue, that we have to argue about the legality of an abortionist plunging a pair of scissors into the back of the tiny neck of a little child whose trunk, arms and legs have already been delivered, and then suctioning out his brains only confirms Dostoyevsky's harsh truth.

We were told in committee by an attending nurse that the little arms and legs stop flailing and suddenly stiffen as the scissors is plunged in. People who say `I feel your pain' are not referring to that little infant.

What kind of people have we become that this procedure is even a matter for debate? Can we not draw the line at torture, and baby torture at that? If we cannot, what has become of us? We are all incensed about ethnic cleansing. What about infant cleansing? There is no argument here about when human life begins. The child who is destroyed is unmistakably alive, unmistakably human and unmistakably brutally destroyed.

The justification for abortion has always been the claim that a women can do with her own body what she will. If you still believe that this four-fifths delivered little baby is a part of the woman's body, then I am afraid your ignorance is invincible.

I finally figured out why supporters of abortion on demand fight this infanticide ban tooth and claw, because for the first time since Roe v. Wade the focus is on the baby, not the mother, not the woman but the baby, and the harm that abortion inflicts on an unborn child, or in this instance a four-fifths born child. That child whom the advocates of abortion on demand have done everything in their power to make us ignore, to dehumanize, is as much a bearer of human rights as any Member of this House. To deny those rights is more than the betrayal of a powerless individual. It betrays the central promise of America, that there is, in this land, justice for all.

The supporters of abortion on demand have exercised an amazing capacity for self-deception by detaching themselves from any sympathy whatsoever for the unborn child, and in doing so they separate themselves from the instinct for justice that gave birth to this country.

The President, reacting angrily to this challenge to his veto, claims not to understand why the morality of those who support a ban on partial birth abortions is superior to the morality of `compassion' that he insists informed his decision to reject Congress' ban on what Senator Moynihan has said is `too close to infanticide.'

Let me explain, Mr. President. There is no moral nor, for that matter, medical justification for this barbaric assault on a partially born infant. Dr. Pamela Smith, director of medical education in the Department of Obstetrics and Gynecology at Chicago's Mount Sinai Hospital, testified to that, as have many other doctors.

Dr. C. Everett Koop, the last credible Surgeon General we had, was interviewed by the American Medical Association on August 19, and he was asked:

Question: `President Clinton just vetoed a bill on partial birth abortions. In so doing, he cited several cases in which women were told these procedures were necessary to preserve their health and their ability to have future pregnancies. How would you characterize the claims being made in favor of the medical need for this procedure?'

Answer: Quoting Dr. Koop, `I believe that Mr. Clinton was misled by his medical advisors on what is fact and what is fiction in reference to late term abortions.'

Question: `In your practice as a pediatric surgeon, have you ever treated children with any of the disabilities cited in this debate? Have you operated on children born with organs outside of their bodies?'

Answer: `Oh, yes, indeed. I've done that many times. The prognosis usually is good. There are two common ways that children are born with organs outside of their body. One is an omphalocele, where the organs are out but still contained in the sac composed of the tissues of the umbilical cord. I have been repairing those since 1946. The other is when the sac has ruptured. That makes it a little more difficult. I don't know what the national mortality would be, but certainly more than half of those babies survive after surgery.

`Now every once in a while, you have other peculiar things, such as the chest being wide open and the heart being outside the body. And I have even replaced hearts back in the body and had children grow to adulthood.'

Question: And live normal lives?

Answer: Living normal lives. In fact, the first child I ever did with a huge omphalocele much bigger than her head went on to develop well and become the head nurse in my intensive care unit many years later.'

The abortionist who is a principal perpetrator of these atrocities, Dr. Martin Haskell, has conceded that at least 80 percent of the partial-birth abortions he performs are entirely elective; 80 percent are elective. And he admits to over a thousands of these abortions, and that is some years ago.

We are told about some extreme cases of malformed babies as though life is only for the privileged, the planned and the perfect. Dr. James McMahon, the late Dr. James McMahon, listed nine such abortions he performed because the baby had a cleft lip.

Many other physicians who care both about the mother and the unborn child have made it clear this is never a medical necessity, but it is a convenience for the abortionist. It is a convenience for those who

choose to abort late in pregnancy when it becomes difficult to dismember the unborn child in the womb.

Well, the President claims he wants to solve a problem by adding a health exception to the partial-birth abortion ban. That is spurious, as anyone who has spent 10 minutes studying the Federal law, understands. Health exceptions are so broadly construed by the court, as to make any ban utterly meaningless.

If there is no consistent commitment that has survived the twists and the turns in policy during this administration, it is an unshakable commitment to a legal regime of abortion on demand. Nothing is or will be done to make abortion rare. No legislative or regulatory act will be allowed to impede the most permissive abortion license in the democratic world.

The President would do us all a favor and make a modest contribution to the health of our democratic process if he would simply concede this obvious fact.

In his memoirs Dwight Eisenhower wrote about the loss of 1.2 million lives in World War II, and he said:

'The loss of lives that might have otherwise been creatively lived scars the mind of the civilized world.'

Mr. Speaker, our souls have been scarred by one and a half million abortions every year in this country. Our souls have so much scar tissue there is not room for any more.

And say, what do we mean by human dignity if we subject innocent children to brutal execution when they are almost born? We all hope and pray for death with dignity. Tell me what is dignified about a death caused by having a scissors stabbed into your neck so your brains can be sucked out.

We have had long and bitter debates in this House about assault weapons. Those scissors and that suction machine are assault weapons worse than any AK-47. One might miss with an AK-47; the doctor never misses with his assault weapon, I can assure my colleagues.

It is not just the babies that are dying for the lethal sin of being unwanted or being handicapped or malformed. We are dying, and not from the darkness, but from the cold, the coldness of self- brutalization that chills our sensibilities, deadens our conscience and allows us to think of this unspeakable act as an act of compassion.

If my colleagues vote to uphold this veto, if they vote to maintain the legality of a procedure that is revolting even to the most hardened heart, then please do not ever use the word compassion again.

A word about anesthesia. Advocates of partial-birth abortions tried to tell us the baby does not feel pain; the mother's anesthesia is transmitted to the baby. We took testimony from five of the country's top anesthesiologists, and they said it is impossible, that result will take so much anesthesia it would kill the mother.

By upholding this tragic veto, those colleagues join the network of complicity in supporting what is essentially a crime against humanity, for that little, almost born infant struggling to live is a member of the human family, and partial-birth abortion is a lethal assault against the very idea of human rights and destroys, along with a defenseless little baby, the moral foundation of our democracy because democracy is not, after all, a mere process. It assigns fundamental rights and values to each human being, the first of which is the inalienable right to life.

One of the great errors of modern politics is our foolish attempt to separate our private consciences from our public acts, and it cannot be done. At the end of the 20th century, is the crowning achievement of our democracy to treat the weak, the powerless, the unwanted as things? To be disposed of? If so, we have not elevated justice; we have disgraced it.

This is not a debate about sectarian religious doctrine nor about policy options. This is a debate about our understanding of human dignity, what does it mean to be human? Our moment in history is marked by a mortal conflict between culture of death and a culture of life, and today, here and now, we must choose sides.

I am not the least embarrassed to say that I believe one day each of us will be called upon to render an account for what we have done, and maybe more importantly, what we fail to do in our lifetime, and while I believe in a merciful God, I believe in a just God, and I would be terrified at the thought of having to explain at the final judgment why I stood unmoved while Herod's slaughter of the innocents was being reenacted here in my own country.

This debate has been about an unspeakable horror. While the details are graphic and grisly, it has been helpful for all of us to recognize the full brutality of what goes on in America's abortuaries day in and day out, week after week, year after year. We are not talking about abstractions here. We are talking about life and death at their most elemental, and we ought to face the truth of what we oppose or support stripped of all euphemisms, and the queen of all euphemisms is `choice' as though one is choosing vanilla and chocolate instead of a dead baby or a live baby.

Now, we have talked so much about the grotesque; permit me a word about beauty. We all have our own images of the beautiful; the face of a loved one, a dawn, a sunset, the evening star. I believe nothing in this world of wonders is more beautiful than the innocence of a child.

Do my colleagues know what a child is? She is an opportunity for love, and a handicapped child is an even greater opportunity for love.

Mr. Speaker, we risk our souls, we risk our humanity when we trifle with that innocence or demean it or brutalize it. We need more caring and less killing.

Let the innocence of the unborn have the last word in this debate. Let their innocence appeal to what President Lincoln called the better angels of our nature. Let our votes prove Raskolnikov is wrong. There is something we will never get used to. Make it clear once again there is justice for all, even for the tiniest, most defenseless in this, our land. □

ALASKA STATE LEGISLATURE

PLEASE ENTER INTO THE RECORD MY TESTIMONY TO THE House Judiciary
COMMITTEE NAME

COMMITTEE ON HB65 DATED 3/7/97
BILL/SUBJECT

I thank you that I can express my vote on this house bill. I support it because it is murder whether or not the babys head is in the birth canal or has taken its first breath. I wonder what situation would requires the need for such a procedure when ceasarian section has been available and would seem safer than the partial birth abortion? I just cant express my heart adequately how cruel and gruesome this is, how I can not understand that it is different from infanticide.

I have had my own children and am trained as an RN, (six live births, one set of twins), and am as against this procedure as anyone could be.

Thank you!

SIGNED [signature]
TESTIFIER

self
REPRESENTING (OPTIONAL)

1789 A Gilmore Dr. Fbks AK 99712 457-2271
ADDRESS/PHONE NUMBER

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on #37 / STA, dated 3/5/97
bill/subject

Please oppose Bill NO. 37. In this age of information we need to focus on educating our children rather than taking away their Rights. If you are Not going to Make consentual sex between two teenagers an offense punishable by law, please do not impose a law on a teenage woman that would force her to bear the burden of an unplanned, unwanted pregnancy. This would be forcing an invasive medical procedure (pregnancy & birth) against her will. (#37) This Represents more gov. restrictions! Please oppose Bill NO. 37

Signed: Lisa Kreder
Testifier

Representing (Optional)

801 Lincoln St. Sitka, AK 99835
Address

747-7547
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on #37/STA, dated 3/5/97.
bill/subject

Please oppose Bill no 37. If this bill passes our teenagers will be at even more risks than just teen pregnancies: parenthood.

Signed: Nicolette I Brown
Testifier

Representing (Optional)

Address

Phone No.

TESTIMONY RE: PROPOSED LEGISLATION BANNING "PARTIAL-BIRTH" ABORTION

Bob Lynn, Vice-President, Alaska Right to Life

Good afternoon, Ladies and Gentlemen.

My name is Bob Lynn. My home address is 4400 Trapline Drive, Anchorage, Alaska. I'm Vice-President of Alaska Right to Life. More importantly, as I said in previous testimony, I'm the father of six children, and also the grandfather of eleven and 5/9th grandchildren.

The bill on which you are receiving testimony is misnamed. You are *not* considering a bill on partial-birth abortion – you are, in fact, debating the propriety of partial-birth *infanticide* - for convenience of mothers, the profit of the abortion industry, and the ghoulish agenda of a Culture of Death.

I will not reiterate the obscene procedure involved in sucking out a baby's brain when the baby is three inches from a routine birth. Only the invincibly ignorant, or hopelessly savage and barbaric, could fail to understand the obscenity. I'm sure you've seen the pictures, and wish you hadn't.

I would, however, point you to answers, with questions.

If the procedure is to protect the mother, why isn't the baby delivered by routine Cesarean delivery? The answer? Killing a baby after a Cesarean is prosecutable homicide. Why does the medicutioner – I cannot in conscience call that person a "doctor" – why does he or she turn the baby for a feet-first breech delivery? The answer? So the baby's head will remain within the birth canal, so the baby cannot cry before or during the procedure. Killing a crying baby could lead to homicide charges.

Killing a partially born baby has *nothing* – I repeat *nothing* – to do with protecting the life of a mother. According to the testimony of Dr. Pamela Smith, before a Committee of the United States Senate, "There is absolutely *no* obstetrical situations . . . which requite a partially delivered human fetus to be destroyed, to preserve the life or health of the mother." This professional opinion is echoed in the American Medical News by Dr. Warren Hern, a leading authority on late-term abortion. He states, "the procedure is *never* necessary to preserve a woman's health.

Furthermore, the little live victim of partial-birth infanticide suffers torturous pain. During Congressional hearings, Dr. Robert Smith, Professor of Neurosurgery at Case Western Reserve University testified that " . . . within this time of gestation, 20 weeks and beyond, the baby is fully capable of experiencing pain and, without a doubt, this is a dreadfully painful experience." In

the words of Congressman Henry Hyde, "People who say 'I feel your pain' are *not* referring to that little infant."

How far down a slippery slope of savagery have we come? How much longer will our elected representatives tolerate such atrocities? How could partial-birth infanticide even be a matter for debate?

This is *not* a so-called "pro-choice" issue. We are not talking here about a "choice" to destroy a microscopic ovum, or fifteen cells - which pro-choice apologists would label a "glob of tissue." What we are talking about is a fully developed - fully developed - baby mere seconds, and three inches, short of birth. The child, from whose skull the brains are suctioned out of, is with*out* doubt alive, is with*out* doubt human, and with*out* doubt suffers unspeakable pain. How *dare* the proponents of such ghastly acts cast stones at those who would engage in ethnic cleansing in Bosnia, and at the same time support "infant cleansing" in America, and here in Alaska!

A ban on partial-birth infanticide, as one should expect, has *widespread* bi-partisan public support in Alaska, and throughout the nation. But partial birth infanticide, killing a nearly born baby, I pray to God, is an issue which *transcends* politics altogether. This is *not* a partisan issue, *not* a gender issue. We are *not* here debating sectarian religious doctrine, or economic theories, or – God forbid – *not* attempting to win political brownie points in our party, or in some

opinion poll. We are *not* speaking here of issues which involve wiping oil off birds, or four dead dogs in the Iditarod. The issue in which we are engaged involves what *is*, and is *not*, sacred *human* dignity, and what *is* - and is not - the acts of a *civilized* community.

Thomas Jefferson stated that the *only* reason a government exists is to protect human life. One need not be a physician, a learned theologian, Mother Teresa, or even a Statesman, to know how one must - in conscience - cast their vote on this issue. Ladies and gentlemen, the ball is in *your* court.

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See Attach A I am submitting an excerpt of the September 19, 1996 Congressional Record which contains an eloquent statement of Congressman Henry Hyde for your thoughtful and honest consideration.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Comm.
committee name

committee on HB37, dated 3/5/97.
bill/subject

See attached

Information you requested

Concerning my verbal statement

Signed: Alice J. Rhoatone
Testifier

Representing (Optional)

213 Shotgun Alley
Address

(907) 747-3931
Phone No.

Laws that restrict access to abortion by requiring parental involvement increase teenage birth rates. For example, according to testimony in the reproductive freedom case *Hodgson v. Minnesota*, the Minneapolis birthrate rose 38.4% among mothers aged 15 to 17 after enforcement of a parental notification law. The birthrate for 18 to 19 year-old women, who were not affected by the law, rose only .3% during the same period.

Having little education, few skills and responsibility for a child they may not have wanted, teenage mothers and their children are seven times more likely to slide into poverty. According to national estimates, children born to teenage mothers in 1987 will receive more than $5.5 billion in federal welfare payments over a 20-year period. And because children born to teenagers are often unwanted, those children may suffer severe psychological and educational disadvantages. As for the minors themselves, their entire adult lives are often limited, if not ruined, by government laws that effectively force them into motherhood.

From: ACLU Briefing Paper on Reproductive Freedom, The Rights of Minors.

TRANSMISSION VERIFICATION REPORT

TIME : 03/03/1997 10:22
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DATE,TIME	03/03 10:22
FAX NO./NAME	19074654410
DURATION	00:00:08
PAGE(S)	00
RESULT	NG
MODE	STANDARD

NG : POOR LINE CONDITION