PARTIAL-BIRTH ABORTION BAN ACT OF 1995—VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 104–198)

The SPEAKER pro tempore. (Mr. LAHOOD). The unfinished business is the further consideration of the veto message of the President of the United States on the bill (H.R. 1833) to amend title 18, United States Code, to ban partial-birth abortions.

The question is, Will the House, on reconsideration, pass the bill, the objections of the President to the contrary notwithstanding?

The gentleman from Florida [Mr. CANADY] is recognized for 1 hour.

Mr. CANADY of Florida. Mr. Speaker, I yield the customary 30 minutes to the gentlewoman from Colorado [Mrs. SCHROEDER].

GENERAL LEAVE

Mr. CANADY of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the legislation under consideration.

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

There was no objection.

Mr. CANADY of Florida. Mr. Speaker, I yield 3 minutes and 30 seconds to the gentleman from Oklahoma [Mr. COBURN].

Mr. COBURN. Mr. Speaker, I have thought a lot about how to best convey what my thoughts are on this subject. I stand here today, not as a member of one party or another, not as somebody who readily admits that they are pro-life. I am. But I stand here today as a doctor.

Mr. Speaker, I have spent the last 18 years of my life, including a great deal of the time of the last 2 years while I have been in this Congress, caring for women who deliver babies. I have personally been involved in over 3,000 births that I have attended. I have seen every complication and every anomaly that has been mentioned in this debate on partial-birth abortion.

I am not standing here as somebody who is pro-life, I am not standing here as somebody that is a freshman Republican. I stand here today to make known to Members that they can vote against an override for only two reasons on this bill. One is that they are totally misinformed of the true medical facts, or that they are pro-abortion at any stage, for any reason. The facts will bear that out.

That is not meant to offend anybody. If somebody feels that way, they should stand up and speak that truth. But this procedure, this procedure is designed to aid and abet the abortionist. There is no truth to the fact that this procedure protects the lives of women. There is no truth to the fact that this procedure preserves fertility. There is no truth to the fact that this procedure in fact is used on complicated, anomalous conceptions. This procedure is used to terminate mid and late second trimester pregnancies at the elective request of women who so desire it.

This has nothing to do with women's emotional health. This has to do with termination of oftentimes viable children by a gruesome and heinous procedure.

What we should hear from those who are going to vote against overriding this is that they agree, that they agree that this procedure is an adequate and expected procedure that should be used, and that it is all right to terminate the life of a 26-week fetus that otherwise the physicians would be held liable under the courts in every State to not save its life, should it be born spontaneously.

So this debate is not about health of women. This debate is about whether or not true facts are going to be discussed in this Chamber on the basis of knowledge and sound science, rather than a political endpoint that sacrifices children in this country.

☐ 1245

Mr. Speaker, this vote is about untruth tied to emotion. We should be willing in our country if we are going to heal our country, if we are going to repair our country, to stand and speak honestly about what this procedure is. I have the experience. There is no one else in this body that has handled all these complications. This procedure never needs to be done again in this United States.

Mr. CONYERS. Mr. Speaker, will the gentleman yield?

Mr. COBURN. If I have time, I would be happy to yield.

Mr. CONYERS. Have you performed this procedure?

The SPEAKER pro tempore (Mr. LAHOOD). The time of the gentleman from Oklahoma has expired.

Mrs. SCHROEDER. Mr. Speaker, I yield 3 minutes to the gentlewoman from New York [Mrs. LOWEY].

Mrs. LOWEY. Mr. Speaker, I rise in opposition to the bill and in support of the President's veto.

Mr. Speaker, I do not speak as a doctor. I speak as a woman with three beautiful grown children. And, Mr. Speaker, and my colleagues, let us be very clear that this debate is all about.

President Clinton stated very clearly that he would sign this bill if it contained a narrow exception to protect the lives and health of American women. The President does not believe that this procedure should be commonly available, he does not believe it should be available on demand, but that it must remain an option for women facing serious risk to life and death and health. In cases where a woman faces a serious health risk like kidney failure, cancer, or diabetes, the decision of how to proceed must be left to the women and the doctor, not this Congress.

So I say to my friends on the other side, let us sit down together, as we offered several times, and write a bill that we could all accept and that the President could sign. In fact, we went to the Republican leadership 3 times, asked to craft a narrow health exception to this bill. Three times we were refused. Why? Because this Republican Congress does not want to ban, it wants an issue, and that is so unfortunate. This is not about abortion. It is about politics, election-year politics, plain and simple.

Mr. Speaker, today's debate is a fitting way to end the most anti-choice Congress in history. This vote is the 52d taken in just the past 2 years to restrict the right to choose, a new record. Bob Dole and NEWT GINGRICH have spent the last 2 years trying to eliminate abortion rights completely, and American women know it.

Thankfully, President Clinton has used his veto pen to protect American women from the back alley. He has stood with American women by protecting the right to choose. He has stood with women like Claudia Ades and Coreen Costello who have had this procedure to save their lives and protect their health when they wanted pregnancy, they wanted a child, but this pregnancy went wrong. President Clinton recognizes that Congress has no place in the operating room during a crisis pregnancy.

The President, Mr. Speaker, will sign a bill if it contains a narrow exception to protect the lives and health of women like Claudia Ades and Coreen Costello. This is not too much to ask. I urge my colleagues to support the President's veto.

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

Mr. BARCIA. Mr. Speaker, I would like to take this opportunity to share an eloquent and touching letter that I received from a constituent who lives in my hometown of Bay City, MI. It reads:

> Daniel John was diagnosed very early as being far less than perfect, according to acclaimed scientific researchers. We were counseled to abort him as our life would be much easier; he would be a difficult child to raise. However, rather than terminating Daniel's life, we ''chose'' to let God do the choosing.
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> After a very difficult pregnancy, Daniel was brought forth into this world alive. He was grossly disfigured, but he was beautiful. The pregnancy wasn't convenient, but he was worth the wait. According to some, he was expendable; to me, he was a priceless jewel.
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> Daniel lived for about four hours before leaving us. What I have today is the precious memory of holding my living, breathing son for a few short moments until he died in my arms. He wasn't a burden, he wasn't a tragedy. He was a blessing, and I loved him.

Mr. Speaker, a baby does not have a voice. I ask my colleagues who voted against H.R. 1833 to carefully and closely reconsider their position. A baby, sick or healthy, should not be thought of as an inconvenience, but as a miracle. Please vote ''yes'' to override the veto of H.R. 1833.

Mrs. SCHROEDER. Mr. Speaker, I yield 2 minutes to the gentleman from

Michigan [Mr. CONYERS], the distinguished ranking member of our committee.

Mr. CONYERS. Mr. Speaker, I say to Mr. BARCIA, my dear colleague from Michigan, nobody, no doctor would have forced you to have the procedure that is being debated today. Nobody would have recommended it to you without allowing you and your wife to make the choice. So why not let everybody else have that same privilege—that same choice—that you had?

Why is it that we as Members of Congress, have now become doctors, Mr. CANADY? Who gave us the right, for the first time in American history, to determine what procedures doctors will employ? Where do you think that inures to you as a humble Member of Congress? What medical background do you bring to this debate that is greater than the knowledge of the members of the American College of Obstetricians and Gynecologists? By what right do you tell people they cannot have this often medically necessary procedure? If Mr. and Mrs. Barcia do not want to undergo the procedure, they don't have to do it. They can choose not to.

Now, let me turn to Dr. COBURN from Oklahoma. Dr. COBURN from Oklahoma, I am not totally misinformed. I am seeking information. I do not have a violent position on this. The fact that I am not supporting you, but instead am supporting most of the doctors in your profession, does not make me totally misinformed. Nor does it make me totally pro-abortion. Let us be fair, doctor.

Mr. CANADY of Florida. Mr. Speaker, I yield 1 minute to the gentlewoman from Washington [Mrs. SMITH].

Mrs. SMITH of Washington. Mr. Speaker, this afternoon the House will be debating a procedure called partial-birth abortion. I think we need to look at the words that are in this. Notice it said birth. This is the clue.

As a woman, I want you to understand that I would be put into labor, I would go through hours of labor, when the baby dropped and the little body started coming out, they would turn it first, take it out feet-first, which is absolutely damaging to a woman, and then right before the little head came through, they would puncture the head.

There are late-term abortions. I was actually pro-abortion for many years. I was never late-term abortion supporting. But even we that might have supported abortion and you that might support late-term abortion need to think about this. This is not for the woman. This is for the abortionist. There are other humane ways, if you believe in late-term abortion, for both the mother and the baby. But this tells us something clear, folks. We have gone a long way from abortion as a rare circumstances to abortion on demand. A long way.

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

Ms. DELAURO. Mr. Speaker, I rise in strong opposition to the motion to override the veto of the late-term medical abortion ban, and I urge my colleagues to vote to sustain this veto.

Today's vote is not about abortion. It is about voting to ban a medical procedure that can save the life of a mother. It is about voting to ban a medical procedure that would allow a mother to have children.

It is about voting against the medical procedure that Vikki Stella had to have to save her life, to see her children grow up and go to school and then to give birth to her son Nicholas.

Vikki wrote to me about the pain that she went through when she and her family discovered that her son was diagnosed with nine major anomalies, including a fluid-filled cranium with no brain tissue at all, compacted, flattened vertebrae, and skeletal dysplasia in the third trimester of her pregnancy. Her doctors told here that the baby would never live outside of her womb.

She wrote:

> My options were extremely limited because I am diabetic and don't heal as well as other people. Waiting for normal labor to occur, inducing labor early, or having a C-section would have put my life at risk. The only option that would ensure that my daughters would not grow up without their mother was a highly specialized, surgical abortion procedure developed for women with similar difficult conditions. Though we were distraught over losing our son, we knew the procedure was the right option . . . and, as promised, the surgery preserved my fertility. Our darling Nicholas was born in December of 1995.

This procedure that we seek to ban today is the procedure that saved Vikki's life and preserved here family. Vikki's situation was heart wrenching. But mothers and fathers need to be able to make medical decisions like that with their doctors, not with religious organizations and not with political organizations, and certainly, and most of all, not with the Congress.

The situation that these families are in is already difficult enough. Overriding this veto will only make it worse. I call on my colleagues, I plead with my colleagues, to vote no on the motion to override the veto.

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

Mrs. VUCANOVICH. Mr. Speaker, we have twice voted—by an overwhelming majority—to outlaw the partial birth abortion procedure. However, this procedure is still done on a daily basis in this country because the President ill-advisedly chose to veto this bill.

It makes me shudder to think that right now somewhere in this country there are little pre-born human beings in their mother's womb who are going to be subject to this brutal procedure.

I am only one of many who find this procedure horrifying. The American Medical Association's legislative council unanimously decided that this procedure was not a recognized medical technique and that this procedure is basically repulsive.

I have also received a multitude of postcards from my constituents in Nevada. They overwhelmingly object to this repugnant procedure, especially in light of the fact that 80 percent of these types of abortion are purely elective.

Regardless of whether you are prolife or pro-choice, it is obvious given the horrible nature of this type of abortion that it must be banned.

It is inhuman to begin the birthing process and nearly complete the delivery of the baby, only to suck the life out of the child.

What does it say about us as a nation when we allow our unborn children to be legally killed in this manner? It is imperative that this stop now.

I strongly urge my colleagues to override the veto of H.R. 1833, which would ban partial birth abortions.

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Mrs. SCHROEDER. Mr. Speaker, I yield 3 minutes to the gentleman from California [Mr. BECERRA], a distinguished member of the Committee on the Judiciary.

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

I want to ask each and every Member who is somewhat in doubt to please vote to sustain the President's veto of H.R. 1833, and let me relate it to something very personal.

My legislative director, Deirdre Martinez, right now is at the hospital. She is at the hospital because she is being induced in her delivery of her baby. She is in good hands, and I know she is in good hands because my wife happens to be her ob-gyn.

My wife, as I have mentioned in the past, is an ob-gyn, and she is a high-risk specialist. She deals with the type of issues we are discussing on the floor right now.

Deirdre is fortunate. My wife says her baby seems to be perfectly normal, good weight, and probably will be born very healthy. There are, unfortunately, too many women sometimes in this country who do not have the good fortune of Deirdre, and it is in time of need that some of these women ask doctors to help them out.

There are late-term abortions that are performed that are not pretty because—by the way, no abortion is pretty; and no woman, I suspect, can stand up here and say they like to see what may happen to that pregnancy. But there are cases where a late-term abortion must be performed. We are not talking about a healthy 8- or 9-month-old baby being extracted from the womb; we are talking about a child that will never have a chance to see the light of day because, for whatever reason, it will never become a child within the womb.

Sometimes there is a need, for the woman's health, for the woman's safety and her life, to perform an abortion,

which we may not like. And as my wife has said, this is not a procedure that is done electively. A woman does not go into a hospital in her eighth month of pregnancy and ask that that fetus be extracted. No doctor in good conscience would do that. What we are talking about is preserving for this woman the opportunity to get past a very difficult situation.

Why we would want to ban that for this woman, I do not understand. How 435 Members who do not practice the profession nor live through that experience, how they can say that this is the best thing to legislate for the entire country, I do not understand, nor does my wife, and I suspect, nor does Deirdre, who I hope will have a healthy baby by today.

What I do understand is this: That we have politicized an issue because we have waited 6 months to take up the issue. If there was so much concern on the part of those who were for this bill to get this on the move so we would protect the lives of all these so-called unborn babies, why did we not try to overturn the President's veto right away?

It is unfortunate, because we know there is an election coming up and there is a point to be made. It is unfortunate because there are a lot of women who are suffering very traumatic times as a result of having these late-term abortions performed. And the saddest part about it is that we have decided to take this issue and politicize it, when it has become a very, very emotional and private issue for that woman.

I hope all those who have been able to watch this debate will learn something from this and take away that the experience is tough for them, but they should not have to worry about the politics of this particular procedure.

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

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

Mr. BRYANT of Tennessee. Mr. Speaker, my remarks are directed to the people who might be trying to decide right now whether to vote to override this veto or not. I strongly support the override of the veto.

This is not an issue of choice, of privacy, of not even medical necessity. This bill provides that we will abolish this very gruesome procedure, we have all seen pictures of it today, but it still allows the exception that if the mother's life is at issue and if there is no other procedure available, it can be done under those circumstances.

So this is not even an issue of medical necessity. This is an issue that says ''no'' to this type of terrible procedure.

We are a country, and we are debating this issue. I cannot believe we are standing here. We are a country that spends years of due process on convicted killers, murderers who commit the most heinous of crimes, and we would not dare think about executing those types of people by this gruesome procedure. Yet we are talking on this floor today about maintaining the legality of this type of terrible procedure when there are alternatives available.

I just cannot believe that. Is this an upside-down world or is it not?

Mrs. SCHROEDER. Mr. Speaker, I yield 3 minutes to the gentlewoman from California [Ms. WATERS], a distinguished member of the Committee on the Judiciary.

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

Ms. WATERS. Mr. Speaker, today I rise in support of the President's veto of a misguided bill, H.R. 1833.

This bill would instruct doctors on medical procedures that politicians know little about. It would put women at risk who deserve the safest, most effective treatment available under any circumstance.

Let me share with you the words of Erica Fox from Los Angeles, a woman who was told that there was something ''seriously wrong'' with her fetus during her sixth month of pregnancy. The outcome at best was very, very poor.

When she got the news, she explains, ''I had my whole family with me, and at least 5 of them are M.D.'s. They had discussed everything with the doctors and they, too, felt there was no other option * * *.''

Her father, Dr. Walter E. Fox, shared these words.

As a doctor, I must say that it worries me greatly that those that represent me in Washington would think to take away my ability to care for my patients and their health to the best of my ability. And, as I see it, H.R. 1833 does just that.

He continues,

You are not doctors and most of you have not had a daughter or a sister or a wife or a patient who has been in this situation. But for those of us who find ourselves there, we need to have every medical advancement working for us, and the choice to use it.

''I feel that [my doctor] saved my life,'' said Erika Fox.

''And that my fetus was spared any pain * * *.

She continues,

My husband and I are now trying again. . . . There is hope that we will have a healthy baby sometime in the not to distant future. Hope is all you have left when your dreams are dashed the way ours were last October.

Don't override Clinton's veto of 1833,

She says:

Don't let the government take away our hope. . . .

I think Mrs. and Dr. Fox's words best explain why Congress must not outlaw a medical procedure. If this woman were your daughter, wife, sister—you would want as many medical options as possible, you would want the best doctor, and you would want her to be able to have children in the future. This bill would take away these options.

Let us leave this issue to people who know the facts. Let us support women, their safety, and their families. Doctors, women, and their families—not politicians—must make these decisions.

Oppose the veto override of H.R. 1833.

Mr. CANADY of Florida. Mr. Speaker, I yield such time as he may consume to the gentleman from Kentucky [Mr. BUNNING].

(Mr. BUNNING of Kentucky asked and was given permission to revise and extend his remarks.)

Mr. BUNNING of Kentucky. Mr. Speaker, I rise in strong support of the override of the Presidential veto on H.R. 1833.

Mr. Speaker, late last year, the House of Representatives took a very moderate step toward eliminating one, specific and particularly horrible method of abortion—the partial birth abortion.

No one can reasonably justify this kind of abortion. It is grotesque. It is repulsive.

Unfortunately, the President of the United States has caved into the pressure of pro-abortion extremists and vetoed this ban of one, single, indefensible procedure. Hopefully, today, the House of Representatives, guided by the voice of moderation and common decency will see fit to override that veto.

There are those who try to argue that this procedure is necessary to protect the life of some mothers. That is not true. Former Surgeon General C. Everett Koop says that partial birth abortion is unnecessary and in no way protects a woman's life.

There are those who say that this procedure is necessary to prevent the birth of children plagued with defects and deformity. As a grandfather of a disabled child, I am outraged that this argument is used to defend such a heinous practice.

Only an extremist could justify or defend partial birth abortion. I urge my colleagues to support moderation and decency, support the ban on partial birth abortions and override the President's veto.

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

Mr. HALL of Texas. Mr. Speaker, I, of course, rise to urge the override of the very ill-advised veto of the ban on partial-birth abortions.

Back, oh, earlier in the year, one of the most widely respected and politically moderate physicians I suppose ever to hold the office of Surgeon General, Dr. C. Everett Koop, criticized this practice. And as recently as August of this year, Dr. Koop granted an interview to an American Medical Association publication on this issue.

He states quite simply that he believes, ''that the President was misled by his medical advisers on what is fact and what is fiction in reference to late-term abortion,'' going on to say that ''In no way can he twist his mind to see that this late-term abortion technique is a necessity for the mother, and certainly can't be a necessity for the baby.''

So I guess we are left to ask the question, why? Why would we even consider condoning a procedure like this when no medical necessity for it can actually be shown?

No acceptable answer can be given to this question because partial-birth

abortion is completely unacceptable, unnecessary, and a cruel procedure that should not be permitted in our policy. I urge the override.

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

Mr. LARGENT. Mr. Speaker, in this age of high technology and medical wonders, there still are many things that are a mystery to the human mind and an awesome reminder of the work of the Creator.

We see it when longtime rivals drop their weapons and come together as friends. We see it when those struggling against oppression and adversity succeed and claim the human dignity that is theirs as children of God. And most often we see the fingerprint of the Almighty and his glorious majesty when we look into the bright eyes of our newborn son or daughter.

It defies logic and the experience of human history then to think that that which grows inside of the womb is not a part of us, not human, and not alive. Whether by technological means, pharmaceutical means, or surgical means, it is outside of our moral and ethical prerogative to snuff out that which was sown by the Creator.

The unborn child is precisely that, an unborn child, and deserves the chance to grasps as much life as Divine Providence will allow. It is up to us as legislators to uphold our sacred duty to protect the lives of the innocent.

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

Mrs. MALONEY. Mr. Speaker, today marks the 52d antichoice vote taken on the floor of Congress during the 104th Congress. As one of my colleagues in the new majority has said, ''We intend to repeal choice procedure by procedure.'' And they are doing it.

This is merely another effort to antagonize and terrorize young women like Becky Bruce of Ohio. At 22 weeks, doctors determined a lethal abnormality in her fetus. She and her husband decided to seek an abortion. Much like the abortion protesters who screamed and pointed at her, frightening her at the clinic, this legislation instills the same kind of fear.

This bill is an effort to chip away at the overall law of the land. Abortion is legal and safe. We cannot begin to make exceptions now. The antichoice supporters of this bill would love to start here, today, moving from their positions as lawmakers to become personal physicians. When women seek medical care, Congress has no place in their choices and no place in their tragedies. Apparently the supporters of this bill believe that it is more important to save a doomed fetus than to save the life and the health of its mother.

Had my colleagues in the majority allowed an amendment with an appropriate exception for the life or physical health of the mother, I would have supported this bill.

There have been many distortions put before Congress today. One is that this procedure is performed all the time. This procedure is performed rarely and only to save the life, health, and the ability to have children, of women. I urge a ''no'' vote.

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

Mr. MORAN. Mr. Speaker, I am very hesitant to speak on this issue. For one thing, I have been associated with the pro-choice side throughout my legislative career, and I do believe that when the issue of abortion is concerned, it really ought not be a legislative issue; it ought to be a personal decision determined by a woman with the advice of her physician, within the context of her religion and family. I do not believe that this issue falls within that rubric, within that context of decisionmaking.

I do agree with the Roe versus Wade decision which attempted to apply our human values, human judgment, to an issue on which none of us can ever be sure: at which point human life begins. And so we decided in Roe v. Wade, the Supreme Court decided that in the first 3 months, the woman should be fully free to exercise her judgment; and in the second trimester, the democratic process through State legislatures should apply restrictions; and in the third trimester, we should try to make it as difficult as possible.

What we are talking about now, though, goes beyond that third trimester. We are talking about the delivery of a fetus clearly in the shape and with the functions of a human being. And when that human being is delivered in the birth canal, it cannot be masked as anything but a human being.

We should not act in any legislative way that sanctions the termination of that life. And that is why I urge my colleagues to vote to override the President's veto of this legislation.

Mr. Speaker, I wish that the prochoice groups, when they saw this issue, would have simply agreed, said, ''You are right. We are not going to get involved in this because there are extremes on every one of these issues.'' This is an extreme that we ought not support.

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

Mrs. SCHROEDER. Mr. Speaker, could the chair please tell us what the time difference is?

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida [Mr. CANADY] has 17 minutes remaining, and the gentlewoman from Colorado [Mrs. SCHROEDER] has 14 minutes remaining.

Mrs. SCHROEDER. Mr. Speaker, would the gentleman from Florida prefer to use more of his time so it is more even?

Mr. CANADY of Florida. Mr. Speaker, I would inform the gentlewoman that I only have about two or three remaining speakers, so I would reserve the balance of my time.

Mrs. SCHROEDER. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from North Carolina [Mr. WATT], a member of the Committee on the Judiciary.

Mr. WATT of North Carolina. Mr. Speaker, I thank the gentlewoman from Colorado for yielding time. I rise in support of sustaining the veto of the President on this bill.

Mr. Speaker there is a tendency on the part of some of my colleagues to try to divide folks into groups, based on their vote on this issue, of whether they support life or do not support life. I respectfully submit that no Member of this body supports death over life; that there are always difficult choices on a number of these votes.

But we heard evidence submitted at hearings in the Committee on the Judiciary that indicated and confirmed that serious medical jeopardy can result to women, and that in some cases this procedure is the only procedure that is available in late-term abortion to save the life of the mother, to preserve the ability of the mother to have children in the future, to protect the health of a prospective mother in those situations.

And when that occurs, to put the doctor and that mother in the position of saying, ''You will be a criminal if you exercise your right to protect yourself from serious health conditions, or to protect your reproductive capacity in the future, or protect even your life,'' I think is irresponsible.

This is not, as some folks would suggest, an easy decision. It is always a difficult decision. And the very people who are always talking about keeping the Government out of our personal lives it seems to me are the ones that are on the opposite side of this issue, because I do want the Government to leave some personal decisions to the individual American women and citizens of this country. And one of those decisions is when it is proper to save one's own life to, save the ability to have children in the future. That ought to be a personal decision made by the woman and her physician.

I want to make one final point that suggests, in the closing days of this Congress, that this is really not about this bill at all; it is really about politics.

The President vetoed this bill quite some time ago. It has been sitting over there in the Committee on the Judiciary, waiting. Well, what has it been waiting for? It could have come out in 2 days to have this vote. It could have come out in 2 weeks to have this vote. But it just sat there.

Mr. Speaker, when does it come out? Right before the election, so that somebody can inject the politics of the moment into a serious public policy discussion. This is about politics, my colleagues. It is about choice of a woman to protect her own health and

safety and her own life. It is about keeping the Government out of our own personal lives, and I think we ought to sustain the President's veto on this bill.

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

Mr. CHABOT. Mr. Speaker, we cast hundreds of votes in this body every year. Very rarely do we vote on an issue as important as this one.

I hope that my colleagues will do the right thing today and overwhelmingly vote to override the President's veto of the Partial-Birth Abortion Ban Act. We have debated this issue for quite some time now. We have listened to the experts, and Americans from all across this Nation, both prolife and prochoice, have spoken out against this particularly gruesome procedure. I have had people who are prochoice call my office and agree that there is no place for a procedure that is as barbaric, as gruesome as this in a civilized society.

Mr. Speaker, I cannot urge my colleagues in strong enough terms to do the right thing: Vote to override the President's veto.

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

Mr. MCINNIS. Mr. Speaker, this is the most barbaric procedure I have ever come across. There is never, ever, ever a reason that makes this necessary.

The previous speaker says we are attempting to divide. We are attempting to protect.

This body today, Republicans and Democrats, will vote overwhelmingly to ban this procedure. Let me quote from the Wall Street Journal, Nancy Romer, today in an article, Partial-birth Abortion Is Bad Medicine:

> 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 the child feet first out of the mother, 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 scull, 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.

This is never, ever necessary, and I urge a ''yes'' vote to override the President's veto.

Mrs. SCHROEDER. The Speaker, I yield 2½ minutes to the distinguished gentlewoman from California [Ms. WOOLSEY].

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

Ms. WOOLSEY. Mr. Speaker, this veto override is a cruel attempt to make a political point. Make no mistake about it, this debate, with all the emotional rhetoric and exaggerated testimony on the other side of the aisle, is a frontal attack on Roe versus Wade, plain and simple.

The Gingrich majority wants to do away with Roe, the radical right wants to do away with Roe, and H.R. 1833 is the first step. So let us be honest about what this veto override is really about.

This bill, which the President courageously vetoed, will outlaw a medical procedure which is rarely used but sometimes required in extreme and tragic cases when the life or the future fertility of the mother is in danger or when a fetus is so malformed that it has no chance of survival.

Like when the fetus has no brain or the fetus is missing organs. Or the spine has grown outside of the body. When the fetus has zero chance of life.

When women are forced to carry a malformed fetus to term, there is danger of chronic hemorrhaging, danger of permanent infertility or death.

Let me read a brief list of organizations that oppose H.R. 1833: The American College of Obstetricians and Gynecologists; the American Public Health Association; the American Nurses Association; the American Medical Women's Association. The list goes on and on.

These medical professionals oppose this bill because they know that H.R. 1833 will cost women their lives or their reproductive health.

Mr. Speaker, the Gingrich majority has proven time and again its resolve to make Roe versus Wade ring hollow for most American women. Do not let this happen. Protect women's lives and women's health. Protect a woman's right to decide with her doctor what is the best medical procedure during very tragic times. Vote ''no'' on the veto override. But if you cannot vote ''no,'' just vote ''present.''

Mrs. SCHROEDER. Mr. Speaker, we only have one remaining speaker, and I want to be sure the gentleman from Florida only has one remaining speaker, because they have double the time. Does the gentleman from Florida only have one remaining speaker?

Mr. CANADY of Florida. Mr. Speaker, I have one remaining speaker, as I indicated earlier. I reserve the balance of my time for closing.

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

□ 1330

The SPEAKER pro tempore (Mr. LAHOOD). The gentlewoman from Colorado [Mrs. SCHROEDER] is recognized for 7½ minutes.

Mrs. SCHROEDER. Mr. Speaker, I must say in the time crunch, I felt terrible in having to cut off the distinguished gentlewoman from California who is a member of the committee. I really want her to stand up and finish what she was talking about. The gentlewoman from California [Ms. LOFGREN] was talking about her mother's best friend and her mother's best friend who was Catholic, going to church and being asked to organize on this issue.

I yield to the gentlewoman from California [Ms. LOFGREN] because I had to cut her off.

Ms. LOFGREN. Mr. Speaker, I did talk to the gentlewoman about my friends, the Wilsons, and the real truth, not the rhetoric, not the misinformation, and the comment is that good Catholics and good Christians do not want to hurt good mothers. If we could keep that in our minds, put aside the politics, I think we would do a far more decent job here today.

Mrs. SCHROEDER. Mr. Speaker, I wanted this body to hear what the gentlewoman said because that has been our position all along. We do not wish to hurt good mothers. That was the President's position. That is still our position.

I was the one who went to the Committee on Rules and went everywhere trying to get an amendment to deal with the serious health issues of a mother. Nobody wants this for vanity purposes. My skin crawls as I hear Members on this floor talking about thousands of women get these late term abortions for vanity purposes, like all women have such dark hearts they would wait to postviability and then suddenly decide, I changed my mind.

There may be some of those cases, I do not know. But I must tell you, all of us are willing to ban those cases. We are talking about the cases where women desperately want to have a family and something goes terribly wrong.

Many of my colleagues have heard about our friend here, have seen this picture before, but the real good news was after she had that procedure, look what she got. She got little Tucker. We really ought to say, this is what this is about, because this women was able to have this procedure late in her term in a very, very sad pregnancy that went very, very wrong. She was able to preserve her reproductive ability and go on to add to this happy American family.

Do we want the Congress of the United States saying no to that? I certainly do not. I certainly do not. I do not think we want the Congress of the United States standing in the same room with this woman and her husband and her doctor and probably her whole family in tears but the Congress says, but if your doctor tries to help you on this, after we pass this, he goes to jail. I do not think that is the American way.

If you really believe that women are running out and having these and this is a vanity issue and is about fitting into a prom dress or something, we are willing to do that. But you would not let us have the amendment. You would not let us have a serious health amendment. And every time we say health,

you say, you mean headaches. We were talking about serious health. You know how to write it; we know how to write it. Let us not kid ourselves. That is what the President said. The President said, serious health amendment.

I find this a very sad day because I really find this is not about whether or not there are thousands of these going on and how awful this is. I think this is all about politics. The President vetoed this bill in April. Let me tell you, in early April he vetoed this bill. It has being sitting in the committee and it could have come to the floor any day thereafter. So if you really thought that this was going on, this is an epidemic, women are losing their minds and running in in late term, if you thought that, you should have stopped it right away. If you thought this was so grisly and horrible, that is when you should have done it. But no, we decided to let it wait until election eve, where we could let it bubble and burn and all of this stuff. So that we could build a huge issue and this is our 52d vote on choice. This is really an attempt to undo choice, this extreme, extreme Congress that we have.

You see the charts that are drawn over there. They are drawn and they eat at your heart and they eat at my heart because they show a perfect, beautiful child, a perfect, beautiful child like Tucker. But let me tell you, the child that came before Tucker that would have prevented Tucker from being born, had there not been this procedure, did not look like Tucker and did not look like those pretty little drawings.

These are seriously deformed children that we are talking about, very seriously deformed, or the mother has a very serious condition.

Do you know what is wrong in this debate? We have been so caught up in this choice/anti-choice debate that we have made pregnancy sound like it is a 9-month cruise and that absolutely nothing can go wrong during that 9-month cruise and the only thing that would ever happen is if they do that, the mother must be some selfish, terrible person with a dark heart. But let me tell you, my colleagues, many things can go wrong.

Do you know by statistics today 25 percent of the vaginal and caesarean births in this country have serious maternal complications, 25 percent? Do you know if a woman has a baby over the age of 40, she is nine times more apt to die in this country. There are serious safe motherhood issues. We have had Members so engaged with their pictures and charts and screaming and playing politics with women's uteruses that we have not really dealt with the safe motherhood issue.

So I find this a very sad vote to end my career on. I thank the President of the United States, who listened to those families. Those families have been in this Congress pushing their strollers around with their babies and their husbands, trying to get Members of Congress to listen. Many of them are right-to-life families who never in the world thought they would ever need this procedure. Yet their world collapsed on them, and they did not want this to be like Russian roulette. This would be like pregnancy Russian roulette. You get one shot at it and, if it does not work, you have blown your chance forever to have a baby. Is that what this Congress is trying to say?

Let me read the words of Coreen Costello. She goes on to say:

I still do not believe in abortion. I have anguished over supporting an abortion procedure. However, I have chosen to come forward, despite my beliefs, because I believe that this bill does not protect women and families.

Coreen was the mother of Tucker. This is Coreen. She never thought she would be there.

Please do not make this happen to everybody before you realize it. Do not take this right away from America's families. And please, please, please, preserve serious health conditions of mothers.

In today's debate, the picture of the American woman that will emerge from the other side is that she is a frivolous and shallow person who would lightly terminate a late-term pregnancy. The supporters of this bill would have you believe that Congress must deprive women of the right to make their own reproductive decisions, because American women and their families cannot be trusted to be responsible decisionmakers.

I have this picture of Coreen Costello and her family beside me as I speak, because I don't want any one to forget that this debate is not about political sound bites or the politics of pitting Americans against each other. This debate is about real American families and the agonizing decisions they have to make when wanted pregnancies go terribly wrong, when serious fetal anomalies or serious threats to the woman's health arise during the pregnancy.

I came to Congress 24 years ago determined to make sure that the Federal Government treats women as responsible adults who are the best decisionmakers with respect to their reproductive health. The bill before us today says that your Member of Congress is somehow better able to make decisions about your reproductive health than you are. For Congress to usurp the power of the American family in this way is not only unconstitutional, it is also an affront to our fundamental commitment to the integrity of the family, and the right that Americans have to be able to make significant medical decisions for themselves.

You may hear, during the course of this debate, allegations that some women have obtained late-term abortions for reasons other than their life or health. Remember this: the individual States as well as the Federal Government, have the power, under the Constitution and Roe versus Wade, to ban all post-viability, late-term abortions except those that are necessary to preserve the woman's life or to avoid serious health consequences to her. The President has made it clear that he would sign such a bill. But every attempt we made to amend this bill to provide an exception for life or serious health consequences was flatly rejected by the other side. Not once did the majority permit this body to vote on an exception to preserve women's health or their future fertility. Not once.

The majority has chosen to have a political campaign issue instead of having a bill that would pass constitutional muster and ban late-term abortions except when the women's life or health is at stake.

I want to show you another picture of Coreen Costello and her family. Look closely, and note that since the time that we first debated this bill, the Costellos have had joyous occasion to sit for a new family picture, because their family has changed. Baby Tucker is the newest member of this family, and his birth was made possible because Coreen Costello and her family were able to use the procedure this bill bans. Let me close with Coreen Costello's own words. She wrote me yesterday and said this about her tragic pregnancy:

My daughter's stiff and rigid body as well as her unusual contorted position in my womb gave my team of doctors deep concern for my health and well-being * * *. With their knowledge and expertise and data from extensive diagnostic testing, my medical experts believed the safest option was an intact D&E, performed by specialist Dr. James McMahon. Reluctantly, my husband and I agreed.

She goes on to say:

I still do not believe in abortion, and I have anguished over supporting an abortion procedure. However, I have chosen to come forward, despite my beliefs, as H.R. 1833 does not protect women and families like mine. President Clinton and Members of Congress asked for an amendment to allow exceptions for serious health consequences. Proponents of this extreme bill refused to allow such a vote. They do not want to believe stories like mine. My baby girl is gone. Not because of an abortion procedure, but because of a terrible disease. Please do not confuse this. It was hard enough for my husband and children to lose Katherine. I thank God they did not lose me, too.

Not a day goes by that my heart doesn't ache for my daughter. Fortunately, my pain has been eased with the joyous birth of our healthy baby boy, Tucker. This would not have been possible without this procedure. It is time for my family to put the pieces of our lives back together. Please, please, give other women and their families this chance. Let us deal with our personal tragedies without any unnecessary interference from our government. Leave us with our God, our families, and our trusted medical experts. Sincerely, Coreen Costello.

Vote with these families. Vote against extremism that would make Congress the decisionmaker for your most intimate and difficult medical decisions. Vote no.

Mr. CARDIN. Mr. Speaker, will the gentlewoman yield?

Mrs. SCHROEDER. I yield to the gentleman from Maryland.

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

Mr. CARDIN. Mr. Speaker, the issue presented by H.R. 1833, the partial birth abortion bill, is one that requires careful thought and consideration. The medical procedure that is addressed by this legislation is, in my judgment and in the judgment of hundreds of my constituents, gruesome. My vote today to sustain the President's veto in no way indicates my support for that procedure.

The fact is, however, that it is a medical procedure. With no medical training, I am not qualified, and I do not think this Congress is qualified, to rule on the necessity of specific medical decisions. This is a medical question, not a political one. If this bill were to become law, it would establish the precedent of Congress placing in our criminal statutes specific medical procedures. That would be a mistake.

It would a different matter to have a straightforward debate about the circumstances under which late-term abortions are medically justified. However, that is not what we're doing today. Instead, we are debating whether to outlaw a specific medical procedure.

I am dismayed that the American Medical Association, or other appropriate governing bodies of medical professionals, has not stepped forward on this issue. They have the expertise and the responsibility to rule on the necessity of this procedure, and I have urged them, in writing, to do so. I hope they will yet act to guide their members on whether this hideous procedure is, in fact, in some cases the only medically safe option to preserve the life and future health of the woman.

I have always defended the right of each woman to make her own decisions about her reproductive rights. The bill before us raises the question whether a particular medical procedure is ever appropriate for any woman. According to many doctors, there are horrific instances where this procedure is the best option for protecting the woman's life and/or health and her ability to have children in the future. I will vote against this bill because, for all the emotion of this issue, I do not believe Congress knows enough to tell doctors how to act in certain circumstances.

Mr. CANADY of Florida. Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. WELDON].

(Mr. WELDON of Pennsylvania asked and was given permission to revise and extend his remarks.)

Mr. WELDON of Pennsylvania. Mr. Speaker, I rise in strong support of the motion to override.

On March 27, this House passed the conference report on H.R. 1833, the ban on partial birth abortions and sent it to our President for his signature. Sticking to his proabortion agenda, the President chose to distance himself from the American people and veto the ban on the most brutal form of infanticide. Following the President's decision, we set out to override his veto and to protect the life of the unborn childn. We have come far and are in sight of our destination.

Today, with the bipartisan support of 285 Members of Congress, this House was able to successfully override the veto. Today, with the support of 285 Members of Congress, this House was able to respond to the millions of Americans who are outraged by this brutal form of abortion. Today, with the support of 285 Members of Congress, this House was able to send the message of the American people to a President who doesn't really seem to care what they think.

Those of us who believe in the life of the unborn, those of us who fight against the crime of partial birth abortion cheer today for our success, but regret the lives and futures that have been lost since the 27th of March, since the hour that we first passed the ban. Let us delay no more, let us be resolute, and let us complete our task in overriding President Clinton's unjust and unjustified veto, that no other child may perish.

We have advanced confidently in the direction of our hopes, and we await the Senate to join us in the completion of our task.

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

The SPEAKER pro tempore. The gentleman from Illinois [Mr. HYDE] is recognized for 15 minutes.

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

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 charge 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 infacticide 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 dehumznize, 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.''

□ 1345

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 use to. Make it clear once again there is justice for all, even for the tiniest, most defenseless in this, our land.

Mr. BISHOP. Mr. Speaker, I rise today to sustain President Bill Clinton's veto of H.R. 1833, the Partial Birth Abortion Ban Act of 1995. The bill makes it a crime to perform a so-called partial-birth abortion unless the abortion is necessary to save the life of the mother. Under the legislation, physicians who perform these abortions are subject to a maximum of 2 years imprisonment, fines, or both. The bill also establishes a civil cause of action for damages against the doctor who performs the procedure.

I am against abortion as a method of birth control and certainly against elective late-term abortions except where necessary to protect the life or health of the mother. Today, I vote to sustain the President's veto because H.R. 1833 would seriously infringe upon a family's right to choose what is best for them. In addition, it would seriously interfere with a physician's attempt to protect a woman's health or future reproductive capacity.

This rare procedure is primarily used in cases of desired pregnancies gone tragically wrong; when a family learns late in pregnancy of severe fetal anomalies or of a medical condition that threatens the woman's life or health. The American Public Health Association, the American Medical Women's Association, and the American College of Obstetricians and Gynecologists, all organizations

dedicated to improving women's health care, oppose the measure. According to the American College of Obstetricians and Gynecologists, this type of procedure is ''done primarily when the abnormalities of the fetus are so extreme that the independent life is not possible or when the fetus has died in utero.'' They further explain that the medical problems which a woman could develop that might require interruption of pregnancy during the third trimester include rare maternal problems that could threaten the life and/or health of the pregnant woman if the pregnancy continued such as severe heart disease, malignancies, kidney failure, or severe toxemia.

I simply cannot tell a mother that she must risk her life carrying a fetus that the medical community has determined would not live. That should be a family decision best left to the family and their God. In these situations, in which a family must make such a difficult decision, the ability to choose this procedure must be protected.

This measure outlaws a valid medical procedure. Other methods of late-term abortion may be more dangerous to the health or life of the woman. Moreover, it compromises the patient-physician relationship. Because it bans one of the safest, least invasive methods available later in pregnancy, physicians would be compelled to balance the health of their patients against the possibility of facing Federal criminal charges.

In short, I cannot vote to override the President's veto because it fails to protect women and families in such dire circumstances and because it treats doctors who perform the procedures as criminals. The life exception in the bill only covers cases in which the doctor believes that the woman will die. It fails to cover cases where, absent the procedure, serious physical harm is very likely to occur. I would support H.R. 1833 if it were amended to add an exception for serious health consequences.

I urge my colleagues to vote to sustain the President's veto.

Mrs. KELLY. Mr. Speaker, I rise in reluctant opposition to the veto override of H.R. 1833.

I am opposed to late-term abortions except in instances where they are necessary to save the life of the mother or for serious, very limited health reasons. Unfortunately, this well-intentioned legislation fails to make these exceptions. Tragedies involving severely deformed or dying fetuses sometimes occur in the late stages of pregnancy. In these crisis situations, women should have access to the safest medical procedure available, and on some occasions the safest such procedure is the intact dilation and evacuation procedure.

If we ban this procedure, Mr. Speaker, as this legislation seeks to do, doctors will resort to other procedures, such as a caesarean section or a dismemberment dilation and evacuation, which can and often do pose greater health risks to women, such as severe hemorrhaging, lacerations of the uterus, or other complications that can threaten a woman's life or her ability to have children again in the future.

Mr. Speaker, passage of H.R. 1833 will not end late-term abortions; the bill only bans one such procedure that, in the judgment of a doctor, might offer the surest way of protecting the mother. The New York chapter of the American College of Obstetricians and Gynecologists opposes H.R. 1833, expressing concern that ''* * * Congress would take any action that would supersede the medical judgment of trained physicians and would criminalize medical procedures that may be necessary to save the life of a woman * * *''.

If H.R. 1833 were amended to include exceptions for situations where a woman's life or health is threatened, ensuring that decisions regarding the well-being of the mother are made by doctors, not politicians, I would gladly support the bill. Without this protection, however, I cannot in good conscience support this legislation today.

Good people will always disagree over the abortion issue, and I respect the passion and depth of feeling that so many of my constituents on both sides of this issue have expressed to me. Maintaining policies which promote healthy mothers and healthy babies should remain above the political fray, and it is for this reason that I oppose the veto override today.

Mr. BLUMENAUER. Mr. Speaker, I oppose the challenge to the President's veto of H.R. 1833. Whatever one's belief on abortion, the late-term procedure most be viewed separately, for this is a procedure to be used only as a last resort to save a woman's life or to avoid a devastating deterioration of her health. Late-term abortion is not about choice. It is about saving women from grave damage to their health, to their ability to bear children in the future, and from death. The President, and the medical community, have assured us that abuses of this procedure can be avoided. Regrettably, those voting to override this veto would apparently prefer to score political points than to heed those assurances. This is being done with indifference to women who face grave circumstances, and in disregard to the potential of this institution to render a serious policy determination on a matter of grave consequence.

Mr. FAZIO of California. I rise today to express my support for the President's position on H.R. 1833 and to urge my colleagues to support it.

This issue has been an incredibly difficult one for me as I'm sure it has been for most of my colleagues. The medical procedures involved are very disturbing, and moreover, intensely personal issues lie at the heart of this debate.

However, I opposed H.R. 1833 for several reasons when we debated this legislation earlier this year, and I remain opposed to this bill.

First, and most important, H.R. 1833 denies women the right to make extremely important and personal medical decisions. If passed, this bill would strip away many of the protections that exist for legal abortion.

Only the mother, in consultation with her doctor, should make the decision. We should not attempt to impose a ''Congress Knows Best'' medical solution on the women of America.

In additional, I opposed this bill because it doesn't contain an exception which would allow for this extremely rare procedure to be performed when circumstances are the most dire; that is, when the life of the mother is endangered. We should not accept a ban on a procedure which may represent the best hope for a woman to avoid serious risks to her health.

Of course we should not make this procedure, or any type of abortion, a purely elective procedure. But if we pass this bill, we are criminalizing a medical procedure that may one day be necessary to save the life of the mother and allow her to have a family.

I urge all of my colleagues to give careful thought to their vote today and oppose the veto override attempt before us.

Mrs. COLLINS of Illinois. Mr. Speaker, I rise in opposition to the motion to override the Presidential veto of H.R. 1833, the late-term abortion ban. The fact that we are voting on this motion today is a true testament to how extreme many of the Members of this House of Representatives are. Despite their campaign pledges to ''get the U.S. government out of your life,'' Gingrich-Dole Republican Members have continued to advocate that the U.S. Congress take unprecedented steps into the personal lives of American women and their families—as well as into their doctor's offices—in order to influence public opinion and undermine current laws in a fashion that they cannot do through the highest court in our land. H.R. 1833 is an attempt by Gingrich extremists to prescribe their own view of proper medical strategy regarding partial birth abortion procedures.

In order to promote this bill, the Republicans have focused on certain aspects of this medical procedure that are intended to elicit emotional responses. What they refuse to focus on, however, is that the only women who seek such rare, third-trimester abortions are overwhelmingly in tragic, heart-rendering situations in which they must make one of the most difficult decisions of their lives.

Often they are faced with personal health risks that threaten their very lives and/or their ability to have children in the future. Others discover very late in their pregnancy—in some cases even after they already know the sex of the child, have picked out a name and gotten the baby's crib—that their child has horrific fetal anomalies that are incompatible with life and will cause the baby terrible pain and tragedy before the end of its short life.

Clearly, each of these situations is serious, tragic, and terribly difficult for the families involved. The decision to seek a late-term, partial-birth abortion is one that is not made carelessly or lightly. The U.S. Congress is the last entity that should be intruding into this type of personal, family decision.

Further, we in Congress have absolutely no right to interfere with a doctor's medical judgment when he or she is making critical decisions affecting the life of a woman, her health and her ability to bear children in the future. It is extremely important to note that this bill makes no exception for the health of the mother. In fact, it makes no mention of the health of the women whatsoever. Clearly, the mother's health and her reproductive future mean nothing to those Members of this body who are pushing this bill forward and who have failed to include this vital exception.

H.R. 1833 takes advantage of tragic circumstances and sacrifices the health and maybe lives of women in order to push an extremist agenda forward during this election year. I urge my colleagues to stay fast in their beliefs for individual rights and to continue to allow a woman's right to her own reproductive choices and not to be dictated to by partisan political action by mean spirited office seekers. I support the President's veto of this bill and will vote to sustain it.

Mr. CUNNINGHAM. Mr. Speaker, I rise today in support of overriding President Clinton's unwise veto of H.R. 1833, the Partial Birth Abortion Ban Act.

Last March, I joined 285 of my House colleagues in support of banning the procedure known as partial-birth abortion. The measure was supported by members like me who are pro-life, and even by many who consider themselves pro-choice. We shared our justification: As New York Senator DANIEL PATRICK MOYNAHAN said, the partial birth abortion procedure is just ''too close to infantacide.'' And I agree.

Yet, after H.R. 1833 was adopted by bipartisan majorities in the House and Senate, President Clinton vetoed the Partial Birth Abortion Ban Act on April 10. The President's veto represents a truly mean and extreme position. His position is that the absolute, most extreme abortion procedure, no matter how barbaric, should continue to be permitted in America. This procedure is such that even a brief description of it causes strong men and women to wince.

Since the President's veto, more than 7,500 of my constituents have written or called me, urging me to support an override of the President's veto. But he did veto it. And on July 15, I wrote House Majority Leader DICK ARMEY, urging the House to fulfill its responsibility to a vote to override President Clinton's veto.

Today we will have that vote. And today I will vote to override the President's decision, which drawn the deep disappointment of pro-life and pro-choice Americans alike. This is a sad day, because one would hope that the President had not vetoed such commonsense, humane legislation in the first place.

Mrs. CHENOWETH. Mr. Speaker, when President Clinton vetoed H.R. 1833, the Partial-Birth Abortion Act, he claimed he was trying to protect women's health.

The President was distorting the truth.

Medical facts show the President's claim to be completely false.

Mr. Speaker, partial-birth abortion is not a legitimate medical procedure and is not needed for any particular circumstance. Doctors at the Metropolitan Medical Clinic in New Jersey say that only a ''minuscule amount'' of the 1,500 partial-birth abortions they perform are for medical reasons. One doctor is quoted as saying, ''Most [partial-birth abortion patients] are Medicaid patients * * * and most are for elective, not medical, reasons; most who did not realize, or didn't care, how far along they were.''

This procedure is used on babies who are four and a half months in the womb or older. It can be employed up until the ninth and final month of pregnancy. The ninth and final month, Mr. Speaker.

Opposition to this technique isn't merely the opinion of a handful of doctors. The American Medical Association has made its position clear.

The AMA's Council on Legislation voted unanimously to recommend that the AMA board of trustees endorse H.R. 1833. One member of AMA's legislative council said that, ''partial birth abortion is not a recognized medical technique,'' and many AMA members agreed that, ''the procedure is basically repulsive.''

Mr. Speaker, my position on abortion has been clear and consistent. I oppose it, except in certain very specific cases.

But I do not understand how people can support this procedure. Abortion advocates will argue that a fetus in the early stages of pregnancy is not human life. I disagree with that. But surely even people who make that argument must understand in their hearts that a pre-born baby in the third trimester of pregnancy is in fact human life. And that human life deserves the protection of law.

The position of those who favor partial birth abortions rests on the absurd notion that if one does not have to look at the baby then one can somehow deny that the baby is alive.

Mr. Speaker, not only is the procedure itself medieval, but so is the logic of those who advocate and apologize for it.

Permitting this ghastly procedure to continue debases the whole medical profession, it debases our system of law, and indeed it debases our very notion of the concept of life.

Our system of laws, our American heritage, is based on the idea that people have certain God-given rights. Those rights are life, liberty, and the pursuit of happiness.

Those rights existed before laws were established. In fact, it is because those rights existed that laws were established in order to protect those rights.

First and foremost among those rights is the right to life.

As lawmakers we have a responsibility to protect the lives of our citizens, in this case, the very youngest, most vulnerable of American citizens.

I urge my colleagues to do the right thing.

I urge my colleagues to stand against this hideous, repugnant practice.

Let us stand up for a good principle and let us override the President's veto.

Mr. HASTERT. Mr. Speaker, I rise in support of this attempt to override President Clinton's veto of the partial birth abortion bill and I hope my colleagues will join me in this effort.

Mr. Speaker, I have listened with some care to the comments by my distinguished colleague from Colorado, Mrs. SCHROEDER, who is leading the effort to preserve this procedure. And I am reminded of some advice that the gentlelady from Colorado gave this House just a day or two ago when we were debating a bill to make Mother Teresa an honorary citizen of the United States. The gentlelady from Colorado, at that time said we could honor Mother Teresa best if, every day, as we considered how to vote on legislation brought to this floor, we reflected upon Mother Teresa's compassion, and her courageous stand for children and the helpless.

As the gentlelady from Colorado knows, I do not always agree with her advice. But on this occasion I think the gentlelady from Colorado's advice the other day does apply to our deliberation today. I think we should let the wisdom of Mother Teresa inform our hearts and our minds. And I think it is quite clear what that gentle woman from Calcutta, India, would say if she were here today—it is the same thing she has said so often—that the taking of innocent human life is wrong.

Mr. Speaker, I urge my colleagues to vote to end partial birth abortion in this country. Override the President's veto.

Mr. LEVIN. Mr. Speaker, I do not favor late-term abortions and believe they should only be allowed in cases where the life or health of the mother is threatened.

I voted to sustain the President's veto because the bill does not allow a physician to take into account even serious threats to a woman's health, as the Supreme Court has required.

I would have voted for H.R. 1833 if there had been an exception to allow their procedure where there is medical evidence that the health of the mother is indeed threatened.

Mr. BENTSEN. Mr. Speaker, today we are considering an override of the President's veto of H.R. 1833, the late-term abortion bill. I oppose the override because this legislation is fundamentally flawed and would put at risk the life, health, and fertility of women facing one of the most difficult, anguished, and personal decisions imaginable.

First, let me say that I oppose late-term abortions except, as the U.S. Supreme Court requires, when necessary to protect the life or health of a woman. H.R. 1833 falls woefully short of meeting this critical standard.

H.R. 1833 provides only a partial exception to protect the life of a woman, and even this partial exception may be invoked only under a very narrow set of circumstances. In other words, this legislation takes away the authority of a physician to select the best medical procedure for saving a woman's life.

Furthermore, this legislation includes no exception whatsoever when a woman faces a severe threat to her health or her ability to have children in the future.

I would support this legislation if its proponents would allow an amendment to reflect not only the Supreme Court's rulings, but State law in Texas. In Texas, late-term abortions are banned except when the woman's life or health is threatened. That is the approach this legislation should take as well.

While I am troubled by the procedure H.R. 1833 seeks to outlaw, I believe it is dangerous and wrong to ban a medical procedure that in some circumstances represents the best hope for a woman to avoid serious risk to her health. The procedure that H.R. 1833 would ban is utilized in the most emotionally wrenching circumstances imaginable—involving cases in which the fetus has developed severe abnormalities that will not allow it to sustain life outside the womb and in which a woman's life, health, and future fertility are jeopardized.

There is no simple solution to reducing the incidence of abortion. However, this Congress could have fashioned a commonsense bill limiting the use of this procedure to cases in which a woman and her doctor decide it is the best way to protect her life and health. Instead, the proponents of H.R. 1833 have chosen to exploit the anguish of families confronting this decision for political gain. How sad and how wrong.

Mrs. SMITH of Washington. Mr. Speaker, I submit for the RECORD the following:

STATEMENT OF DAVID J. BIRNBACH, M.D.

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

I am here today to take issue with the previous testimony before committees of the Congress that suggests that anesthesia causes fetal demise. I believe that I am qualified to address this issue because I am a practicing obstetric anesthesiologist. Since completing my anesthesiology and obstetric anesthesiology training at Harvard University, I have administered analgesia to more than five thousand women in labor and anesthesia to over a thousand women undergoing

cesarean section. Although the majority of these cases were at full term gestation, I have provided anesthesia to approximately 200 patients who were carrying fetuses of less than 30 weeks gestation and who needed emergency non-obstetric surgery during pregnancy. These operations have included appendectomies, gall bladder surgeries, numerous orthopedic procedures such as fractured ankles, uterine and ovarian procedures (including malignant tumor removal), breast surgery, neurosurgery, and cardiac surgery.

The anesthetics which I have administered have included general, epidural, spinal and local. The patients have included healthy as well as very sick pregnant patients. Although I often use spinal and epidural anesthesia in pregnant patients, I also administer general anesthesia to these patients and, on occasion, have needed to administer huge doses of general anesthesia in order to allow surgeons to perform cardiac surgery or neurosurgery.

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

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

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

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

(1) Dr. James McMahon, now deceased, testified that anesthesia causes neurologic fetal demise.

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

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

My responses to these statements are as follows:

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

2. Dr. Koplick has stated that the ''massive'' doses used by Dr. McMahon are responsible for fetal demise. *This again, is incorrect and there is no scientific or clinical data to support this allegation.* I have personally administered ''massive'' doses of narcotics to intubated critically ill pregnant patients who were being treated in an intensive care unit. I am pleased to say that the fetuses were born alive and did well.

3. Dr. Campbell has described the narcotic protocol which Dr. McMahon had used during his D & X procedures: it includes the administration of Midazolam (10–40 mg) and Fentanyl (900–2500 μg). 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. These doses are far in excess of any anesthetic that would be used by an anesthesiologist and even if they were incrementally given over a two or three hour period these doses would in all probability cause enough respiratory depression of the mother, to necessitate intubation and/or assisted respiration. Since Dr. McMahon can not be questioned regarding his ''heavy handed'' anesthetic practice. I am unable to explain why he would willingly administer such huge amounts of drugs if he did indeed administer 2500 μg of fentanyl and 40mg of midazolam to a patient in a clinic, without an anesthesiologist present, he was definitely placing the mother's life at great risk.

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

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

STATEMENT OF NORIG ELLISON, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Chairman Canady, members of the Subcommittee. My name is Norig Ellison, M.D., I am the President of the American Society of Anesthesiologists (ASA), a national professional society consisting of over 34,000 anesthesiologists and other scientists engaged or specially interested in the medical practice of anesthesiology. I am also Professor and Vice-Chair of the Department of Anesthesiology at the University of Pennsylvania School of Medicine in Philadelphia and a staff anesthesiologist at the Hospital of the University of Pennsylvania.

I appear here today for one purpose, and one purpose only: to take this issue with the testimony of James T. McMahon, M.D., before this Subcommittee last June. According to his written testimony, of which I have a copy, Dr. McMahon stated that anesthesia given to the mother as part of dilation and extraction abortion procedure eliminates any pain to the fetus and that a medical coma is induced in the fetus, causing a ''neurological fetal demise'', or—in lay terms—''brain death''.

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary, even life-saving, medical procedures, total unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus. Annually over 50,000 pregnant women are anesthetized for such necessary procedures.

Although it is certainly true that some general analgesic medications given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant women are routinely heavily sedated during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death or ''brain death''. In my medical judgment, it would be necessary—in order to achieve ''neurological demise'' of the fetus in a ''partial birth'' abortion—to anesthetize the mother to such a degree as to place her own health in serious jeopardy.

As you are aware, Mr. Chairman, I gave the same testimony to a Senate committee four months ago. That testimony received wide circulation in anesthesiology circles and to a lesser extent in the lay press. You may be interested in the fact that since my appearance, not one single anesthesiologist or other physician has contacted me to dispute my stated conclusions. Indeed, two eminent obstetric anesthesiologists appear with me today, testifying on their own behalf and not as ASA representatives. I am pleased to note that their testimony reaches the same conclusions that I have expressed.

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

Mr. HOEKSTRA. Mr. Speaker, I submit for the RECORD the following:

SECOND TRIMESTER ABORTION: FROM EVERY ANGLE—FALL RISK MANAGEMENT SEMINAR

INTRODUCTION

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

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

This procedure can be performed in a properly equipped physician's office under local

anesthesia. It can be used successfully in patients 20–26 weeks in pregnancy.

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

BACKGROUND

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

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

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

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

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

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

PATIENT SELECTION

The author routinely performs this procedure on all patients 20 through 24 weeks LMP 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; and 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; and recovery.

Day 1—Dilation: The patient is evaluated with an ultrasound, hemoglobin and Rh. Hadlock scales are used to interpret all ultrasound measurements.

In the operating room, the cervix is prepped, anesthetized and dilated to 9.11 mm. Five, six of 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 anesthetized. Between 15 and 25 Dilapan are placed in the cervical canal. The patient returns home or to a motel overnight.

Day 3—The Operation: The patient returns to the operating room where the previous day's Dilapan are removed. The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized and grasped with a tenaculum. The membranes are ruptured, if they are not already.

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

The surgeon introduces a large grasping forcep, such as 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 hand along the back of the fetus and ''hooks'' the shoulders of the fetus wit 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, 100 mgm 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 intramuscularly is provided to all Rh negative patients on Day 3.

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

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

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

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

FOLLOWUP

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

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

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

THIRD TRIMESTER

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

SUMMARY

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

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

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

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Chicago, IL, July 11, 1995.

Hon. CHARLES T. CANADY,
Chairman, Subcommittee on the Constitution, Committee on the Judiciary, House of Representatives, Washington, DC.

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

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

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

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

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

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

Respectfully yours,

BARBARA BOLSEN,
Editor.

Attachment.

AMERICAN MEDICAL NEWS TRANSCRIPT

(Relevant portions of recorded interview with Martin Haskell, 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 rapid supporters of abortion. They work in the office there. And . . . some of them have never seen one performed . . .

Comments on elective vs. non-elective abortions:

Haskell: And I'll be quite frank: most of my abortions are elective in that 20–24 week range . . . In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective . . .

[From the American Medical News]

SHOCK-TACTIC ADS TARGET LATE-TERM ABORTION PROCEDURE

FOES HOPE CAMPAIGN WILL SINK FEDERAL ABORTION RIGHTS LEGISLATION

(By Diane M. Gianelli)

WASHINGTON.—In an attempt to derail an abortion-rights bill maneuvering toward a congressional showdown, opponents have launched a full-scale campaign against late-term abortions.

The centerpieces of the effort are newspaper advertisements and brochures that graphically illustrate a technique used in some second- and third-trimester abortions. A handful of newspapers have run the ads so far, and the National Right to Life Committee has distributed 4 million of the brochures, which were inserted into about a dozen other papers.

By depicting a procedure expected to make most readers squeamish, campaign sponsors hope to convince voters and elected officials that a proposed federal abortion-rights bill is so extreme that states would have no authority to limit abortions—even on potentially viable fetuses.

According to the Alan Guttmacher Institute, a research group affiliated with Planned Parenthood, about 10% of the estimated 1.6 million abortions done each year are in the second and third trimesters.

Barbara Radford of the National Abortion Federation denounced the ad campaign as disingenuous, saying its ''real agenda is to outlaw virtually all abortions, not just late-term ones.'' But she acknowledged it is having an impact, reporting scores of calls from congressional staffers and others who have seen the ads and brochures and are asking pointed questions about the procedure depicted.

The Minneapolis Star-Tribune ran the ad May 12, on its op-ed page. The anti-abortion group Minnesota Citizens Concerned for Life paid for it.

In a series of drawings, the ad illustrates a procedure called ''dilation and extraction,'' or D&X, in which forceps are used to remove second- and third-trimester fetuses from the uterus intact, with only the head remaining inside the uterus.

The surgeon is then shown jamming scissors into the skull. The ad says this is done to create an opening large enough to insert a catheter that suctions the brain, while at the same time making the skull small enough to pull through the cervix.

''Do these drawings shock you?'' the ad reads. ''We're sorry, but we think you should know the truth.''

The ad quotes Martin Haskell, MD, who described the procedure at a September 1992 abortion federation meeting, as saying he personally has performed 700 of them. It then states that the proposed ''Freedom of Choice Act'' now moving through Congress would ''protect the practice of abortion at all stages and would lead to an increase in the use of this grisly procedure.''

ACCURACY QUESTIONED

Some abortion rights advocates have questioned the ad's accuracy.

A letter to the Star-Tribune said the procedure shown ''is only performed after fetal death when an autopsy is necessary or to save the life of the mother.'' And the Morrisville, Vt., Transcript, which said in an editorial that it allowed the brochure to be inserted in its paper only because it feared legal action if it refused quoted the abortion federation as providing similar information. ''The fetus is dead 24 hours before the pictured procedure is undertaken,'' the editorial stated.

But Dr. Haskell and another doctor who routinely use the procedure for late-term abortions told AMNews that the majority of fetuses aborted this way are alive until the end of the procedure.

Dr. Haskell said the drawings were accurate ''from a technical point of view.'' But he took issue with the implication that the fetuses were 'aware and resisting.''

Radford also acknowledged that the information her group was quoted as providing was inaccurate. She has since sent a letter to federation members, outlining guidelines for discussing the matter. Among the points:

Don't apologize; this is a legal procedure.

No abortion method is acceptable to abortion opponents.

The language and graphics in the ads are disturbing to some readers. ''Much of the negative reaction, however, is the same reaction that might be invoked if one were to listen to a surgeon describing step-by-step almost any other surgical procedure involving blood, human tissue, etc.''

Late-abortion specialists

Only Dr. Haskell, James T. McMahon, MD. of Los Angeles, and a handful of other doctors perform the D&X procedure, which Dr. McMahon refers to as ''intact D&E.'' The

more common late-term abortion methods are the classic D&E and induction, which usually involves injecting digoxin or another substance into the fetal heart to kill it, then dilating the cervix and inducing labor.

Dr. Haskell, who owns abortion clinics in Cincinnati and Dayton, said he started performing D&Es for late abortions out of necessity. Local hospitals did not allow inductions pass 18 weeks, and he had no place to keep patients overnight while doing the procedure.

But the classic D&E, in which the fetus is broken apart inside the womb, carries the risk of perforation, tearing and hemorrhaging, he said. So he turned to the D&X, which he says is far less risky to the mother.

Dr. McMahon acknowledged that the procedure he, Dr. Haskell and a handful of other doctors use makes some people queasy. But he defends it. ''Once you decide the uterus must be emptied, you then have to have 100% allegiance to maternal risk. There's no justification to doing a more dangerous procedure because somehow this doesn't offend your sensibilities as much.''

Brochure cites N.Y. case

The four-page anti-abortion brochures also include a graphic depiction of the D&X procedure. But the cover features a photograph of 16-month-old Ana Rosa Rodriquez, whose right arm was severed during an abortion attempt when her mother was 7 months pregnant.

The child was born two days later, at 32 to 34 weeks' gestation. Abu Hayat, MD. of New York, was convicted of assault and performing an illegal abortion. He was sentenced to up to 29 years in prison for this and another related offense.

New York law bans abortions after 24 weeks, except to save the mother's life. The brochure states that Dr. Hayat never would have been prosecuted if the federal ''Freedom of Choice Act'' were in effect, because the act would invalidate the New York statute.

The proposed law would allow abortion for any reason until viability. But it would leave it up to individual practitoners—not the state—to define that point. Postviability abortions, however, could not be restricted if done to save a woman's life or health, including emotional health.

The abortion federation's Radford called the Hayat case ''an aberration'' and stressed that the vast majority of abortions occur within the first trimester. She also said that later abortions usually are done for reasons of fetal abnormality or maternal health.

But Douglas Johnston of the National Right to Life committee called that suggestion ''blatantly false.''

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

Numbers game

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

About 60,000 of those occurred in the 16- to 20-week period with 10,660 at week 21 and beyond the institute says. Estimates were based on actual gestational age, as opposed to last menstrual period.

There is particular debate over the number of third-trimester abortions. Former Surgeon General C. Everett Koop, MD, estimated in 1984 that 4,000 are performed annually. The abortion federation puts the number at 300 to 500. Dr. Haskell says that ''probably Koop's numbers are more correct.''

Dr. Haskell said he performs abortions ''up until about 25 weeks'' gestation, most of them elective. Dr. McMahon does abortions through all 40 weeks of pregnancy, but said he won't do an elective procedure after 26 weeks. About 80% of those he does after 21 weeks are nonelective, he said.

Mixed feelings

Dr. McMahon admits having mixed feelings about the procedure in which he has chosen to specialize.

''I have two positions that may be internally inconsistent, and that's probably why I fight with this all the time,'' he said.

''I do have moral compunctions. And if I see a case that's later, like after 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.'

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

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

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

''I think it's important to distinguish the two,'' he says, adding that his cutoff point is within the viability threshold noted in Roe v. Wade, the Supreme Court decision that legalized abortion. The decision said that point usually occurred at 28 weeks ''but may occur earlier, even at 24 weeks.''

Viability is generally accepted to be ''somewhere between 25 and 26 weeks,'' said Dr. Haskell. ''It just depends on who you talk to.

''We don't have a viability law in Ohio. In New York they have a 24-week limitation. That's how Dr. Hayat got in trouble. If somebody tells me I have to use 22 weeks, that's fine. . . . I'm not a trailblazer or activist trying to constantly press the limits.''

Campaign's impact debated

Whether the ad and brochures will have the full impact abortion opponents intend is yet to be seen.

Congress has yet to schedule a final showdown on the bill. Although it has already passed through the necessary committees, supporters are reluctant to move it for a full House and Senate vote until they are sure they can win.

In fact, House Speaker Tom Foley (D, Wash.) has said he wants to bring the bill for a vote under a ''closed rule'' procedure, which would prohibit consideration of amendments.

But opponents are lobbying heavily against Foley's plan. Among the amendments they wish to offer is one that would allow, but not require, states to restrict abortion—except to save the mother's life—after 24 weeks.

Mr. BACHUS. Mr. Speaker, today I urge my colleagues to override President Clinton's veto of the most barbaric of abortion procedures. The Partial-Birth Abortion Ban Act will end this most cruel practice—a practice that even the American Medical Association's legislative council has publicly stated is, ''not a recognized medical technique.'' They also called this procedure, ''repulsive.'' I call it a cruel inhumane act—unfitting of a civilized society.

Abortion advocates argue that partial birth abortions are only used after 26 weeks of pregnancy in cases where the procedure is non-elective. But the abortionist's interpretation of non-elective has an enormous scope and includes: Severe fetal abnormality, Down's syndrome, cleft palate, pediatric pelvis—that is if the mother is under age 18, depression of the mother, and even ignorance of human reproduction.

Today, those who would support this horrible procedure tell us that it is not a common practice. Can anyone really take comfort in debating the number of babies subject to his death? And newly released information indicates that in New Jersey alone, over 1,500 partial birth abortions are performed annually—over three times the supposed national total. Whether it is a few hundred or tens of thousands or even one, wrong is wrong and no argument on how many will ever change that. A single life being taken in this way is reprehensible.

We as a society would not allow or condone the execution of a confessed, convicted mass murderer using this procedure. How could we in good conscience even consider its use against an innocent, unborn child.

The House has come so close to having the two-thirds majority necessary for a veto override. I say to my colleagues who have opposed this bill in the past—look again, deeply into your hearts, and I am sure you will come to the same conclusion that I have and act to end this terrible procedure.

Mr. POSHARD. Mr. Speaker, I rise in very strong support of the vote today to override the President's veto of the Partial-Birth Abortion Ban Act, and urge my colleagues to follow suit in finally banning this unethical abortion procedure.

Let me begin by saying, the question of whether partial-birth abortions are right or wrong goes far beyond whether an individual takes a pro-life or pro-choice stance. This debate is about using humane and ethical medical practices. Former Surgeon General C. Everett Koop said, ''Such a procedure cannot truthfully be called medically necessary for either the mother or for the baby.'' As compassionate human beings, we should not allow physicians to continue to perform this procedure, one that was simply created to make it easier and faster for them to perform late-term abortions.

During my time in Congress, I have always opposed abortion except to save the life of a mother. Opponents of this legislation continue to argue the procedure is necessary to saving the lives of many expectant mothers. However, they fail to recognize that H.R. 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.'' What the bill does is ban this procedure from being used electively, which a majority of those serving in Congress believes is the right and ethical thing to do.

The veto override of the Partial-Birth Abortion Ban Act deserves the support of every Member of Congress, regardless of your stance on the issue of abortion. I urge all of my colleagues—Democrat, Republican, pro-life, and pro-choice—to seriously consider the morality of this procedure. In fact because of the sheer nature of the procedure, a number of historically pro-choice members of this body supported the ban on both occasions it was considered by the House of Representatives. Let us again join together in a bipartisan manner and override the veto of the Partial-Birth Abortion Ban Act.

Ms. FURSE. Mr. Speaker, I rise to oppose the motion to override the President's veto of the Partial-Birth Abortion Ban Act, H.R. 1833. I voted against H.R. 1833 earlier this year. Sadly, there are rare and tragic circumstances in which a woman may be advised by her doctor that this procedure is medically necessary to save her life or avoid dire consequences to her health.

H.R. 1833 does not contain an exception for saving the health of the mother, and could actually increase risks to the mother's health. The exception in H.R. 1833 also fails to cover cases where the mother could lose her ability to have more children.

However rare, tragic circumstances surrounding a woman's pregnancy do sometimes exist. A woman who faces this awful choice should make her decision in consultation with her family and her physician, and I feel strongly that Congress should not second-guess the medical advice of licensed doctors or the moral decisions of families in such devastating situations.

I urge my colleagues to oppose this motion to override the President's veto.

Mr. BROWNBACK. Mr. Speaker, I submit the following for the RECORD:

AUSTRALIAN PLANNED PARENTHOOD DIRECTOR LISTS MANY REASONS FOR HIS PARTIAL-BIRTH ABORTIONS

(By Douglas Johnson, NRLC Federal Legislative Director)

The medical director for Planned Parenthood of Australia has revealed that he uses the partial-birth abortion procedure 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.

These revelations by Dr. David Grundmann have provoked a storm of controversy in the state of Queensland, the large state that occupies northeastern Australia.

Dr. Grundmann performs abortions at a Planned Parenthood clinic in Brisbane, the capital of Queensland. He described his abortion practices in a paper that he presented on August 30, 1994, at a conference at Monash University.

In the paper, Dr. Grundmann wrote that ''abortion is an integral part of family planning. Theoretically this means abortion at any stage of gestation. Therefore I favor the availability of abortion beyond 20 weeks.''

Dr. Grundmann wrote that ''dilatation and extraction'' is his ''method of choice'' for performing abortions from 20 weeks on. ''Dilatation and extraction'' (or ''dilation and extraction'') is a term ''coined'' by Dr. Martin Haskell of Dayton, Ohio, for the partial-birth abortion procedure, in which a living baby is partly delivered feet first, after which the skull is punctured and the brain removed by suction.

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 his 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 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'':

''Minor or doubtful fetal abnormalities.''

''Extreme material immaturity, i.e., girls in the 11 to 14 year age group.''

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 . . .''

''Intellectually impaired women, who are unaware of basic biology . . .''

''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.''

''Abortion beyond 20 weeks is unavailable anywhere in Australia, except at our [Planned Parenthood] clinics for the last 5 categories,'' Dr. Grundmann wrote. Under the heading ''What can be done to improve or expand this service?'' Dr. Grundmann wrote, ''Demystify abortion particularly late abortion by appropriate education of the population.''

Election Issue: Dr. Grundmann's paper has been publicized by the Queensland Right to Life Association, and it has produced considerable controversy over the past two years, Dr. David van Gend said in an interview with NRL News. Dr. van Gend, a Brisbane general practitioner, is the secretary of the Queensland chapter of the World Federation of Doctors Who Respect Human Life (WFDWRHL).

Dr. van Gend took Dr. Grundmann's paper to Michael Horan, a member of the Queensland Parliament, who was the ''shadow health minister'' for the National-Liberal Coalition, which at that time was the opposition to the ruling government, which was headed by Premier Wayne Goss of the Labor Party.

Beginning in October 1994, Mr. Horan strongly attacked Dr. Grundmann's abortion practices in speeches on the floor of the Parliament. Mr. Horan demanded that the Goss Government take strong action to stop Dr. Grundmann's late abortions, which, he argued, violate Queensland law.

''What will it mean for the conscience of society and its respect for the law, if people are vividly aware of such brutality, such illegality, and then they see their leaders do nothing about it?'' Mr. Horan said in one speech. ''More importantly, what will it mean for all the defenseless babies who, unlike their peers in the hospital nurseries, will never see a human face, never feel a human touch, except that tight grip on their legs and the stab to the head?''

However, for more than a year, the Goss Government refused to take any meaningful action. Leaders of the Coalition promised to take steps against Dr. Grundmann if they were placed in power, and this became a major issue in the February 1996 elections, in which the Goss Government lost power.

''The late-term abortion issue was the clearest issue distinguishing the parties in the February election,'' Dr. van Gend told NRL News. ''The Labor Government had refused to act against Dr. Grundmann, while the National-Liberal Coalition leaders promised to immediately investigate the matter.''

For example, Liberal Party leader Joan Sheldon said that the partial-birth abortions ''are horrific and should be stopped.''

When the Coalition took over the government, Michael Horan became the Minister of Health. Recently, the government has placed an investigation of Dr. Grundmann in the hands of the state Medical Board, which has quasi-judicial investigative punitive powers, Dr. van Gend said.

AMA Rebukes Grundmann: The Queensland Branch of the Australian Medical Association (AMA) formed a ''working party'' on late abortion, which interviewed Dr. Grundmann regarding his abortion practices in September 1995.

As quoted by Mr. Horan in his speeches in Parliament, during this interview Dr. Grundmann said he has performed the partial-birth abortion procedure as late as 26½ weeks (past 6 months).

''There is no stage of pregnancy at which I regard the fetus as my patient,'' Dr. Grundmann told the panel.

Dr. Grundmann told the panel that just that month he had aborted a baby at 23 weeks for severe cleft palate. When it was pointed out that this condition can be corrected by surgery, Dr. Grundmann replied that this depends on whether the woman wants to put ''her fetus'' through all that surgery.

In April 1996, the AMA Queensland Branch issued a formal policy statement that said,''There is a duty of care to the fetus in the late second trimester of pregnancy.'' Therefore, the organization ''opposes late second trimester termination of pregnancy except in the gravest of circumstances,'' these being ''lethal'' or ''severe'' fetal malformation or ''unequivocal risk to the life of the mother where no other medical procedure would suffice to save the mother.'' This was viewed as a rebuke to Dr. Grundmann.

Dr. van Gend said that in an interview with Dr. Grundmann, ''I asked him if there was not something cold and premeditated, even grotesque, about setting out to dilate the birth canal to 75% of the fetal skull diameter, in order to ensure the head will lodge in the cervix [the opening to the womb], in order to have leisure to push a puncturing instrument through that head, in order to ensure 'no chance of delivering a live fetus'—when by dilating the canal one more centimetre he would enable the baby to slip out and be given to the care of a pediatrician. His response was to the effect that he was there to terminate that pregnancy, not to put the woman's fetus in an incubator.''

Asked by a radio interviewer, ''At what point do you believe the fetus becomes a sentient being?,'' Dr. Grundmann responded, ''When it is born.''

Dr. van Gend told *NRL News,*''At no stage during the Australian debate over partial-birth abortions has Dr. Grundmann or anyone else tried to pretend that the baby is already dead before the head is punctured. The Baby is wide awake and fully sensitive.''

Dr. van Gend explained that in Queensland, statutory law generally prohibits abortion,

but a 1986 court ruling known as ''the McGuire ruling'' provides for exceptions in cases in which there is a ''serious'' danger to a woman's life or health, including mental health. Dr. Grundmann has asserted that all of his abortions fit under these criteria. However, in a 1995 civil case, a Queensland judge ruled, ''I disbelieve Dr. Grundmann's assertions that he honestly and sincerely applied that test before each and every abortion which he performed.''

''If Dr. Grundmann is ever prosecuted, a jury would be asked to decide whether these late abortions—for these reasons, by this method— are justified under our law,'' Dr. van Gend said.

Queensland law requires that a death certificate be filed for abortions performed after 20 weeks, which Dr. Grundmann wrote is ''certainly an inconvenience.''

Mr. WATTS of Oklahoma. Mr. Speaker, recently, a physician asked exactly what we meant by the term, partial-birth abortion ban and instead of going through the grotesque explanation, we told her that she was right—we had been calling it by the wrong name. Late-term, or just plain abortion was probably more accurate.

However, one physician from my home State of Oklahoma said that she called it infanticide. No matter what you call it, this veto needs to be overridden.

Mr. Speaker, we are not talking about a medically proven treatment that is going to save thousands of lives. In fact, we are stating the exact opposite. This is not a medically necessary procedure. This is a gruesome execution.

We need to be a Congress that stands for right causes, right decisions, and plain old doing the right thing.

This late-term abortion—when the fetus is a viable baby—is the right thing for this Congress to do. It is commanded by anyone who believes in the sanctity of life.

We have had hundreds and hundreds of postcards, a petition with literally thousands of names of it and letters of support from Catholic bishops, evangelical pastors, and rabbis.

To my colleagues, I have to tell you: This is the right thing to do. Please vote to override the veto and stop this infanticide.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to H.R. 1833 and thus, in opposition to the misguided attempt to override the President's veto. I do so for many reasons, all of which I have stated before but will gladly reiterate in the hope of convincing those who might support this override attempt of the error of their actions.

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

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

The second reason for my opposition is that H.R. 1833 would ban a range of late term abortion procedures that are used when a woman's health or life is threatened or when a fetus is diagnosed with severe abnormalities incompatible with life. Because H.R. 1833 does not use medical terminology, it fails to clearly identify which abortion procedures it seeks to prohibit, and as a result could prohibit physicians from using a range of abortion techniques, including those safest for the woman. If enacted, such a law would have a devastating effect on women who learn late in their pregnancies that their lives or health are at risk or that the fetuses they are carrying have severe, often fatal, anomalies.

The Republican Members of this body need look no further than their own party for women who have offered their own stories, as testimony to the need for such medical procedures.

Women like Coreen Costello, a loyal Republican and former abortion protester whose baby had a lethal neurological disease; Mary-Dorothy Lines, a conservative Republican who discovered her baby had severe hydrocephalus; and many others who needed this procedure to insure not only their health, but their ability to have more children in the future. These are the women who would be hurt by H.R. 1833—women and their families who face a terrible tragedy—the loss of a wanted pregnancy.

I heard first hand, during judiciary committee hearings, the pain of women who had this procedure. For hours we listened to their tales of emotional and physical suffering during their testimony.

In April, the President was joined by five women who were heartbroken to learn of their baby's fatal conditions. These women wanted their children more than life itself, but were advised that this procedure was their best chance to avert the risk of death or grave harm. He found their testimony moving, because for them, this was not about choice, but rather life. One of them described her predicament:

Our little boy had hydrocephally. All the doctors told us there was no hope. We asked about in utero surgery, about shunts to remove the fluid, but there was absolutely nothing we could do. I cannot express the pain we still feel. This was our precious little baby, and he was being taken from us before we even had him. This was not our choice, for not only was our son going to die, but the complications of the pregnancy put my health in danger, as well.

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

Finally, and perhaps most importantly, this bill would create an unwarranted intrusion into the physician-patient relationship by preventing physicians from providing necessary medical care to their patients. It would further intrude into this sacred association by making doctors felons for doing that which they have taken an oath to do: protect the lives of their patients. I am incredulous that physicians will be seen as criminals in the eyes of the law for attempting to save the life of an innocent mother. Furthermore, it would impose a horrendous burden on families who are already facing a crushing personal situation.

In passing H.R. 1833, this Congress would set an undesirable precedent which goes way beyond the scope of the abortion debate. Will we someday be standing here debating the validity of a triple bypass or hip replacement procedure? Many of my colleagues decry the intrusion of the Federal Government into the lives of its citizens, but isn't interfering in the doctor-patient relationship one of the most intrusive actions that can be conceived?

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

The determination of the medical need for, and effectiveness of, particular medical procedures must be left to the medical profession, to be reflected in the standard of care.

While these are my reasons for opposing H.R. 1833 and this veto override, I believe it is time to clear up some facts associated with the procedure being debated here.

To begin with, the term ''partial birth abortion'' is not found in any medical dictionaries, textbooks or coding manuals. The definition in H.R. 1833 is so vague as to be uninterpretable, yet chilling. Many OB/GYN's fear that this language could be interpreted to ban all abortions where the fetus remains intact. The supporters of this bill want to intimidate doctors into refusing to do abortions. Given the bill's vagueness, few doctors will risk going to jail in order to perform this procedure. As a result, women and their families will find it even more difficult, if not impossible, to find a doctor who will perform a late-term abortion, and women's lives will be put in even more jeopardy.

In addition, late term abortions are not common. Ninety-five and five tenths percent of abortions take place before 15 weeks. Only a little more than one-half of one percent take place at or after 20 weeks. Fewer than 600 abortions per year are done in the third trimester and all are done for reasons of life or health of the mother—severe heart disease, kidney, failure, or rapidly advancing cancer—and in the case of severe fetal abnormalities incompatible with life—no eyes, no kidneys, a heart with one chamber instead of four or large amounts of brain tissue missing or positioned outside of the skull, which itself may be missing.

An abortion performed in the last second trimester or in the third trimester of pregnancy is extremely difficult for everyone involved. However, when serious fetal anomalies are discovered late in a pregnancy, or the mother develops a life-threatening medical condition that is inconsistent with the continuation of the pregnancy, abortion—however heart-wrenching—may be medically necessary.

In such cases, the intact dilation and extraction procedure [IDE]—which would be outlawed by this bill—may provide substantial medical benefits. It is safer in several respects than the alternatives, maintaining uterine integrity, and reducing blood loss and other potential complications.

Let me set the record straight, no one is advocating the abuse of this process and those who would state differently are exaggerating the frequency and circumstances under which this procedure is done. I have great confidence in the American doctors and women to do the right thing and not use this procedure for nothing less than saving the life of the mother.

The decision to have an abortion is a very difficult one for any woman, and I do not understand how the many Members of this House, who will never face the possibility, can belittle the anguish that such a decision causes. The determination of whether abortion is appropriate for any individual is something that should be left up to herself, her family and her God. And I am sickened and appalled that so many Members of this usually honorable body would use this very private issue for political gain. How they can minimize the tragedy that befalls families when the loved and desired child is found to be inviable and the ability for the mother to bear future children is in great jeopardy, I do not know nor do I understand. During these times of misfortune, one calls upon one's spiritual strength and to think the Government would have the effrontery to intrude makes a mockery of the Constitution and an individual's right to privacy. In short, we are not advocating this procedure on demand or for feeble complaints regarding health or convenience. To deny physicians the ability to use all of their medical resources to avoid loss of life and save the mother would be to treat these women less than human.

The legislative process is ill-suited to evaluate complex medical procedures whose importance may vary with a particular patient's case and with the state of scientific knowledge. The mothers and families who seek late term abortions are already severely distressed. They do not want an abortion—they want a child. Tammy Watts told us that she would have done anything to save her child. She said, ''If I could have given my life for my child's I would have done it in a second.''

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

Mr. COYNE. Mr. Speaker, I am opposed to H.R. 1833 because I oppose any legislation that fails to provide for the health concerns of the mother when she and her doctor believe that her health is in jeopardy. This legislation does not provide an exception for serious health risks to the mother.

This procedure should only be used in cases where there is a serious risk to a woman's health and I believe the legislation could have been drafted to allow a limited exception for those cases in which it is truly necessary. In fact, Pennsylvania has such an exception in its abortion law. Under Pennsylvania law, all late-term abortions are prohibited, except in cases in which it is necessary to preserve the life of the mother or to ''prevent a substantial and irreversible impairment of a major bodily function.'' Surely the supporters of this legislation could have written a health exception that would prohibit the procedure in most cases but that would allow women and their physicians, in the most limited and serious of cases, access to a procedure that will preserve both the life and health of the women involved.

Further, I am opposed to this legislation because I believe that medical decisions of this nature should be left to trained medical professionals, in consultation with their patients. I do not believe that this legislation, which forecloses medical options for women, belongs before the Congress. This Congress is not comprised of medical professionals with the knowledge or expertise to make medical judgments about appropriate treatment for women in these tragic circumstances. I believe that these judgments must be left in the hands of people who are trained to give medical guidance to their patients, and then the decision regarding the course of action to take must rest with women, their families, their physicians and their religious counselors—not with Congress.

I am ready to support legislation that limits this abortion procedure to the most serious of cases, but I am not prepared to ban it in those cases where it represents the best hope for a woman to avoid serious risk of her health.

Mr. BUNN of Oregon. Mr. Speaker, over 300 physicians, including C. Everett Koop, have joined together to expose the misinformation campaign of the supporters of partial-birth abortion. I insert the facts provided by PHACT in the CONGRESSIONAL RECORD:

A NATIONAL COALITION OF DOCTORS SAYS IT'S UNSAFE AND UNNECESSARY

The Physicians' Ad Hoc Coalition for Truth (PHACT) was formed because we, as physicians, can no longer stand by while abortion advocates, the President of the United States and the media continue to repeat false claims to members of Congress and to the public about partial-birth abortion. We are over 300 doctors strong, most specialists in obstetrics, gynecology, maternal/fetal medicine and pediatrics.

By congressional definition, partial-birth abortion is the killing of an infant who has already been partially delivered outside his or her mother's body. Medically, it is accomplished by pulling an infant feet-first out of the birth-canal until all but the head is exposed. The surgeon then forces scissors into the base of the baby's skull, spreads them, and inserts a suction catheter through which he suctions out the brain.

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

On the contrary, this procedure can pose a significant threat to both. I the words of former Surgeon General C. Everett Koop: ''In no way can I twist my mind to see that partial birth—and then destruction of the unborn child before the head is born—is a medical necessity for the mother.''

Now you know the facts.

We urge you to tell your representatives to stop this unnecessary and dangerous procedure. The vote is this week. Please call now.

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.

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 703–683–6004.

PHYSICIANS' AD HOC
COALITION FOR TRUTH,
Alexandria, VA, 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 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,

NANCY G. ROMER, M.D.,
FACOG, Clinical Professor, Department of Obstetrics and Gynecology, Wright State University, Chairman, Dept. of Ob/Gyn, Miami Valley Hospital, OH.

CURTIS R. COOK, M.D.,
Maternal Fetal Medicine, Butterworth Hospital, Michigan State College of Human Medicine.

PAMELA E. SMITH, M.D.,
Director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Medical Center, Chicago, IL., Member, Association of Professors of Ob/Gyn.

JOSEPH L. DECOOK, M.D.,
FACOG, Holland, MI.

DOCTORS' GROUP PROMOTING MEDICAL FACTS ABOUT PARTIAL-BIRTH ABORTION QUICKLY SWELLS TO OVER 300 MEMBERS—MEDICAL SPECIALISTS NATIONWIDE STAND FIRM: PARTIAL-BIRTH ABORTION NEVER A MEDICAL NECESSITY

ALEXANDRIA, VA.—The Physicians Ad-hoc Coalition for Truth (PHACT) has quickly grown to over 300 doctors nationwide, actively promoting the fact that partial-birth abortions are never medically necessary.

PHACT was formed by medical professionals concerned about repeated medical misstatements about the procedure known as partial-birth abortion. The misleading and false information is potentially dangerous to women and their children.

Specialists from around the country in the fields of obstetrics, gynecology, perinatology (maternal and fetal medicine) and pediatric medicine have joined PHACT to correct misstatements and distortions rampant in the debate over partial-birth abortions, and to promote the fact that a partial-birth abortion is never medically necessary to protect the health of a woman or to protect her future fertility. In fact, the procedure can pose grave dangers to the woman, and is not recognized in the medical community.

Recently, former Surgeon General G. Everett Koop publicly confirmed that the partial birth abortions are not medically necessary procedures. During an interview published in 8/19/96 issue of American Medical News, Dr. Koop remarked ''I believe 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 late-term abortion as described—you know, the 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.''

The current PHACT membership of over 300 far surpasses the founding members' stated goal to attract 200 members. PHACT was formed in late July of this year, and held a Congressional briefing on July 24 as their debut event to educate Congress and the public on the medical facts about partial-birth abortion.

The Physicians' Ad-hoc Coalition for Truth (PHACT) 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 and Michelle Powers at 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 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.''

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.

Mr. UNDERWOOD. Mr. Speaker, I rise today to urge my colleagues to vote for the override of the President's veto of the partial birth abortion bill. I sponsored the original legislation because it would protect the sanctity of life and prevent the cruel and inhumane killing of unborn children.

We know all too well the arguments on both sides of this issue. Opponents of the bill argue that the partial birth abortion procedure does not exist because it is only used to deliver babies who are already dead. This argument is nonsensical because the definition of a partial birth abortion requires the partial delivery of a fetus which is still alive. A living fetus is viable and we should respect its humananity.

Another argument offered by those who oppose the bill is that this procedure is rare and utilized only in dire circumstances, when the baby is defective or the mother's life is in danger. This is not true. Many doctors admit that partial birth abortions are elective and are quite common. There are many reasons why women have late-term abortions. Some cite the lack of money or adequate health insurance to support the child. Others may have social or psychological problems which hinder their ability to go to full term on their pregnancy.

No matter what reasons are cited, this brutal and senseless procedure should never be allowed.

We can certainly find humane ways to deal with whatever reasons or undue burdens which cause women to resort to partial birth abortions. But we should not, as a nation, sanction this procedure: it is wrong, wrong, wrong.

For me and the people of Guam whom I represent, the importance of childbearing and the worth of children in our culture are cornerstones for sustaining family values. For us, abortion is not an option; it is something we vigorously oppose because it destroys our concept of family preservation.

I join the U.S. Catholic Conference, a number of antiabortion groups, and a majority of my colleagues in the House in supporting the overturn of the veto on this important legislation. This is not a constitutional issue, nor a health policy issue—this is an issue of protecting children who are killed before they are given a chance to experience their humanity.

Mr. BEILENSON. Mr. Speaker, I rise in strong opposition to the ill-advised attempt to override the President's veto of H.R. 1833.

The President's veto should be sustained—especially because this is a bill that, on the pretense of seeking to ban certain vaguely defined abortion procedures, is in reality an assault on the constitutionally guaranteed right of women to reproductive freedom and on the freedom of physicians to practice medicine without government intrusion.

This legislation would be a direct blow to the fight many of us led for many, many years to secure—and then to preserve and to protect—the right of every woman to choose a safe medical procedure to terminate a wanted pregnancy that has gone tragically wrong, and when her life or health are endangered.

The President correctly vetoed the legislation because it does not contain a true life and health exception provision. It does contain an extremely narrow life exception, and it requires further that no other medial procedure would suffice. But it provides no exception at all to preserve the woman's health, no matter how seriously or permanently it will be damaged.

This exception is obviously a basic and fundamental concern to women and their families. Without it, the bill will force a woman and her physician to resort to procedures that may be more dangerous to the woman's health—and to her very life—and that may be more threatening to her ability to bear other children, than the method banned.

If this exception had been included, the bill would have at least shown some respect for the paramount importance of a woman's life, health, and future fertility.

The truth is, however, that we have absolutely no business considering this prohibition and criminalization of a constitutionally protected medical procedure.

This is a dangerous piece of legislation. It is the first time the Federal Government would ban a particular method of abortion, and it is part of an effort to make it almost impossible for any abortion to be performed late in a pregnancy—no matter how endangered the mother's life or health might be.

At stake here is whether or not we will be compassionate enough to recognize that none of us in this legislative body has all the answers to every tragic situation.

We are debating not merely whether to outlaw a procedure, but under what terms. If legislation must be passed that is unprecedented in telling physicians which medical procedures they may not, despite their own best judgment, use, then it must permit a life or adverse health exception. That is the only way that the legislation might possibly meet the requirements that have been handed down by the U.S. Supreme Court.

Mr. Speaker, on a personal note, I authored California's Therapeutic Abortion Act, which was one of the first laws in the Nation to protect the lives and health of women. Members may recall that then Gov. Ronald Reagan signed my legislation into law in 1967. That was a difficult and hard-won fight; it helped, I believe, save the lives of several million women, and as I look back on my legislative career, it is the legislation I am most proud of.

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

I see now that I was obviously wrong, because this Congress is willing even to criminalize for the first time a safe medical procedure that is used only very, very rarely and to end the most tragic of pregnancies. These are situations that are so desperate that it is hard to understand why most people, except those who are opposed to abortion under any circumstance at all, would not be able to understand that these are the very situations that should be protected.

This is not a moderate measure, Mr. Speaker. It is an absolute tragedy for women and their families who could very well find themselves in the very desperate and tragic situation of other women who have had the courage to talk about the seriously defective pregnancies they had to end if they were to live or to protect their health and future fertility.

We are talking about making a crime a medical procedure that is used only in very rare cases—fewer than 500 a year. It is a procedure that is needed only as a last resort, in cases where pregnancies that were planned, and that are wanted, have gone tragically wrong.

Choosing to have an abortion is always a terribly difficult and awful decision for a family to make. But we are dealing here with particularly wrenching decisions in particularly tragic circumstances. It seems to me that it would be more than fitting if we showed restraint and compassion for women who are facing those devastating decisions.

Mr. Speaker, we should uphold the President's veto of this legislation that is unwise, unconstitutional, and terrible public policy that would return us to the dangerous situation that existed over 30 years ago.

Mr. McDADE. Mr. Speaker, today the House of Representatives has the opportunity to stop the appalling practice known as partial-birth abortion. I cosponsored and supported the legislation to ban partial-birth abortions both because I am committed to protecting the rights of the unborn and because they are particularly morally repugnant.

I will vote to override the President's veto and encourage my colleagues to join me so that H.R. 1833, the Partial Birth Abortion Ban Act can be enacted.

A partial-birth abortion is not, as President Clinton would have us believe, an ordinary medical procedure. It is a gruesome practice which pulls a baby from its mother's womb and ends its life.

There is no gray area in this debate. This heinous practice—coming very late in the pregnancy—is clearly the killing of a human baby.

Thousands of Americans have written and called this House to plead that we enact the Partial-Birth Abortion Ban Act and protect the right to life of these late-term children. I pray that we will hear their plea and override the President's veto.

Mr. SENSENBRENNER, Mr. Speaker, I strongly support overriding President Clinton's veto of H.R. 1833, the Partial Birth Abortion Ban Act.

The President's veto of the Partial Birth Abortion Ban Act is morally indefensible and his reason for vetoing the bill does not hold up under closer scrutiny. The President claims this abortion procedure is necessary, in fact, the ''only way,'' for women with certain prenatal complications to avoid serious physical damage, including the ability to bear further

children. If this is true, then why is partial-birth abortion not taught in a single medical residency program anywhere in the United States? Why is it not recognized as an accepted surgery by the American College of Obstetricians and Gynecologists? Actually, the American Medical Association's legislative council voted unanimously to endorse the partial-birth abortion ban.

The fact is, a partial-birth abortion is never necessary to preserve the health of future fertility of the mother. However, you do not have to take my word for it, listen to what former Surgeon General C. Everett Koop has to say on the subject. Mr. Koop stated:

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.

The dangerous reality is, according to undisputed expert medical testimony given before the House Subcommittee on the Constitution, the partial-birth abortion can be harmful to the mother in several ways. First, the cervix must be forcefully dilated, threatening future pregnancies by weakening the cervix. Next, the surgeon's hand must be inserted into the uterus to turn the baby around. This maneuver is so dangerous that it has been avoided in obstetrical practice for decades. Finally, the removal of the baby's brain while the head remains in utero may expose sharp fragments of bone. Uterine laceration and severe hemorrhaging may result.

The difference between a partial-birth abortion and homicide is a mere three inches. A society that strives for civility should not tolerate such barbarism.

Mr. KLECZKA. Mr. Speaker, I rise today in strong support of H.R. 1833, which will stop the senseless and inhumane practice of partial birth abortions.

Patial birth abortions are gruesome, they are horrific and they are wrong.

I voted in favor of H.R. 1833 on November 1, 1995 and again on March 27, 1996. Today, I continue my support for this much-needed legislation by once again voting for H.R. 1833—and voting to override the President's veto.

Critics of this bill say the majority of these procedures are health related. Yet documents obtained by the committees studying this issue show that the majority of late-term abortions are not done for medical reasons at all.

Critics of this measure say it will harm mothers whose babies pose a life-threatening hazard to their health. Yet H.R. 1833 contains an exception that protects the mother if her life is in danger. This exception allows the procedure if it is ever ''necessary to save the life of a woman whose life is endangered by a physician disorder, illness, or injury, provided that no other medical procedure would suffice for that purpose.''

We must, as a society, move to address this issue with compassion and with courage. The destruction of human life that results from a partial birth abortion must stop now. I am pleased to join my colleagues in voting to end this unnecessary and unethical procedure.

Mr. Christensen. Mr. Speaker, I rise today in favor of overriding the President's veto of the Partial-Birth Abortion Ban Act.

I was honored to be an original cosponsor of this legislation because it takes a stand against the most horrid abuses of the abortion industry—abortions that are committed on a child that is partially born before the abortionist kills the child.

This procedure is so indefensible that its proponents have been left to medical distortions and falsehoods to defend their position.

According to Dr. Nancy Romer, of Wright State University, ''there is no medical evidence that the partial birth abortion procedure is safer or necessary to provide comprehensive health care to women.'' Dr. Romer dealt with the medical issues surrounding this procedure in greater detail in an op-ed in today's Wall Street Journal, and I submit it for the RECORD.

I believe that each of us—not just as Members of Congress but as citizens and as human beings—has a moral obligation to stand up in defense of our Nation's children and put an end to this horrible procedure, and I urge my colleagues to support over-riding the President's veto.

[From the Wall Street Journal, Sept. 19, 1996]

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 women's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant women'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 women's cervix is forcibly dilated over several days, which risks creating an ''incompetent cervix,'' the leading cause of premature delivers. 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?

[From the National Right to Life Committee, Inc., Tuesday, Sept. 17, 1996]

TWO MAJOR NEWSPAPERS DISCREDIT KEY CLAIMS OF WHITE HOUSE AND OTHER FOES OF PARTIAL-BIRTH ABORTION BAN

WASHINGTON.—The U.S. House of Representatives is scheduled to vote as early as Thursday, September 19, on whether to override President Clinton's veto of a bill to ban partial-birth abortions (except to save a mother's life). This week, two daily newspapers—the Washington Post and the Record of Bergen County, New Jersey—have published investigative reports that discredit false claims by the White House and pro-abortion advocacy groups that partial-birth abortions are ''extremely rate'' and are performed only or mainly in cases of risk to the mother or lethal disorders of the fetus/baby.

The Record's investigative report, titled ''the Facts on Partial-Birth Abortions,'' was written by ''women's issues'' staff writer Ruth Padawer and published on September 15. The Record quoted the insistent claims of pro-abortion advocacy groups that partial-birth procedures are performed in rare and medically dire circumstances, before reporting: ''But interviews with physicians who use the method reveal that in New Jersey alone, at least 1,500 partial-birth abortions are performed each year''—triple the 450–500 number which the National Abortion Federation (NAF), a lobby for abortion clinics, has claimed occur in the entire country.

The Record reported, ''Doctors at Metropolitan Medical in Englewood [New Jersey] estimate that their clinic alone performs 3,000 abortions a year on fetuses between 20 and 24 weeks [i.e., 4½ to 5½ months], of which at least half are intact dilation and evacuation'' [i.e., partial-birth abortion]. The abortion doctors at the Englewood facility ''say 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 reporters Barbara Vobejda and David M. Brown, M.D., who 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.

In addition to the abortionists at the Metropolitan Medical facility, the Record learned of at least five other doctors performing partial-birth abortions in the region: ''Another metropolitan area doctor who works outside New Jersey said he does about 260 post-20-week abortions a year, of which half are by intact D&E. The doctor, who is also a professor at two prestigious teaching hospitals, said he has been teaching intact D&E since 1981, and he said he knows of two former students on Long Island and two in New York City who use the procedure.''

Both articles unfairly say that leading supporters of the Partial-Birth Abortion Ban Act have implied that partial-birth abortions are performed primarily during the last three months of pregnancy. In truth, it has been opponents of the bill, including President Clinton, who have tried to narrow the focus of the debate to ''third trimester'' procedures. In contrast, NRLC has publicly and consistently challenged attempts to characterize the bill as a ban on primarily ''third trimester'' procedures, and has stressed that most partial-birth abortions are performed from 20 to 26 weeks—4½ to 6 months—for entirely non-medical reasons. At even 24 weeks, an unborn baby is (on average) 10 inches long, and if born prematurely has a one-in-three chance of survival in a neonatal unit.

[However, it is also well documented that many partial-birth abortions have been performed even after 26 weeks (i.e., during the third trimester), and in a variety of circumstances besides ''severe fetal anomalies.'' Indeed, in a 1995 written submission to the House Judiciary Committee, the late Dr. James McMahon indicated that even at 29–30 weeks, fully one-fourth of the partial-birth abortions that he performed were on fetuses with no ''flaw'' whatever.]

A questionnaire submitted to candidates by the U.S. Catholic Conference, published on September 16, asked, ''What is your position on a law banning partial-birth abortion?'' The Clinton campaign responded: ''If Congress sends the president a bill that bars third-trimester abortions with an appropriate exception for life or health, the president would sign it.'' [emphasis added] By limiting this commitment to ''third-trimester'' abortions, Mr. Clinton's ''restriction'' effectively excludes most partial-birth abortions. Moreover, as the Washington Post reported in its Sept. 17 examination of the issue, the Supreme Court has defined ''health'' abortions to include those performed ''in the light of all factors—physical, emotional, psychological, familial and the woman's age.'' The Post's reporters accurately concluded, ''Because of this definition, life-threatening conditions need not exist in order for a woman to get a third-trimester abortion.'' [Sept. 17 Washington Post Health, page 17]

In an advertisement published today in USA Today and other newspapers, the Physicians' Ad Hoc Coalition for Truth (PHACT), a coalition of about 300 medical specialists including former Surgeon General C. Everett Koop, says emphatically that even in cases involving severe fetal disorders, ''partial-birth abortion is never medically necessary to protect a mother's health or her future fertility.''

The SPEAKER pro tempore (Mr. LAHOOD). All time having expired, without objection, the previous question is ordered.

There was no objection.

The SPEAKER pro tempore. The question is, Will the House, on reconsideration, pass the bill, the objections of the President to the contrary notwithstanding?

Under the Constitution, the vote must be determined by the yeas and nays.

The vote was taken by electronic device, and there were—yeas 285, nays 137, not voting 12, as follows:

[Roll No. 422]

YEAS—285

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

NAYS—137

Abercrombie	Frelinghuysen	Owens
Ackerman	Frost	Pallone
Andrews	Gejdenson	Pastor
Baldacci	Gibbons	Payne (NJ)
Becerra	Gilman	Pelosi
Beilenson	Gonzalez	Pickett
Bentsen	Green (TX)	Rangel
Berman	Greenwood	Reed
Bishop	Gutierrez	Richardson
Blumenauer	Harman	Rivers
Boehlert	Hastings (FL)	Rose
Boucher	Hilliard	Roybal-Allard
Brown (CA)	Hinchey	Rush
Brown (FL)	Horn	Sabo
Brown (OH)	Hoyer	Sanders
Bryant (TX)	Jackson (IL)	Sawyer
Campbell	Jackson-Lee (TX)	Schroeder
Cardin	Johnson (CT)	Schumer
Chapman	Johnson, E.B.	Scott
Clay	Kelly	Serrano
Clayton	Kennedy (MA)	Shays
Clyburn	Kennelly	Skaggs
Coleman	Kolbe	Slaughter
Collins (IL)	Lantos	Stark
Collins (MI)	Levin	Stokes
Conyers	Lewis (GA)	Studds
Coyne	Lofgren	Thompson
Cummings	Lowey	Thurman
DeFazio	Luther	Torkildsen
DeLauro	Maloney	Torres
Dellums	Markey	Torricelli
Deutsch	Matsui	Towns
Dixon	McCarthy	Velazquez
Doggett	McDermott	Vento
Dooley	McKinney	Ward
Durbin	Meehan	Waters
Edwards	Meek	Watt (NC)
Engel	Menendez	Waxman
Eshoo	Meyers	Williams
Evans	Millender-McDonald	Wilson
Farr	Miller (CA)	Wise
Fattah	Mink	Woolsey
Fazio	Morella	Wynn
Filner	Nadler	Yates
Ford	Olver	Zimmer
Frank (MA)		
Franks (CT)		

NOT VOTING—12

Dicks	Ganske	Lincoln
Fields (LA)	Hayes	Longley
Fields (TX)	Heineman	Peterson (FL)
Furse	Johnston	Thornton

□ 1414

The Clerk announced the following pairs:

On this vote:

Mr. Hayes and Mr. Ganske for, with Ms. Furse against.

Mr. Longley and Mr. Fields of Texas for, with Mr. Johnston of Florida against.

Mr. DOGGETT changed his vote from ''yea'' to ''nay.''

So, two-thirds having voted in favor thereof, the bill was passed, the objections of the President to the contrary notwithstanding.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. LAHOOD). The Clerk will notify the Senate of the action of the House.

□ 1415

PRIVILEGES OF THE HOUSE—RESOLUTION REQUIRING THAT INVESTIGATION INTO MATTERS SURROUNDING COMPLAINT ON REPRESENTATIVE RICHARD GEPHARDT BE ASSIGNED TO SPECIAL COUNSEL

Mr. LINDER. Mr. Speaker, pursuant to notice given earlier this day, under rule IX, I offer a resolution (H. Res. 524) raising a question of the privileges of the House, and I ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 524

Whereas, a complaint filed against Representative GEPHARDT alleges House Rules have been violated by Representative GEPHARDT's concealment of profits gained through a complex series of real estate tax exchanges and;

Whereas, the complaint also alleges possible violations of banking disclosure and campaign finance laws or regulations and;

Whereas, the Committee on Standards of Official Conduct has in complex matters involving complaints hired outside counsel with expertise in tax laws and regulations and;

Whereas, the Committee on Standards of Official Conduct is responsible for determining whether Representative GEPHARDT's financial transactions violated standards of conduct or specific rules of House of Representatives and;

Whereas, the complaint against Representative GEPHARDT has been languishing before the committee for more than seven months and the integrity of the ethics process and the manner in which Members are disciplined is called into question; now be it

Resolved that the Committee on Standards of Official Conduct is authorized and directed to hire a special counsel to assist in the investigation of this matter.

Resolved that all relevant materials presented to, or developed by, the committee to date on the complaint be submitted to a special counsel, for review and recommendation to determine whether the committee should proceed to a preliminary inquiry.

The SPEAKER pro tempore (Mr. LAHOOD). The resolution constitutes a question of privilege under rule IX.

MOTION TO TABLE OFFERED BY MR. ARMEY

Mr. ARMEY. Mr. Speaker, I offer a privileged motion.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. ARMEY moves to lay the resolution on the table.

The SPEAKER pro tempore. The question is on the motion to table offered by the gentleman from Texas [Mr. ARMEY].

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

RECORDED VOTE

Mr. ARMEY. Mr. Speaker, I demand a recorded vote. A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 395, noes 9, answered ''present'' 10, not voting 19, as follows:

[Roll No. 423]

AYES—395

Abercrombie	Bartlett	Boehlert
Ackerman	Barton	Boehner
Allard	Bass	Bonilla
Andrews	Bateman	Bonior
Archer	Becerra	Bono
Armey	Beilenson	Boucher
Bachus	Bentsen	Brewster
Baesler	Bereuter	Browder
Baker (CA)	Berman	Brown (CA)
Baker (LA)	Bevill	Brown (FL)
Baldacci	Bilbray	Brown (OH)
Ballenger	Bilirakis	Brownback
Barcia	Bishop	Bryant (TN)
Barr	Bliley	Bryant (TX)
Barrett (NE)	Blumenauer	Bunn
Barrett (WI)	Blute	Bunning
Burr	Gordon	Metcalf
Burton	Graham	Mica
Buyer	Green (TX)	Millender-McDonald
Callahan	Greene (UT)	Miller (CA)
Calvert	Greenwood	Miller (FL)
Camp	Gunderson	Minge
Campbell	Gutierrez	Mink
Canady	Gutknecht	Moakley
Castle	Hall (OH)	Molinari
Chabot	Hall (TX)	Mollohan
Chambliss	Hamilton	Montgomery
Chapman	Hancock	Moorhead
Chenoweth	Hansen	Moran
Christensen	Harman	Morella
Chrysler	Hastert	Murtha
Clay	Hastings (FL)	Myers
Clayton	Hastings (WA)	Myrick
Clement	Hayworth	Nadler
Clinger	Hefley	Neal
Clyburn	Hefner	Nethercutt
Coble	Herger	Neumann
Coburn	Hilleary	Ney
Coleman	Hilliard	Norwood
Collins (GA)	Hinchey	Nussle
Collins (IL)	Hoekstra	Oberstar
Collins (MI)	Hoke	Obey
Combest	Horn	Olver
Condit	Hostettler	Ortiz
Costello	Houghton	Orton
Cox	Hoyer	Owens
Coyne	Hunter	Oxley
Cramer	Hutchinson	Packard
Crane	Hyde	Pallone
Crapo	Inglis	Parker
Cremeans	Istook	Pastor
Cubin	Jackson (IL)	Paxon
Cummings	Jackson-Lee (TX)	Payne (NJ)
Cunningham	Jacobs	Payne (VA)
Danner	Jefferson	Peterson (MN)
Davis	Johnson (SD)	Petri
de la Garza	Johnson, E. B.	Pickett
Deal	Johnson, Sam	Pombo
DeFazio	Jones	Pomeroy
DeLauro	Kasich	Porter
DeLay	Kelly	Portman
Dellums	Kennedy (MA)	Poshard
Deutsch	Kennelly	Pryce
Diaz-Balart	Kildee	Radanovich
Dickey	Kim	Rahall
Dingell	King	Ramstad
Dixon	Kingston	Rangel
Doggett	Kleczka	Reed
Dooley	Klug	Regula
Doolittle	Knollenberg	Richardson
Dornan	Kolbe	Riggs
Dreier	LaFalce	Rivers
Duncan	LaHood	Roberts
Dunn	Lantos	Roemer
Durbin	Largent	Rogers
Edwards	Latham	Rohrabacher
Ehlers	LaTourette	Ros-Lehtinen
Ehrlich	Laughlin	Rose
Engel	Lazio	Roth
English	Leach	Roukema
Ensign	Levin	Roybal-Allard
Eshoo	Lewis (CA)	Royce
Evans	Lewis (GA)	Rush
Everett	Lewis (KY)	Sabo
Ewing	Lightfoot	Salmon
Farr	Linder	Sanders
Fattah	Lipinski	Sanford
Fawell	Livingston	Saxton
Fazio	LoBiondo	Scarborough
Filner	Lofgren	Schaefer
Flake	Lowey	Schroeder
Flanagan	Lucas	Schumer
Foglietta	Luther	Scott
Foley	Maloney	Seastrand
Forbes	Manton	Sensenbrenner
Ford	Manzullo	Serrano
Fowler	Markey	Shadegg
Fox	Martinez	Shaw
Frank (MA)	Martini	Shays
Franks (CT)	Mascara	Shuster
Franks (NJ)	Matsui	Sisisky
Frelinghuysen	McCarthy	Skaggs
Frisa	McCollum	Skeen
Frost	McCrery	Skelton
Funderburk	McDade	Slaughter
Gallegly	McHugh	Smith (MI)
Gejdenson	McInnis	Smith (NJ)
Gekas	McIntosh	Smith (TX)
Geren	McKeon	Smith (WA)
Gilchrest	McKinney	Solomon
Gillmor	McNulty	Souder
Gilman	Meehan	Spence
Gonzalez	Meek	Spratt
Goodlatte	Menendez	Stark
Goodling		