It may come as a surprise to some, but most Americans are pretty good at knowing what is good for them. They might even know better than those of us in Washington who so often tell them what to do.

RECESS

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate now stand in recess until the hour of 2:15 today.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senate will be in recess until 2:15.

There being no objection, at 12:23 p.m., the Senate recessed until 2:14; whereupon, the Senate reassembled when called to order by the Presiding Officer (Mr. COATS).

Mr. COHEN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. COHEN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered,

MORNING BUSINESS

Mr. COHEN. Mr. President, I ask unanimous consent that the Senate now go into a period of morning business with Members allowed to speak for up to 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COHEN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DORGAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. Mr. President, are we in morning business?

The PRESIDING OFFICER. The Senate is in morning business, with Senators allowed to speak for up to 5 minutes.

Mr. DORGAN. Mr. President, I ask unanimous consent to be allowed to speak for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota is recognize to speak for 10 minutes.

Mr. DORGAN. Mr. President, I would like to make two points today; one very brief and then I would like to make some remarks, along with my colleague, Senator ASHCROFT, and introduce a piece of legislation.

NO CHANGE IN THE FEDERAL FUNDS RATE

Mr. DORGAN. Mr. President, the first point is that the Federal Reserve Board apparently now has broken up its meeting today and announced that there will be no change in the Federal funds rate—the interest rate that the Federal Reserve sets that has a significant impact on our economy, obviously.

I have been a frequent critic of the Federal Reserve Board. I would say that, if they have decided not to increase interest rates today, I commend them for that decision. I think it is the right decision.

The Federal funds rate is already one-half of 1 percent above where it ought to be historically, given the rate of inflation. There is no justification for an interest rate increase by the Federal Reserve Board. Inflation is under control—well under control—coming down 5 years in a row. Last month there was a one-tenth of 1 percent increase in the Consumer Price Index, virtually no inflation. So there was no basis for the Federal Reserve Board to consider an interest rate increase.

Some have suggested the Fed would meet in secret today if they wanted to, go in the room, shut the door, and make the decision in secret, and it would in effect increase interest rates today in order to respond to what they consider to be the need in the marketplace. But the Fed apparently decided not to do so. Again, I want to say that I think that is the right decision for this country, and for our economy because they ought not fight a foe that does not exist with remedy that is inappropriate. That is what they would have done, if they had increased interest rates today.

I found it interesting the other day that the Washington Post had a story saying the FBI has been called out to find out who leaked information at the Fed about what the regional Fed bank presidents have recommended with respect to interest rates. I would much sooner see the FBI called out to find out who withheld information from the American people, and what they talk about is the incredible secrecy of this institution called the Federal Reserve Board. Would it not be nice if everyone could have all the information about how and when they make decisions about monetary policy instead of calling the FBI out to find out who leaked information so the American people have some knowledge about who was recommending what on interest rate policies?

Mr. President, thank you. That is therapy for me to get that off my chest this early after the Federal Reserve Board met and apparently made the right decision. There is an old saying. ''Even the stopped clock is right twice a day.'' I will not compare the Fed to a stopped clock, but at least to say that the Fed is right on interest rates. They did not change the rate. There was no justification in making a change, and they should not have made a change.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

Mr. DORGAN. I thank the Chair.

(The remarks of Mr. DORGAN and Mr. ASHCROFT pertaining to the introduction of S. 2108 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. SANTORUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

PARTIAL-BIRTH ABORTIONS

Mr. SANTORUM. Mr. President, I think it is appropriate, as a result of the comments of the Senator from North Dakota and the Senator from Missouri, to talk about another issue that deals with the issue of life, an issue that will be before us in a very short few days. That is the issue of partial-birth abortions.

I took to the floor on Friday afternoon when this place was pretty empty to talk about the issue of partial-birth abortions. I said at that time that while the term ''partial-birth abortion'' is used, this is not a pro-life or pro-choice issue. This is not whether you are for or against abortion. This debate should be limited, must be limited to the procedure that we are discussing, and that is the procedure called partial-birth abortions.

I said at that time that I thought we should have a good debate, that the Senate, being the greatest deliberative body in the history of the world, should live up to its moniker, that we should have a deliberate, thoughtful debate on facts. I felt if we did have such a debate here, if we had such a deliberate, thoughtful debate, that, in fact, people who may have voted one way the last time, when presented with all the facts, in reexamining all the information that has come to light since the original vote in the Senate, might feel compelled to vote for this bill and override the President's veto.

I read an article today in the Washington Post that gave me some hope that people who consider themselves to be pro-choice can take a good look at the facts and change their mind on this procedure, this gruesome procedure. What gave me heart was an article published today in the Washington Post by Richard Cohen. Richard Cohen is a columnist who proclaims himself to be, and has consistently been, pro-choice. He believes in the woman's right to choose—in fact, in this article so states again.

Mr. Cohen, back in June of last year, wrote an article that condemned the bill.

In fact, it says, ''In Defense of Late-Term Abortions,'' Tuesday, June 20, 1995, the Washington Post.

He goes on to give his reasons why he believes that partial-birth abortions should continue to be legal in this country.

Fast forward to today an article by Richard Cohen: ''A New Look at Late-Term Abortion'':

A rigid refusal even to consider society's interest in the matter endangers abortion rights.

He writes this article from the perspective of someone who is a defender of abortion rights, someone who still believes in a woman's right to choose, using his terms.

I ask unanimous consent to have this article printed in the RECORD.

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

A NEW LOOK AT LATE-TERM ABORTION—A RIGID REFUSAL EVEN TO CONSIDER SOCIETY'S INTEREST IN THE MATTER ENDANGERS ABORTION RIGHTS

(By Richard Cohen)

Back in June, I interviewed a woman—a rabbi, as it happens—who had one of those late-term abortions that Congress would have outlawed last spring had not President Clinton vetoed the bill. My reason for interviewing the rabbi was patently obvious: Here was a mature, ethical and religious woman who, because her fetus was deformed, concluded in her 17th week that she had no choice other than terminate her pregnancy. Who was the government to second-guess her?

Now, though, I must second-guess my own column—although not the rabbi and not her husband (also a rabbi). Her abortion back in 1984 seemed justifiable to me last June, and it does to me now. But back then I also was led to believe that these late-term abortions were extremely rare and performed only when the life of the mother was in danger or the fetus irreparably deformed. I was wrong.

I didn't know it at the time, of course, and maybe the people who supplied my data—the usual pro-choice groups—were giving me what they thought was precise information. And precise I was. I wrote the ''just four one-hundredths of one percent of abortions are performed after 24 weeks'' and that ''most, if not all, are performed because the fetus is found to be severely damaged or because the life of the mother is clearly in danger.''

It turns out, though, that no one really knows what percentage of abortions are late-term. No one keep figures. But my Washington Post colleague David Brown looked behind the purported figures and the purported rationale for these abortions and found something other than medical crises of one sort or another. After interviewing doctors who performed late-term abortions and surveying the literature, Brown—a physician himself—wrote: ''These doctors say that while a significant number of their patients have late abortions for medical reasons, many others—perhaps the majority—do not.''

Brown's findings brought me up short. If, in fact, most women seeking late-term abortions have just come to grips a bit late with their pregnancy, then the word ''choice'' has been stretched past a reasonable point. I realize that many of these women are dazed teenagers or rape victims and that their anguish is real and their decision probably not capricious. But I know, too, that the fetus being destroyed fits my personal definition of life. A 3-inch embryo (under 12 weeks) is one thing; but a nearly fully formed infant is something else.

It's true, of course, that many opponents of what are often called ''partial-birth abortions'' are opposed to any abortions whatever. And it also is true that many of them hope to use popular repugnance over late-term abortions as a foot in the door. First these, then others and then still others. This is the argument made by pro-choice groups: Give the antiabortion forces this one inch, and they'll take the next mile.

It is instructive to look at two other issues: gun control and welfare. The gun lobby also thinks that if it gives in just a little, its enemies will have it by the throat. That explains such public relations disasters as the fight to retain assault rifles. It also explains why the National Rifle Association has such an image problem. Sometimes it seems just plain nuts.

Welfare is another area where the indefensible was defended for so long that popular support for the program evaporated. In the 1960s, '70s and even later, it was almost impossible to get welfare advocates to concede that cheating was a problem and that welfare just might be financing generation after generation of households where no one works. This year, the program on the federal level was trashed. It had few defenders.

This must not happen with abortion. A woman really ought to have the right to choose. But society has certain rights, too, and one of them is to insist that late-term abortions—what seems pretty close to infanticide—are severely restricted, limited to women whose health is on the line or who are carrying severely deformed fetuses. In the latter stages of pregnancy, the word abortion does not quite suffice; we are talking about the killing of the fetus—and, too often, not for any urgent medical reason.

President Clinton, apparently as misinformed as I was about late-term abortions, now ought to look at the new data. So should the Senate, which has been expected to sustain the president's veto. Late-term abortions once seemed to be the choice of women who, really, had no other choice. The facts now are different. If that's the case, then so should be the law.

Mr. SANTORUM. Mr. President, I will not read the entire article, but it is in the RECORD, and I do not think what I do read, which is most of the article, takes away from the meaning.

He mentioned a case in his previous article in June of a woman who had an abortion and used that sort of to justify late-term abortions and particularly the partial-birth abortion procedure. He revisits that in the beginning of the article and says he still agreed this woman who did not have a partial-birth abortion but had a late-term abortion, was right to do so. But he said, ''What seemed justifiable to me last June, does not now.''

He said:

I was led to believe that these late-term abortions were extremely rare and performed only when the life of the mother was in danger or the fetus irreparably deformed.

You heard in the House of Representatives last week when they were debating this issue and you will hear over and over again from the advocates of partial-birth abortions that this is only done in extreme medical emergencies when fetuses have no chance of survival outside of the womb and that they are done very rarely.

Mr. Cohen says:

I was wrong. I didn't know at the time, of course, and maybe the people who supplied my data, the usual pro-choice groups * * *

The PRESIDING OFFICER. The Chair informs the Senator from Pennsylvania that the 5 minutes have expired.

Mr. SANTORUM. Mr. President, I ask unanimous consent to speak in morning business for 10 minutes.

Mrs. BOXER. Reserving the right to object, I ask my colleague, since I want to respond to some of what he said and I do not have that much time and we are under a 5-minute rule, if he can complete in 2, and then I can make my 5-minute remarks, because I cannot stay to hear the rest of my friend's remarks. So if he can complete in 2 minutes.

Mr. SANTORUM. I ask unanimous consent that the Senator from California speak for 5 minutes, and I will just continue from there.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. The Senator from California is recognized for 5 minutes.

Mrs. BOXER. Mr. President, I came to the floor today because I listened to the Senator's presentation, and I think it is very interesting. We have had a number of high-profile men comment on this particular vote that is coming up, and my colleague from Pennsylvania goes at length into the remarks of a columnist.

I think it is very important to listen to the women who were told that if they didn't have this particular procedure that my colleague wants to outlaw they could die, they could be made permanently infertile, they could be paralyzed for life, these women who have come to our offices to beg us to stay out of the emergency room, to stay out of the surgical room, to support the President's veto of this extreme bill.

Why do I call it extreme? I call it extreme because this bill would ban the procedure, regardless of the circumstance. It has a narrow exception, and I have it here: ''* * * to save the life of a mother whose life is endangered by a physical disorder, illness or injury, provided that no other medical procedure would suffice.''

This is the first time in history that the people who oppose abortion have made such a narrow life exception. The Hyde amendment simply says we can outlaw the procedure except ''to save the life of the mother'' if the pregnancy is carried to term.

This life exception is so narrow in this bill that a physician could only use this life-saving procedure if the woman had a preexisting condition such as diabetes, but not if he believed carrying the pregnancy forward or a Caesarean section or other methods would, in fact, endanger her life.

If a physician does choose to use this procedure, even in the situation of a preexisting condition of the woman, this physician could be hauled into court and have to provide a defense for himself.

I say to my friends, if this debate was really about outlawing this procedure, we could pass this bill in 1 minute. Every one of us who voted for the amendment that I offered, which simply said make an exception for the health and life of the mother—and we did not even leave it open-ended; we said serious adverse health risk—we

were willing to ban this procedure, every one of us who voted against this bill, if it had a true life exception and if, in fact, it had a health exception tightly drawn so that if a woman was told, ''You may not bear another child again unless you have this procedure,'' or ''You may be paralyzed for life unless you have this procedure,'' or, ''You could even die if that procedure goes forward in those cases,'' we would all vote together.

If the people who stand up here and quote columnists would come together with us, we could craft a bill in a minute that would, in fact, outlaw this procedure, except if the woman's life was threatened if the pregnancy was carried to term or she had severe health consequences facing her family. We could pass that 100 to nothing. But we don't have that before us today, because those on the other side would rather have a political hot-potato issue again.

It is sad. We can outlaw this procedure today with an exception for life of the mother or serious health impacts, but, no, better to make the President have to explain it. And let me tell you, he is explaining it.

I ask unanimous consent to have printed in the RECORD a letter dated September 23 that he has sent to us.

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

THE WHITE HOUSE,
Washington, DC, September 23, 1996.

Hon. THOMAS A. DASCHLE,
Democratic Leader, U.S. Senate, Washington, DC.

DEAR MR. LEADER: I am writing to urge that you vote to uphold my veto of H.R. 1833, a bill banning so-called partial-birth abortions. My views on this legislation have been widely misrepresented, so I would like to take a moment to state my position clearly.

First, I am against late-term abortions and have long opposed them, except, as the Supreme Court requires, where necessary to protect the life or health of the mother. As Governor or Arkansas, I signed into law a bill that barred third trimester abortions, with an appropriate exception for life or health. I would sign a bill to do the same thing at the federal level if it were presented to me.

The procedure aimed at in H.R. 1833 poses a difficult and disturbing issue. Initially, I anticipated that I would support the bill. But after I studied the matter and learned more about it, I came to believe that it should be permitted as a last resort when doctors judge it necessary to save a woman's life or to avert serious consequences to her health.

In April, I was joined in the White House by five women who were devastated to learn that their babies had fatal conditions. These women wanted anything other than an abortion, but were advised by their doctors that this procedure was their best chance to avert the risk of death or grave harm, including, in some cases, an inability to bear children. These women gave moving testimony. For them, this was not about choice. Their babies were certain to perish before, during or shortly after birth. The only question was how much grave damage the women were going to suffer. One of them described the serious risks to her health that she faced, including the possibility of hemorrhaging, a ruptured cervix and loss of her ability to bear children in the future. She talked of her predicament:

''Our little boy had . . . hydrocephaly. 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.''

Some have raised the question whether this procedure is ever most appropriate as a matter of medical practice. The best answer comes from the medical community, which believes that, in those rare cases where a woman's serious health interests are at stake, the decision of whether to use the procedure should be left to the best exercise of their medical judgment.

The problem with H.R. 1833 is that it provides an exception to the ban on this procedure *only* when a doctor is convinced that a woman's life is at risk, but not when the doctor believes she faces real, grave risks to her health.

Let me be clear. I do not contend that this procedure, today, is always used in circumstances that meet my standard. The procedure may well be used in situations where a woman's serious health interests are not at risk. But I do not support such uses, I do not defend them, and I would sign appropriate legislation banning them.

At the same time, I cannot and will not accept a ban on this procedure in those cases where it represents the best hope for a woman to avoid serious risks to her health.

I also understand that many who support this bill believe that a health exception could be stretched to cover almost anything, such as emotional stress, financial hardship or inconvenience. That is *not* the kind of exception I support. I support an exception that takes effect *only* where a woman faces real, serious risks to her health. Some have cited cases where fraudulent health reasons are relied upon as an excuse—excuses I could never condone. But people of good faith must recognize that there are also cases where the health risks facing a woman are deadly serious and real. It is in those cases that I believe an exception to the general ban on the procedure should be allowed.

Further, I reject the view of those who say it is impossible to draft a bill imposing real, stringent limits on the use of this procedure—a bill making crystal clear that the procedure may be used only in cases where a woman risks death or serious damage to her health, and in no other case. Working in a bipartisan manner, Congress could fashion such a bill.

That is why I asked Congress, by letter dated February 28 and in my veto message, to add a limited exemption for the small number of compelling cases where use of the procedure is necessary to avoid serious health consequences. As I have said before, if Congress produced a bill with such an exemption, I would sign it.

In short, I do not support the use of this procedure on demand or on the strength of mild or fraudulent health complaints. But I do believe that it is wrong to abandon women, like the women I spoke with, whose doctors advise them that they need the procedure to avoid serious injury. That, in my judgment, would be the true inhumanity. Accordingly, I urge that you vote to uphold my veto of H.R. 1833.

I continue to hope that a solution can be reached on this painful issue. But enacting H.R. 1833 would not be that solution.

Sincerely,

BILL CLINTON.

Mrs. BOXER. Mr. President, in this letter, the President says that he would sign such a bill that outlawed this procedure with those humane exceptions.

So, Mr. President, as we approach this vote, I am going to be on this floor as often as I can, and I hope others will, to make the offer to my friends on the other side.

The PRESIDING OFFICER. The Chair informs the Senator from California that the 5 minutes under morning business have expired.

Mrs. BOXER. Mr. President, let's ban this procedure except for life of the mother or serious health impact.

Thank you very much, Mr. President.

(Disturbance in the galleries.)

The PRESIDING OFFICER. The Chair reminds the galleries that applause is not appropriate.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. Mr. President, as I was saying, quoting Mr. COHEN:

I didn't know at the time—

Mr. COHEN, who, again, previously wrote that he was in favor of allowing this procedure to be legal, says:

I didn't know at the time, of course, and maybe the people who supplied my data—the usual pro-choice groups—were giving me what they thought was precise information. And precise I was. I wrote that ''just four one-hundredths of one percent of abortions are performed after 24 weeks'' and that ''most, if not all, are performed because the fetus is found to be severely damaged or because the life of the mother is clearly in danger.''

It turns out, though, that no one really knows what percentage of abortions are late-term. No one keeps figures. But my Washington Post colleague David Brown looked behind the purported figures and the purported rationale for these abortions and found something other than medical crises of one sort or another. After interviewing doctors who performed late-term abortions and surveying the literature, Brown—a physician himself—wrote: ''These doctors say that while a significant number of their patients have late-term abortions for medical reasons, many others—perhaps the majority—do not.

Brown's findings brought me up short. If, in fact, most women seeking late-term abortions have just come to grips a little bit late with their pregnancy, then the word ''choice'' has been stretched past a reasonable point. I realize that many of these women are dazed teenagers or rape victims and that their anguish is real and their decision probably not capricious. But I know, too, that the fetus being destroyed fits my personal definition of life. A 3-inch embryo (under 12 weeks) is one thing; but a nearly fully formed infant is something else.

He goes on to say:

A woman really ought to have the right to choose. But society has certain rights, too, and one of them is to insist that late-term abortions—[which] seems pretty close to infanticide—are severely restricted, limited to women whose health is on the line or who are carrying severely deformed fetuses. In the latter stages of pregnancy, the word abortion does not quite suffice; we are talking about the killing of the fetus—and, too often, not for any urgent medical reason.

President Clinton, apparently as misinformed as I was about late-term abortions,

now ought to look at the new data. So should the Senate, which has been expected to sustain the president's veto. Late-term abortions once seemed to be the choice of women who, really, had no other choice. The facts now are different. If that's the case, then so should be the law.

Mr. President, what Mr. Cohen talks about is the fact that late-term abortions are not as rare as some would suggest, and that partial-birth abortions are not as rare.

The Senator from California said that we should not get involved in the emergency room. The Senator from California knows that the partial-birth abortion procedure is not an emergency procedure. It is a 3-day procedure. It takes 3 days from the time the woman presents herself to the abortionist to the time that the abortion is completed. So it can never be used in an emergency.

She also said, well, if we only had an exception for the health of the mother. The Senator from California, who debates this issue on the floor a lot, knows fully well, that health of the mother has been interpreted by courts over and over and over again to include virtually everything. When I say that, what do I mean? Yes, it includes physical health, but it includes mental health, financial health, social health, any kind of health impact. That is a limitation without limit.

There is no limitation when we put in there health of the mother. And that is exactly what she wants to accomplish. That is exactly what she wants to accomplish. She does not want to limit this procedure, or any other abortion procedure, at any time during the pregnancy for any reason. I respect her opinion. I just do not agree with it. I do not think the Members of the Senate agree with that. There is new evidence out. I hope that my colleagues—and the Senator from California made it sound like this was a pro-life/pro-choice issue. I can give her a laundry list. She knows them well, and that many people who are pro-choice here in the Senate and in the House voted for this bill to outlaw this procedure.

Why? Because this crosses the line. This goes too far. You have a person here who, in very strong terms in this article, talks about how adamantly pro-choice he is; and he in fact writes the reason we should draw the line here is because if you do not draw the line, you endanger a woman's right to choose generally because of the extremism of this position.

I do not think the Senate should go down in history as that body that allowed infanticide to continue, as so described, not only by Mr. Cohen, but by the former Surgeon General, C. Everett Koop and the Pope, and many others. Senator MOYNIHAN, others—Senator MOYNIHAN, I say to Senator BOXER, is not adamantly pro-life by any stretch of the imagination, and has said this looks perilously close to infanticide.

How often does this procedure take place? Again, let us look at all the information that we have gathered since the original vote in the Senate. This is The Sunday Record in Bergen County, NJ, September 15, 1996, just a few days ago, an article, ''The facts on partial-birth abortion.''

Mr. President, I ask unanimous consent that this article be printed in the RECORD.

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

THE FACTS ON PARTIAL-BIRTH ABORTION—BOTH SIDES HAVE MISLED THE PUBLIC

(By Ruth Pabawer)

Even by the highly emotional standards of the abortion debate, the rhetoric on so-called ''partial-birth'' abortions has been exceptionally intense. But while indignation has been abundant, facts have not.

Pro-choice activists categorically insist that only 500 of the 1.5 million abortions performed each year, in this country involve the partial-birth method, in which a live fetus is pulled partway into the birth canal before it is aborted. They also contend that the procedure is reserved for pregnancies gone tragically awry, when the mother's life or health is endangered, or when the fetus is so defective that it won't survive after birth anyway.

The pro-choice claim has been passed on without question in several leading newspapers and by prominent commentators and politicians, including President Clinton.

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—three times the supposed national rate. Moreover, doctors say only a ''minuscule amount'' are for medical reasons.

Within two weeks, Congress is expected to decide whether to criminalize the procedure. The vote must override Clinton's recent veto. In anticipation of that showdown, lobbyists from both camps have orchestrated aggressive campaigns long on rhetoric and short on accuracy.

For their part, abortion foes have implied that the method is often used on healthy, full-term fetuses, an almost-born baby delivered whole. In the three years since they began their campaign against the procedure, they have distributed more than 9 million brochures graphically describing how doctors ''deliver'' the fetus except for its head, then puncture the back of the neck and aspirate brain tissue until the skull collapses and slips through the cervix—an image that prompted even pro-choice Sen. Daniel P. Moynihan, D–N.Y., to call it ''just too close to infanticide.''

But the vast majority of partial-birth abortions are not performed on almost-born babies. They occur in the middle of the second trimester, when the fetus is too young to survive outside the womb.

The reason for the fervor over partial birth is plain: The bill marks the first time the House has ever voted to criminalize the abortion procedure since the landmark Roe v. Wade ruling. Both sides know an override could open the door to more severe abortion restrictions, a thought that comforts one side and horrifies the other.

HOW OFTEN IT'S DONE

No one keeps statistics on how many partial-birth abortions are done, but pro-choice advocates have argued that intact ''dilation and evacuation''—a common name for the method, for which no standard medical term exists—is very rare, ''an obstetrical non-entity,'' as one put it. And indeed, less than 1.5 percent of abortions occur after 20 weeks gestation, the earliest point at which this method can be used, according to estimates by the Alan Guttmacher Institute of New York, a respected source of data on reproductive health.

The National Abortion Federation, the professional association of abortion providers and the source of data and case histories for this pro-choice fight, estimates that the number of intact cases in the second and third trimesters is about 500 nationwide. The National Abortion and Reproductive Rights Action League says ''450 to 800'' are done annually.

But those estimates are belied by reports from abortion providers who use the method. Doctors at Metropolitan Medical in Englewood estimate that their clinic alone performs 3,000 abortions a year on fetuses between 20 and 24 weeks, of which at least half are by intact dilation and evacuation. They are the only physicians in the state authorized to perform abortions that late, according to the state Board of Medical Examiners, which governs physicians' practice.

The physicians' estimate jibe with state figures from the federal Centers for Disease Control, which collects data on the number of abortions performed.

''I always try an intact D&E first,'' said a Metropolitan Medical gynecologist, who, like every other provider interviewed for this article, spoke on condition of anonymity for fear of retribution. If the fetus isn't breech, or if the cervix isn't dilated enough, providers switch to traditional, or ''classic,'' D&E—in utero dismemberment.

Another metropolitan area doctor who works outside New Jersey said he does about 250 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. ''I do an intact D&E whenever I can, because it's far safer,'' he said.

The National Abortion Federation said 40 of its 300 member clinics perform abortions as late as 26 weeks, and although no one knows how many of them rely on intact D&E, the number performed nationwide is clearly more than the 500 estimated by pro-choice groups like the federation.

The federation's executive director, Vicki Saporta, said the group drew its 500-abortion estimate from the two doctors best known for using intact D&E, Dr. Martin Haskell in Ohio, who Saporta said does about 125 a year, and Dr. James McMahon in California, who did about 375 annually and has since died. Saporta said the federation has heard of more and more doctors using intact D&E, but never revised its estimate, figuring those doctors just picked up the slack following McMahon's death.

''We've made umpteen phone calls [to find intact D&E practioners],'' said Saporta, who said she was surprised by The Record's findings. ''We've been looking for spokespeople on this issue. . . . People do not want to come forward [to us] because they're concerned they'll become targets of violence and harassment.''

WHEN IT'S DONE

The pro-choice camp is not the only one promulgating misleading information. A key component of The National Right to Life Committee's campaign against the procedure is a widely distributed illustration of a well-formed fetus being aborted by the partial-birth method. The committee's literature calls the aborted fetuses ''babies'' and asserts that the partial-birth method has ''often been performed'' in the third trimester.

The National Right to Life Committee and the National Conference of Catholic Bishops

have highlighted cases in which the procedure has been performed well into the third trimester, and overlaid that on instances in which women have had less-than-compelling reasons for abortion. In a full-page ad in the Washington Post in March, the bishops' conference illustrated the procedure and said, women would use it for reasons as frivolous ad ''hates being fat,'' ''can't afford a baby and a new car,'' and ''won't fit in to prom dress.''

''We were very concerned that if partial-birth abortion were allowed to continue, you could kill not just an unborn, but a mostly born. And that's not far from legitimizing actual infanticide,'' said Helen Alvare, the bishops' spokeswoman.

Forty-one states restrict third-trimester abortions, and even states that don't—such as New Jersey—may have no physicians or hospitals willing to do them for any reason. Metropolitan Medical's staff won't do abortions after 24 weeks of gestation. ''The nurses would stage a war,'' said a provider there. ''The law is one thing. Real life is something else.''

In reality, only about 600—or 0.04 percent—of abortions of any type are performed after 26 weeks, according to the latest figures from Guttmacher. Physicians who use the procedures say the vast majority are done in the second trimester, prior to fetal viability, generally thought to be 24 weeks. Full term is 40 weeks.

Right to Life legislative director Douglas Johnson denied that his group had focused on third-trimester abortions, adding, ''Even if our drawings did show a more developed baby, that would be defensible because 30-week fetuses have been aborted frequently by this method, and many of those were not flawed, even by an expansive definition.

WHY IT'S DONE

Abortion rights advocates have consistently argued that intact D&Es are used under only the most compelling circumstances. In 1995, the Planned Parenthood Federation of America issued a press release asserting that the procedure ''is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality.''

In February, the National Abortion Federation issued a release saying, ''This procedure is most often performed when women discover late in wanted pregnancies that they are carrying fetuses with anomalies incompatible with life.''

Clinton offered the same massage when he vetoed the Partial Birth Abortion Ban Act in April, and surrounded himself with women who had wrenching testimony about why they needed abortions. One was an anti-abortion marcher whose health was compromised by her 7-month-old fetus neuromuscular disorder.

The woman, Coreen Costello, wanted desperately to give birth naturally, even knowing her child would not survive. But because the fetus was paralyzed, her doctors told her a live vaginal delivery was impossible. Costello had two options, they said: abortion or a type of Caesarean section that might ruin her chances of ever having another child. She chose an intact D&E.

But most intact D&E cases are not like Coreen Costello's. Although many third-trimester abortions are for heart-wrenching medical reasons, most intact D&E patients have their abortions in the middle of the second trimester. And unlike Coreen Costello, they have no medical reason for termination.

''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 physician who teaches said: ''In my private practice, 90 to 95 percent are medically indicated. Three of them today are Trisomy–21 [Down syndrome] with heart * * *, the mother has brain cancer and needs chemo. But in the population I see at the teaching hospitals, which is mostly a clinic population, many, many fewer are medically indicated.''

Even the Abortion Federation's two prominent providers of intact D&E have showed documents that publicly contradict the federation's claims.

In a 1992 presentation at an Abortion Federation seminar, Haskell described intact D&E in detail and said he routinely used it on patients 20 to 24 weeks pregnant. Haskell went on to tell the American Medical News, the official paper of the American Medical Association, that 80 percent of those abortions were ''purely elective.''

The federation's other leading provider, Dr. McMahon, released a chart to the House Judiciary Committee listing ''depression'' as the most common maternal reason for his late-term non-elective abortions, and listing ''cleft lip'' several times as the fetal indication. Saporta said 85 percent of McMahon's abortions were for severe medical reasons.

Even using Saporta's figures, simple math shows 56 of McMahon's abortions and 100 of Haskell's each year were not associated with medical need. Thus, even if they were the only two doctors performing the procedure, more than 30 percent of their cases were not associated with health concerns.

Asked about the disparity, Saporta said the pro-choice movement focused on the compelling cases because those were the majority of McMahon's practice, which was mostly third-trimester abortions. Besides; Saporta said, ''When the Catholic bishops and Right to Life debate us on TV and radio, they say a woman at 40 weeks can walk in and get an abortion even if she and the fetus are healthy.'' Saporta said that claim is not true. ''That has been their focus, and been playing defenses ever since.''

WHERE LOBBYING HAS LEFT US

Doctors who rely on the procedure say the way the debate has been framed obscures what they believe is the real issue. Banning the partial-birth method will not reduce the number of abortions performed. Instead, it will remove one of the safest options for mid-pregnancy termination.

''Look, abortion is abortion. Does it really matter if the fetus dies in utero or when half of it's already out?'' said one of the * * * method at Metropolitan Medical in Englewood. * * * what's safest for the woman,'' and this procedure, he said, is safest for abortion patients 20 weeks pregnant or more. There is less risk of uterine perforation from sharp broken bones and destructive instruments, one reasons the American College of Obstetricians and Gynecologists has opposed the ban.

Pro-choice activists have emphasized that nine of 10 abortions in the United States occur in the first trimester, and that these have nothing to do with the procedure abortion foes have drawn so much attention to. That's true, physicians say, but it ducks the broader issue.

By highlighting the tragic Coreen Costellos, they say, pro-choice forces have obscured the fact that criminalizing intact D&E would jettison the safest abortion not only for women like Costello, but for the far more common patient: a woman 4½ to 6 months pregnant with a less compelling reason—but still a legal right—to abort.

That strategy is no surprise, given Americans queasiness about later-term abortions. Why reargue the morality of or the right to a second-trimester abortion when anguishing examples like Costello's can more compellingly make the case for intact D&E?

To get around the bill, abortion providers say they could inject poison into the amniotic fluid or fetal heart to induce death in utero, but that adds another level of complication and risk to the pregnant woman. Or they could use induction—poisoning the fetus and then ''delivering'' it dead after 12 to 48 hours of painful labor. That method is clearly more dangerous, and if it doesn't work, the patient must have a Caesarean section, major surgery with far more risks.

Ironically, the most likely response to the ban is that doctors will return to classic D&Es, arguably a far more gruesome method than the one currently under fire. And, pro-choice advocates now wonder how safe from attack that is, now that abortion foes have American's attention.

Congress is expected to call for the override vote this week or next, once again turning up the heat on Clinton barely seven weeks from the election.

Legislative observers from both camps predict that the vote in the House will be close. If the override suceeds—a two-thirds majority is required—the measure will be sent to the Senate, where the override is less likely, given that the initial bill passed by 54 to 44.

. . .

Mr. SANTORUM. Mr. President, let me, if I can, just quote from some of the article as to the facts that were uncovered.

You heard Mr. Cohen reference Dr. Brown in his work with the Washington Post finding out about more of these procedures being performed in more late-term abortion procedures being done in this country. Let me share with you this analysis done by a Ruth Padawer, who is the health reporter for the newspaper. She talks about how the prochoice people say that this is a very rare procedure. I quote:

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—three times the supposed national rate. Moreover, doctors say only a ''minuscule amount'' are for medical reasons.

What are we talking about here? We are talking about abortions performed—I know this is an uncomfortable topic for many people to listen to, and I am sure some people are tuning out and turning off. But this is going on in this country. We have an obligation to face up to who we are and what we are doing here, and not turn our backs because it is just not proper dinner conversation.

We are performing abortions in this country on babies, fully formed babies in their third trimester, and viable babies who are in the late second. I am talking about 22, 23, 24 weeks, the second trimester.

As I said on Friday, my wife is a neonatal intensive care nurse. She took care of 22-week-olds and 21-week-olds and 24-week-olds in Pittsburgh at Magee Woman's Hospital. She has told me story after story of how many of them have survived and how the percentages are increasing.

We are talking about delivering these babies, for no medical reason, feet first through the birth canal, and then kill, by taking a pair of metzenbaum scissors and shoving them into the base of the skull, inserting the catheter into the brain and sucking the brains out to kill the baby, and then deliver the head. And 1,500 times, according to this article, it happens in New Jersey alone every year. The facts, as presented by those who argued against the bill, the facts they quoted from reputable sources, were only a few hundred in the country done every year.

The article goes on:

But those estimates are belied by reports from abortion providers who use the method. Doctors at Metropolitan Medical Center in Englewood estimate that their clinic alone performs 3,000 abortions a year on fetuses between 20 and 24 weeks, of which at least half are by partial-birth abortions.

''I always try an intact D&E (which is the medical term for partial-birth abortion) first,'' said a Metropolitan Medical gynecologist, who, like every other provider interviewed for this article, spoke on condition of anonymity.

Another metropolitan area doctor who works outside New Jersey said he does about 260 post 20-week abortions a year, of which half are partial-birth abortions.

The PRESIDING OFFICER. The Senator's 10 minutes has expired.

Mr. SANTORUM. Mr. President, I ask unanimous consent for 5 additional minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SANTORUM. Thank you, Mr. President.

The doctor, who is also a professor at two prestigious teaching hospitals, said he has been teaching intact D&E partial-birth abortions since 1981, and he said he knows of two former students on Long Island and two in New York City who use the procedure.

In fact, he says, ''I do an intact D&E whenever I can * * *''

This is not a rare procedure. This is a procedure that is done all too frequently in this country. Those were not presented to this Senate when it deliberated on this bill the first time. Those facts were somehow not researched well by the prochoice groups, like the Guttmacher Institute that provided us the statistics we were using in the first place, because there is no, as Mr. Cohen said, national record keeping of this. There is no agency in Government that keeps track of this. We only have to go by the people who provide the abortions to tell us what they do. And of course—I shouldn't say ''of course''—but what has happened, in fact, is that they provided us a number that is not anywhere close to the numbers that really go on in this country.

I would suggest that if they were so cavalier with their numbers as to how many, how cavalier are they with other facts associated with this issue? The fact of the matter is, this is not a prolife/prochoice issue. This is an issue about how far we will go as a country, how far we have gone in blurring the lines.

I asked the question to a person the other day on the Fox Morning News when I was on last week—I will ask it to the Senator from California, if she would answer—and that is, if we had a 24-week baby or 25-week or 26-week baby delivered, normal baby, healthy fetus, that someone just decided, as these articles indicate, they wanted to have a late-term abortion because they just did not get around to it sooner, or they had a change of heart, if that baby were pulled through the birth canal, feet first, and delivered, everything except for the head, and by some mistake of the doctor, the baby's head also was delivered, instead of the doctor, as has been testified before having to hold the baby's head in so he can puncture the skull and suction the brains, if the doctor let the baby's head slip out, I ask the Senator from California, if that baby's head slipped out and that baby was born, would the doctor and the mother have a right to choose whether that baby should live? Would the doctor be able to kill the baby at that point?

I am happy to yield time to the Senator from California if the Senator would like to answer that question. Would the doctor be permitted at that point to kill the baby?

Mrs. BOXER. Well, the Senator clearly does not understand the Supreme Court decision of Roe versus Wade, which I strongly support, and I daresay the majority of Senators and the majority of the American people support. That is, a woman has the right to choose in the first trimester, and after that the State comes in with strong and strict controls. A woman does not have an unfettered right to choose after the first trimester. The Senator should know that and should read that case. She does not, except if her life is threatened.

I would assume, frankly, since the Republican platform does not even have a like exception——

Mr. SANTORUM. I reclaim my time. I would like an answer. If I can, let me restate the question again, based on the information that has been read here and the facts that have been provided.

You have the former Surgeon General of the United States who says this procedure is never medically necessary. You have an article that I will be reading from later, from a series, a group of gynecologists and obstetricians that say partial-birth abortion is bad medicine.

You have some organizations who support—I think the American College of Gynecologists opposes the legislation, but not because they support partial-birth abortions. They do not recognize that as proper medical procedure. They do not like any criminalization of anything. They do not like to have doctors be subject to any kind of criminal complaints. That is why they are opposed to it. That is what they said in their letter to Congress.

We should focus on the question. The fact of the matter is, we have sufficient evidence here that these are not medically necessary abortions. They are not to save the life of the mother. In fact, we have a provision in our bill, as the Senator knows, to make an exception for the life of the mother. They are not medically necessary. It is for the health of the mother. You have physician after physician after physician saying so. So talk about the facts.

I ask this question—and I know the Senator would like to give a long answer and give a speech—but see if you can answer the question very succinctly.

The PRESIDING OFFICER (Mr. GRAMS). The time of the Senator has expired.

Mr. SANTORUM. I ask unanimous consent for 1 minute.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SANTORUM. If a partial-birth abortion was being performed on this baby, and for some reason the head slipped out and the baby was delivered, which, in my understanding, is not unprecedented, would the doctor, in consultation with the mother, be able to choose to kill the baby?

Mrs. BOXER. I say to my friend that I am going to take 5 minutes to answer his question because it is a very serious question and I intend to answer it in my time, so he can finish up in his time.

Mr. SANTORUM. Mr. President, after the Senator from California speaks, I will talk about the medical necessity for this procedure, and I will cite a group of physicians and other people, other physicians, who have written extensively on the fact that this procedure is never medically indicated. In fact, it is contraindicated. In fact, it is more dangerous to the mother to have one than to do other procedures that are not under the debate here in the Senate.

I will get to that as soon as the Senator answers my question.

Mr. DORGAN. Mr. President, I do not want to interrupt the debate, and I have a different subject I want to comment on.

I ask unanimous consent that if the Senator from California is going to speak for 5 minutes, that I be allowed by unanimous consent to follow the Senator from California for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I thank my friend from North Dakota because I know he has been patiently waiting to talk about another topic. I was not going to come back to the floor, but I understand that the Senator from Pennsylvania, in what I consider to be a very unfair way, described my position on a woman's right to choose. Now, I would never, never do that for another Senator because this is a crucial issue.

As a mother, as a grandmother, whose grandson is the most precious thing in my life, I do not want to hear that there is another Senator on the floor talking about how I regard pregnancy, motherhood, or childbearing. I

would rather have the chance, if someone is going to attack me on an issue, that that person be courageous enough to do it when I am on the floor of the U.S. Senate. So I have come back to the floor to speak.

What I want to say is that the vast majority of Americans believe this entire subject should be left to the privacy of families, to the religious convictions of our people, and that U.S. Senators do not belong in the hospital room, they do not belong in the consulting room, and if the woman is told by a doctor, ''You might die unless I use a certain procedure, you might die, and the children you have now will not have a mother,'' and if that doctor believes this procedure is the only one to save the life of that woman or to spare her a life of infertility or paralysis, I believe families should have the right to make that choice.

If the Senator from Pennsylvania was faced with that choice, if his daughter was in that situation, I really do believe in his heart of hearts if this was not a hot political issue, that he would want the ability, with his God, with his family, to make this decision.

Now, my colleague talks about doctors who say this procedure is not necessary. Some believe it is not. They do not have to use this procedure.

The American College of Obstetricians and Gynecologists, who do this work every day, opposes this legislation that does not have an exception for the life and health of the mother. The American Medical Women's Association opposes this legislation that does not have a true life exception or a health exception. The California Medical Association strongly opposes this extreme legislation.

Now, I just want to put on the record when we are talking about emergency procedures and abortions that take place in late term, this is not about a woman's right to choose. This is about an emergency health situation. My colleagues come here and quote columnists, and on and on. I wish they would look in the eyes of the women in this country who have had this procedure who know because of this procedure they were able to bear children.

I say to my colleagues, I know this is a hard vote, but when the American people understand that the legislation before the Senate has no life exemption, it only says if a woman has a preexisting condition her doctor may use that procedure, and then he will have to defend himself in a courtroom if he does, but it does not have the Hyde language—life-of-the-mother, straightforward—that we have seen in other pieces of legislation. That Hyde exception is not in this bill. That is why some of my colleagues are going to stand against this bill.

Now, the Boxer amendment we put forward said very simply that this procedure can only be used if it can spare a woman's life or if she could suffer long-term, serious, adverse health impacts. Now, does that not sound reasonable? Does that not sound fair?

I say to my colleagues, if they look in their heart and it happened to their wife, and the doctor said, ''She will die if I do not use this procedure,'' not because she has diabetes or a preexisting condition but because the problem with the fetus is so great, if she does not have this procedure she could bleed to death, I say to my colleagues, if they look in their heart, and the doctor looked at them and said, ''You could lose your wife unless I use this procedure,'' they look in their heart and they are honest; or, if the doctor said, ''You will never have another baby unless I use this procedure,'' or she will be paralyzed from the waist down and in a wheelchair for the rest of her life.

I honestly believe—I do believe—my colleagues, that if you take away the 30-second commercials that Americans are going to see in this campaign, you would say to the doctors, ''Save my life.'' And that is all we are asking. All we are asking is only use this procedure if the woman's life is at stake or she would suffer serious adverse health risks if the procedure was not used. I think that is a moderate position. Roe versus Wade does not allow abortions at the end term. The State has a right to regulate it. I hope Senators will not misstate other Senators' positions. It is too important of a debate.

Thank you very much, Mr. President. I yield my time.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

WATER ISSUES

Mr. DORGAN. Mr. President, I wish to address a different subject. It has to do with water issues, a subject that will cause some eyes to glaze over perhaps in some quarters, but an important subject to my State.

You know that I come from a small State. I come from the State of North Dakota, which is large in expanse, 10 times the size of Massachusetts, but with 640,000 people. So it is a sparsely populated State.

A lot of people do not know that we have a flood in North Dakota that came and stayed—a permanent flood the size of the State of Rhode Island. It was not an accidental flood. It was a flood that came and stayed in my State because 50 years ago there were some who felt that we should harness the Missouri and Mississippi Rivers and, as part of the flood control provisions called the Pick-Sloan Act, to harness the Missouri River so that it didn't flood the cities downstream. So that they could have reliable navigation downstream, they decided, ''Let us build some dams on the Missouri River.'' One of those dams was built in North Dakota. President Eisenhower came out to dedicate the dam. It is called the Garrison Dam.

What the Federal Government said then to the State of North Dakota is, in order for us to control flooding downstream and to protect the larger cities downstream, would you please play host to a large flood that comes and stays forever? The people of North Dakota said, why would we want to play host to a large flood that comes to stay, a one-half-million-acre flood forever? The Federal Government says, if you will do that, we will make certain promises to you. We will promise that that dam will be able to generate cheap hydroelectric power, and that will benefit the residents of the region. And, No. 2, more importantly, we will allow you to take the water from behind that dam and move it all around your State for economic and municipal and rural water systems. That will help you develop economically, and it will provide new jobs and new opportunities for your State.

So the people of North Dakota 50 years ago said, ''Well, that sounds like a reasonable proposition.'' And the dam was built and dedicated, as I said, by President Eisenhower in the 1950's. The Garrison diversion project was authorized in 1965 by the Congress. Work began on it, and in the 1970's it became very controversial. In fact, some portions of this project, some features to move water around our State, became so controversial that some of the major environmental organizations in the country decided to try to kill the project altogether. Remember, this is part of a promise that was made to North Dakota that relates very much to its economic opportunity and its economic future.

Recognizing that it was very troublesome to have the opposition of some of these major organizations, I worked to reformulate this project. In 1986 the Congress passed a reformulation act called the Garrison Diversion Reformulation Act. This year, 10 years later, we appropriated $23 million for this project. That brings it to nearly $350 million during the past 10 years since it was reformulated. Now it appears that we will once again be required in the next Congress to make a final revision in this project in order to see its completion for our State.

A substantial amount has been done in North Dakota with this project; $200 million, in what is called an MR&I fund, has been available to North Dakota to move water around the State with a southwest pipeline in southwestern North Dakota. It has improved water quality in many communities in North Dakota.

So we have derived substantial benefit from it. But we have not been able to move Missouri water to the eastern part of North Dakota into the Red River to help the cities of Fargo and Grand Forks, among others. That has not been completed, and all of us are anxious to get that done.

I hope in the next Congress to propose, along with my colleagues, a final revision of the Garrison diversion project that will achieve two goals: First, with the realistic constraints that we have on financing here in the