this year to take testimony from North Dakotans about the revisions necessary in order to meet the State's current water needs and to finally finish work on the project. We will work with the governor, the State legislature, Indian tribes, local communities, the Garrison Conservancy District, the North Dakota Water Coalition, environmental groups, water users and all interested North Dakotans in order to reach a statewide consensus on this issue.

Mr. President, I'd like to offer my colleagues some history on how the Garrison diversion project got started and why a final revision is necessary in order to complete the project.

In the 1940's the Federal Government wanted to harness the Missouri River to prevent massive downstream flooding in States along the Lower Missouri and Mississippi Rivers. Annual flood damage to downstream cities on the Missouri River was very costly. Also, the lack of stable water levels prevented reliable commercial navigation on the Missouri River.

So the Federal Government proposed a series of six dams, one of which was to be located in North Dakota. The Garrison Dam would wall up water in a reservoir that would be one-half million acres in size. In short, the Federal Government asked North Dakota to play host to a permanent flood as big as the entire State of Rhode Island.

The Federal Government said if you North Dakotans will do that, we will provide you with some significant benefits. The dam itself will generate low cost hydro-electric power and you will have access to some of this inexpensive electricity for rural development. And more importantly, the Federal Government will provide a Garrison diversion project which will allow you to move reservoir water around your State for massive irrigation—over 1 million acres—and for municipal, rural, and industrial uses.

The Army Corps of Engineers completed work on the dam in the mid-1950's. The permanent flood arrived in North Dakota and the downstream States received the bulk of the immediate benefits. The Missouri River no longer raged with uncontrolled flooding in the spring. Downstream navigation and barge traffic was reliable once again.

For North Dakota, the Congress authorized in 1965 a Garrison diversion project with water systems and an irrigation plan—downsized to 250,000 acres—as a payment for our permanent flood. The features of that project included a series of canals and pumping stations that would move water from the Missouri River in the western part of North Dakota to the eastern part of our State, all the way to the Red River and would allow for substantial amounts of irrigation with the diverted water along the way.

Some features of the Garrison diversion project became very controversial in the 1970's and national environmental organizations attempted to kill the project. The result was that progress on the project was slowed.

In 1986 the Congress enacted my legislation reformulating the Garrison diversion project and resolving the controversies. The irrigation features were reduced in scope to 130,000 acres and a municipal and industrial water fund of $200 million was created and given priority in appropriations.

A new feature called the Sykeston Canal was created to be a replacement for the Lonetree Reservoir, which had become a lightening rod for opposition to the project. At the time, the engineering and cost evaluation of the Sykeston Canal was suspect and we agreed then that if the Sykeston Canal proved to be unworkable we would have to revisit that issue.

The Garrison Diversion Unit Reformulation Act also provided for a water treatment facility to treat Missouri River water that would reach the Hudson Bay drainage after it flowed through for use by cities such as Fargo and Grand Forks along the Red River. The act also established requirements for wildlife mitigation, and for recreation development in North Dakota.

In the intervening years since the 1986 Reformulation Act, Congress has provided nearly $350 million in expenditures, most of which was used for the $200 million MR&I Fund. North Dakota has made enormous progress in building a southwest water pipeline and many other expenditures that have improved water delivery for cities and towns with undrinkable or inadequate water in our State.

However, we are impatient in wanting to finally finish the features of the project and move Missouri water to eastern North Dakota so that our eastern cities have an assured supply of municipal and industrial water.

It is now clear that the Sykeston Canal is not a workable feature, from both an engineering and a cost standpoint so we must develop a new connecting link can be completed in a way that achieves our goal.

Therefore, it is necessary to make one last revision to this project. This final revision should include a substitute for the Sykeston Canal, as well as converting the bulk of the authorized irrigation acreage to a more flexible state water development fund that can be used for a wide range of North Dakota needs.

The Garrison Conservancy District has proposed a pipeline approach as a replacement for the Sykeston Canal. I believe that has substantial promise. Most of the work has been completed on the key features of this project and we are close to being able to realize the dream of a water diversion project that will help all of our State.

Naturally, some needs remain unchanged. There is a continuing requirement to permanently solve the water problems of the Devils Lake Basin. The lake suffers from an intermittent cycle of ruinous drought and chronic flooding, which warrants the construction of an inlet/outlet system as part of a comprehensive water management plan for the basin. Presently, Devils Lake is threatened by a 120-year flood, which may require the construction of an emergency outlet for which plans have already been developed.

Likewise, a final Garrison plan must meet the water development needs of native Americans and citizens of the Red River Valley. Native Americans suffered the most from the inundation of lands in North Dakota and their requirements for MR&I and irrigation must be addressed by the Congress. The cities of Fargo and Grand Forks and communities up and down the Red River Valley likewise look to Garrison diversion as the only realistic resource for problems of water quality and quantity.

The final form of Garrison diversion will also continue the State's commitment to protect and enhance wildlife and habitat. It has established a precedent-setting wildlife trust fund. Recreational development provided under Garrison diversion will also contribute to fish and wildlife management.

In the final analysis, this issue is about a future of jobs and opportunity in North Dakota's future. And it is about good faith—on the part of the Federal Government to fulfill its pledge to the people of North Dakota for water development.

All of us are impatient to get this project completed. But the reality is projects of this size are not completed quickly just because they are so massive in scope. Controversies must be resolved.

Since the project was authorized in the mid-1960's, North Dakota's elected leaders have spoken with one bipartisan voice in support of this project and I hope that will continue to be the case. It takes all of the collective energy that we can muster in a State of our size to get this project completed. We must plan together, work together and pull together to finish the work on this project.

Mr. COVERDELL. Mr. President, are we functioning as in morning business, each Senator allotted time?

The PRESIDING OFFICER. The Senator from Georgia is correct. We are operating in morning business. Each Senator is allotted up to 5 minutes.

VALUJET

Mr. COVERDELL. Mr. President, I rise today on a matter of vital concern to the economic well-being of thousands of Georgia families. I think we all remember the tragedy of the event in May, May 11, when ValuJet 592 plunged into the Florida Everglades. And, forever, as with any incident like this, we all are grieving over the families that were affected.

However, following this investigation, ValuJet airlines was grounded and went through the most thorough, grinding analysis of every aspect of

their procedures possible. Because, obviously, safety is first and foremost, the center of any question as to whether the airlines could return to the air. I do not think it is generally known that on August 29, at 3:45 p.m., after having gone through this arduous procedure, the Federal Aviation Administration returned ValuJet airline's carrier operating certificate. In their own press release it says, ''This action will permit ValuJet to resume operations at a future date if the airline is found to be managerially and financially fit by the Department of Transportation.''

The point I want to make here is that 4,000 employees have been unable to draw a paycheck; 4,000 homes, not to mention the hundreds of business associated with the peripheral support of the airline, they have not been able to draw a paycheck. The FAA settled the preeminent question, is the airline safe? And they returned the certificate.

The Department of Transportation, which I had not realized, also must verify or issue a certificate to allow the airline to return to operations. It is now September 24, nearly a full month—and this is just the story of Washington over and over and over. The Department of Transportation said, on August 29, that the background and experience of ValuJet's management team fully qualifies them to oversee the carrier's operation. The Department of Transportation review of ValuJet, its forecast of current financial condition, finds that, ''the company continues to have available to it funds sufficient to allow it to recommence operations at its planned, scaled-back level without undue economic risk to consumers. ValuJet has taken a number of steps to strengthen management procedures and has demonstrated a disposition to comply with all applicable laws and regulations.''

August 29: FAA returns the certificate. It is safe. August 29: The Department of Transportation issues its findings that in the three major criteria it is to review it appears the airline is ready to fly. Today is September 24, and there is not one engine turning and there is not one paycheck being issued to one of those 4,000 families. In fact, we are being threatened with firing the remaining 400 employees. This is not right. This is not right. This is what everybody out there becomes so incensed about in the Washington apparatus. This airline is now ready to fly. Those workers need to be put back to work. The economic health that this airline represents needs to be returned to the air.

They have met the criteria that their Government demanded for safety and they have met the other basic criteria. We are now mired in bureaucracy. There was a period of time when this press release was issued, 7 days, during which anybody who had anything to say could say it. The airline had 4 days to comment on it. That has happened. It is long since passed. We still do not have the authorization to fly. I am just stunned by it. I do not know why. It happens every day in this town, the insensitivity, the 9 to 5 attitude. So what if 4,000 people are not getting a paycheck? So what if every day that goes by actually threatens one of the major criteria, economic solvency? Obviously, they do not become more solvent by sitting nailed to a tarmac. So what if we are about to fire 400 more people, even though FAA has said it is ready to go and DOT has said for all practical purposes it is ready to go?

Mr. President, these folks need to get their bureaucratic mishmash settled, and they need to get this airline back in the air, and they need to get these families economically solvent and able to pay their mortgages and pay for their kids' education, and get their families back together.

Mr. President, I can see the consternation on your face, which means my 5 minutes has expired. I appreciate the Chair's patience, and I yield the floor.

Mr. SANTORUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, while my colleague from California was on the floor I didn't get a chance to hear her, and much of what she said was in response to my question—and I use that term loosely because, in what I heard, she did not respond to the question. My question is a very simple question. The question, obviously, needs to be asked and, hopefully, at some point someone will answer me. That is, what will be the position of innocence if, in the performance of this procedure where the baby is delivered feet first, this birth canal, the entire baby's arms and legs, torso, are outside of the mother's womb completely, arms and legs moving outside the mother, all that is left in is the head, that is, when this procedure is performed and the baby is then killed, what if—which is not unknown from what I understand—if, for some reason, when the shoulders were delivered the head were accidentally delivered, will the mother and the physician then have a right to choose whether that baby lives or not? Or, would they be responsible—would the physician have to do something to keep the baby alive, since it is now completely outside the mother?

I understand the Senator from California went in, started talking about when the procedure should be used, and certain facilities, and all the things that could happen as a result of not using this procedure, talked about Roe versus Wade, but did not answer the question as to whether it was still the woman's right to choose at that point. Since she wanted to have the abortion, whether it would still be the woman's right to terminate that pregnancy? She defends the procedure, but she does not answer the question, and I will ask that question again, as I will be on the floor for some time. I will ask that question again of the Senator from California or anybody else who wants to defend this procedure being used on a 24-week-old or 30-week-old baby.

The Senator from California talked about this procedure as medically necessary to stop—to prohibit infertility or if it is more dangerous because it could cause paralysis, and all of these medical-health reasons why this procedure should be performed. Let me read to you some information from a group of physicians. They call themselves FACT, Physicians Ad Hoc Coalition for Truth.

The first quote is from a doctor, Nancy Romer, chairman of obstetrics and gynecology at Miami Valley Hospital, in Ohio. People deserve to know, ''partial-birth abortion is never medically indicated to protect a woman's health or her fertility.''

''Never medically indicated.'' The Senator from California talked about how the American College of Obstetricians and Gynecologists support this procedure. You hear this often, how ACOG, which is how they go, American College of Obstetricians and Gynecologists, have come out in opposition to the bill and support partial-birth abortions. That is only half true.

They have opposed this bill. I will read to you the letter. I have a copy of the letter sent to the Speaker of the House dated last week:

> DEAR MR. SPEAKER: The American College of Obstetricians and Gynecologists, an organization representing more than 37,000 physicians dedicated to improving women's health care, does not support H.R. 1833, the Partial-Birth Abortion Ban Act of 1995. The College finds very disturbing that Congress would take any action that would supersede the medical judgment of trained physicians and criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may not perform, H.R. 1833 employs terminology that is not even recognized in the medical community—demonstrating why Congressional opinion should never be substituted for professional medical judgment. For these reasons we urge to you oppose the veto override. . . .

They do not support this procedure. What is very clear in this letter, to me, and I think to everyone who reads it, is they do not like having procedures criminalized. They do not want any doctor procedure criminalized. They want the doctor, basically, to have the say what kind of procedures they perform, if any.

I would ask the American College of Obstetricians and Gynecologists—and they will give me an answer. I guarantee you, in fact we will write them a letter today and fax it over: If this procedure was done and the baby's head slipped out, would the obstetrician be allowed to kill the baby?

If they would be so kind as to respond to that I will send the letter, if necessary. But I would suspect the answer would be pretty clear: No. No.

I do not know if we will get that answer from anybody on the other side.

The PRESIDING OFFICER. The time of the Senator from Pennsylvania has expired.

Mr. DEWINE addressed the Chair.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. I thank the Chair.

Mr. President, let me return to the issue of partial-birth abortion. I would like to respond to a comment that was made about an hour ago, I guess, by my colleague from California, Senator BOXER. She is certainly very eloquent. She and I have debated this issue before, and I suspect we will be debating it again.

She made a statement to the effect that we have heard from the men, we have heard men come down to the floor, we have heard from the men, now let's hear from the women. Mr. President, there are many women in this country adamantly opposed to partial-birth abortions. I have received in my office over 90,000 postcards and letters from people in Ohio. That does not include the thousands of calls that we have received. By looking at some of these postcards, it is clear that a large number of these individuals are women who are writing about this issue.

But let's talk about three specific people, three women, three women who are professionals, who are experts, who have, I think, something really to say about this issue.

Let me first start with Brenda Shafer. Brenda Shafer described herself as pro-choice. She is working as a nurse in Dayton, OH. I am going to read very briefly from the testimony that she gave to the Judiciary Committee on November 17, 1995. She is describing at this point, Mr. President, in her testimony how she came to work in Dr. Haskell's office. This is what she said:

> So, because of strong pro-choice views that I held at that time, I thought this assignment would be no problem for me. But I was wrong. I stood at the doctor's side as he performed the partial-birth abortion procedure, and what I saw is branded on my mind forever.

Then she describes what she saw:

> The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head and the baby's arms jerked out, like a startled reaction, like a flinch, like a baby does when he thinks he is going to fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening and sucked the baby's brains out. Now the baby went completely limp. I was really completely unprepared for what I was seeing. I almost threw up as I watched Dr. Haskell doing these things.

Then she goes on:

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

Finally, she concluded:

> I will never be able to forget it. What I saw done to that little boy and to those other babies should not be allowed in this country. I hope that you will pass the Partial-Birth Abortion Ban Act.

Brenda Shafer described herself as pro-choice. She knew she was walking into a clinic where abortions were done. That is what they did. That is what she saw. That is what she described. No dispute about it. Dr. Haskell himself in the printed literature, articles he has written, describes, basically, the same procedure. That is Brenda Shafer.

The next woman I would like to reference and call the Senate's attention to and the testimony she gave to our committee is Dr. Pamela Smith. Dr. Pamela Smith is the director of medical education, department of obstetrics and gynecology, Mt. Sinai Medical Center, Chicago, IL.

In her testimony, she systematically described how this procedure is really not indicated, that it is not a medical procedure that is required. It does not really have to take place.

Let me read a portion of the testimony that she gave.

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

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

Mr. DEWINE. Mr. President, here is what she says about the necessity of this procedure:

> I went around and described the procedure of partial-birth abortion to a number of physicians and lay persons who I knew to be pro-choice. They were horrified to learn that such a procedure was even legal.

Later on in her testimony she says the following. Again, this is Dr. Pamela Smith:

> Now, the cruelty to the baby is there for everyone to see, if you will acknowledge it. But I think that it is more difficult for people to recognize the risk to the mother that is associated with these procedures. I might also add that these risks have been acknowledged not only in standard medical literature, but by people who perform abortions as well.

Continuing her testimony, she concludes as follows:

> Enactment of this legislation is needed both to protect human offspring from being subjected to a brutal procedure and to safeguard the health of pregnant women in America.

This is just one of the witnesses that we heard who said this procedure is simply not indicated, it is not something that is accepted in the medical field. It is not something that medical journals recognize. It is not something that doctors believe is necessary. That was Dr. Pamela Smith.

Let me conclude with a third individual, and that is Dr. Nancy Romer, a medical doctor. She is a clinical professor, ob-gyn, Wright State University, chairman of the department. This is her quote:

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

Again, only one of several witnesses who testified that this is really not an accepted medical procedure at all.

Mr. President, I will be commenting further about this issue later on in the debate.

Let me conclude by saying what we are really about today, tomorrow and Thursday when we vote on this matter when we determine whether or not there are enough votes in this Senate to do what the House did, and that is override the President's veto, a veto that I believe was very misguided. The issue really is about what kind of a people we are and what we will tolerate, what we will turn our back to, what we will turn our head on and what we will say is OK: ''I wouldn't do it, I don't like it, but I'm not going to do anything about it.''

I think we really define who we are as a people, what kind of a people we are in this debate, because, Mr. President, if this procedure can be accepted, can be allowed in this country, I think virtually anything can be allowed.

My colleague from Pennsylvania, who has been very eloquent in this matter, and other colleagues have referred to the fact that this child—there is nothing else to call it, a child—is within seconds of being born, is within inches of being born. It is almost all the way out when that child is killed in the manner described by Nurse Shafer, and that if this procedure—and I think that almost debases the English language by calling it a ''procedure,'' it is such a sterile word—is allowed to continue in this country, there is literally no limit to what we will tolerate, what we will turn our back on, what we will say: ''We don't like it, but we will put up with it.''

So I think we really do in this debate define what we are as a people, what we care about, what is important to us and what is not important to us. I yield the floor, Mr. President.

Mr. SANTORUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Thank you, Mr. President. I thank my colleague from Ohio for his statement and for the tremendous amount of work he has done on this issue from the committee level through passage in the Senate, and here he is back again.

I can tell you that those of us who have spoken on this issue do not relish the opportunity to do so. It is a very difficult issue. It is a very tough issue to talk about. And Senator DEWINE has eight children. I have three children. My wife and I are expecting our fourth in March. We know how very serious this issue is. And we very much believe that in this case, on this issue, this is an issue of the life and death of a little baby. And we think it is important for us to stand up and say something about it.

Mr. President, I ask unanimous consent that I be given 20 minutes to speak on this issue.

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

Mr. SANTORUM. Thank you, Mr. President.

Mr. President, what I was talking about a few minutes ago, Senator DEWINE highlighted. I just want to reinforce some of the evidence that has come forward throughout the process of the hearings and the debates in the House and Senate, but also new information that has been made available to us. I want to say again to Members who are thinking about this issue, who have possibly opposed this issue in the past, that there certainly is enough information that has come out since the original passage of this bill that would give any Member who truly does deliberate on this issue the opportunity to take another look and to gather all the facts.

I am going to read an article written by four obstetricians, two who the Senator from Ohio just referred to, Nancy Romer and Pamela Smith, but also Curtis Cook and Joseph DeCook. These are all obstetricians. They are members of an organization called PAHCT, which is, Physicians Ad Hoc Coalition for Truth. My understanding is that that group is now comprised of over 300 such physicians who share the opinion of this text that was printed on Thursday, September 19, in the Wall Street Journal.

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?

And speaking as obstetricians.

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

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

None of this risk is ever necessary for any reason. We and many other doctors across the U.S. regularly threat 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 here head''—went on to become the head nurse in his intensive care unit many years later.

So he delivered this baby that had these organs outside the body. Not only was that repaired, but that woman went on to become the head nurse in his intensive care unit.

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?

Mr. President, I would like to read from the American Medical News. This was an interview with C. Everett Koop. In fact, I read most of it. I ask unanimous consent that this be printed in the RECORD.

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

[From American Medical News, Aug. 19, 1996]

THE VIEW FROM MOUNT KOOP

(By Diane Gianelli and Christina Kent)

Q: Clinton just vetoed a bill to ban ''partial birth'' abortions, a late-term abortion technique that practitioners refer to as ''intact dilation and evacuation'' or ''dilation and extraction.'' 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?

A: 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.

Q: In your practice as a pediatric surgeon, have you ever treated children with any of the disabilities cited in this debate? For example, have you operated on children born with organs outside of their bodies?

A: 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 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.

Q: And live normal lives?

A: Serving 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.

Mr. SANTORUM. Thank you, Mr. President.

I think it is important to realize again the new information that has come out. The information provided by

these physicians, the information provided by Mr. Cohen. And I have an article here by David Brown, published in the Washington Post, on September 17, just last week. This was the article that Mr. Cohen referred to in his column where he changed his mind. He changed his mind. Someone who is admittedly very pro-choice changed his mind on whether this procedure should be legal or not.

One of the reasons he changed his mind—the principal reason was as a result of Dr. Brown's article talking about "Late Term Abortions, Who Gets Them and Why," which is the name of the article by David Brown. He talks about who gets them and why. He talks about Dr. Haskell from Ohio, who says, "I'll be quite frank: most of my abortions are elective in that 20–24 week range. In my particular case, probably 20 percent of the abortions are for genetic reasons. And the other 80 percent are purely elective."

Elective means, according to David Brown, that the fetuses were normal, or that the pregnant woman was not seriously ill.

I ask unanimous consent this article by David Brown be printed in the RECORD.

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

[From the Washington Post, Sept. 17, 1996]

LATE TERM ABORTIONS

(By David Brown)

In a White House ceremony in April, President Clinton vetoed a bill outlawing a technique of abortion done only in the second half of pregnancy. Termed "partial-birth abortion" by the people who decry it, and "intact dilation and evacuation" by the people who perform it, the technique has become the latest lightning rod in the nation's stormy debate about abortion.

Standing next to the president when he announced the veto were five women who had undergone late-term abortions with the controversial technique because their fetuses had severe developmental defects.

The women, Clinton said, "represent a small, but extremely vulnerable group . . . They all desperately wanted their children. They didn't want abortions. They made agonizing decisions only when it became clear their babies would not survive, their own lives, their health, and in some cases their capacity to have children in the future were in danger."

Others have sketched similar pictures. The Planned Parenthood Federation of America called this procedure "extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." The National Abortion Federation, an abortion providers' organization, said that "in the majority of cases" where it is used, there is a "severe fetal anomaly [birth defect]."

But it is not possible to speak with certainty about who undergoes "intact D&E," as the "partial-birth abortion" is known in medicine. The federal government does not collect such information. Physicians do not have to report it to the state health departments. Researchers do not study the question or publish their findings in medical journals.

Interviews with doctors who use the procedure and public comments by others show that the situation is much more complex. These doctors say that while a significant number of their patients have late abortions for medical reasons, many others—perhaps the majority—do not. Often they are young or poor. Some are victims of rape or incest.

Physicians who perform abortions beyond the first third of pregnancy say that use of intact D&E is quite rare. Just over 1 percent (about 17,000) of all abortions in this country occur after the 20th week of fetal development; it is after that point when the intact D&E procedure is sometimes used. Only a fraction are believed to be intact D&Es, the controversial method in which the fetus is pulled by the feet out of the uterus and the head is punctured so it can also pass through the cervix. What's more, very few doctors perform this surgery; interviews with abortion experts suggest that there are less than 20.

What follows are sketches of the experience of several physicians who perform the intact D&E procedure, as well as the experience of doctors who perform abortions on patients with advanced pregnancies using an alternative technique. Taken as a group, the descriptions and observations by these practitioners paint a more complete picture of who decides to end their pregnancy at an advanced stage, and why.

A QUESTION OF SAFETY

One of the better-known practitioners of intact D&E is Martin Haskell, an Ohio physician who in 1992 presented a "how-to" paper on the technique at a medical conference in Texas. The dissemination of this document to antiabortion activists set the stage for the current campaign to ban the technique.

Although Haskell declined to be interviewed for this article, in his 1992 paper he said he had performed "over 700 of these procedures." Three years ago, American Medical News, a weekly publication of the American Medical Association, interviewed Haskell about his technique.

"I'll be quite frank most of my abortions are elective in that 20–24 week range," Haskell said, according to a transcript of the interview, which has circulated widely during the debate on the "partial-birth abortion" bill. "In my particular case, probably 20 percent [of the abortions] are for genetic reasons. And the other 80 percent are purely elective."

"Elective" is not a medical term generally used with abortion, but it is often used in medicine to denote procedures that are not medically required. In this context, it appears to mean that the fetuses were normal or that the pregnant woman was not seriously ill.

The American Medical News reporter also asked Haskell "whether or not the fetus was dead beforehand." The doctor answered: "No it's not. No it's really not. A percentage are for various numbers of reasons. . . . In my case, I would think probably about a third of those are definitely dead before I actually start to remove the fetus. And probably the other two-thirds are not."

Also performing intact D&E abortions in Ohio is a 45-year-old physician named Martin Ruddock. Interviewed recently, he declined to estimate how many abortions he did each year, but said that only 5 to 10 percent were done in the later stages of pregnancy. Beyond the 18th or 19th week, Ruddock prefers to use the intact D&E technique.

He believes it is safer than its most common alternative, which is called "dismemberment dilation and evacuation." In that procedure, the fetus is removed in pieces, generally limbs first. It requires that the surgeon exert a great deal of force on the fetus inside the uterus, and it often produces short, bony fragments that can damage a woman's reproductive organs. On rare occasions, "dismemberment D&E" also exposes a woman to fetal substance (primarily brain tissue) that can cause dangerous reactions.

"To minimize those problems is why the [intact] procedure was developed," Ruddock said.

In practice, however, he employs it only a third of the times he'd like to, he said. Often the position of the fetus, or some other variable, makes intact D&E impossible, and he uses dismemberment instead. However, whenever he uses the intact method, he first cuts the umbilical cord—a maneuver designed to make sure the fetus is dead before he punctures its skull.

"The fundamental argument [of the technique's opponents] is that the fetus is alive. And what I am saying is that in my practice that never happens," he said.

In 45 percent of the cases done beyond 20 weeks of gestation, he said, the fetuses have obvious developmental abnormalities or the women carrying them have illnesses that are being made worse by the pregnancy. In the other 55 percent, however, the fetuses are normal.

Another practitioner, who did not want to be identified, is a physician in the New York area who is affiliated with several teaching institutions. He does about 750 in the second trimester of pregnancy. He uses intact D&E in "well under a quarter" of those, he said. About one-third are his private patients, and the rest are ones he sees at the teaching hospitals, where he instructs physicians in training.

This doctor said that the "great majority" of the private patients have medical reasons for their abortions: Either the fetus is abnormal or the pregnant woman's health is threatened by the pregnancy.

The nonprivate patients, however, are different. They tend to have lower incomes, and the fraction of them who have medical reasons for abortion "is not nearly as high, [but] I can't quantify it," he said. In the cases in which there is no medical indication, the fetuses are usually normal.

A CALIFORNIA DOCTOR'S EXPERIENCE

The notion that intact D&E is done only in the third trimester—very late in the pregnancy, generally after 24 weeks—and only when the fetus has catastrophic defects, appears to have arisen from widespread publicity about the practice of a doctor in Los Angeles named James T. McMahon, who died last year. His specialty was the very late abortion of fetuses with severe developmental defects.

Patients came to him from across the United States and sometimes even from outside the country. All of the women who appear with Clinton at the veto ceremony had their abortions done by him.

McMahon used intact D&E extensively because after about the 26th week of gestation dismemberment of fetuses is extremely difficult, if not impossible.

In a letter written in 1993 to doctors who referred patients to him, he said that in 1991 he'd done 65 third-trimester abortions. All of these cases, he said, were "nonelective." Of all the abortions done beyond 20 weeks, 80 percent were for that he termed "therapeutic indications"—that is, medical reasons.

In documents submitted to the House subcommittee on the Constitution, McMahon provided a list of some of these reasons. He categorized 1,358 abortions he'd performed over the years, all of them done (his testimony suggested) on women at least 24 weeks pregnant.

Most of them were for extremely rare genetic defects.

The list contained a few slightly more common conditions including anencephaly

(lack of a brain) in 29 cases, spina bifida (open spinal column) in 28 cases and congenital heart disease in 31 cases. A few of the conditions on the list, however, are rarely fatal. Cleft lip, cited as the ''indication'' in 9 cases, is surgically correctable after birth, sometimes with permanent disability and sometimes without.

The maternal indications in McMahon's list were similarly varied. The severity of the illnesses can't be inferred, although many of the problems he gave are not commonly life-threatening. These included breathlessness on exertion, one case; electrolyte disturbance, one case; diabetes, five cases; and hyperemesis gravidarum (intractable vomiting during pregnancy), six cases. The two most common maternal indications were depression (39 cases) and sexual assault (19 cases).

Although the few other doctors who are known to use the intact D&E method refused to be interviewed, one overseas practitioner would. He is David Grundmann, a 49-year-old physician from Brisbane, Australia, who learned the technique from McMahon about five years ago during a visit to the United States.

Grundmann performs abortion up to 22 weeks of gestation and, like McMahon, treats patients who travel great distances for his services. He and his two partners do 60 to 100 intact D&E cases a year.

In an interview last week, he said that in about 15 percent of those cases, there is a severe defect of the fetus.

* * * * *

THE WOMEN AFFECTED

It's difficult to say how representative these five doctors are of the rest of the small fraternity of practitioners who perform intact D&E in the United States. Interviews with physicians who use other abortion techniques—generally dismemberment—may help indirectly illuminate why most late-term abortions, including intact D&E abortions, are done.

Warren Hern, a 57-year-old physician who practices in Boulder, Colo., has a master's degree in public health and a doctorate in anthropology. He is one of the few providers of late-stage abortions who publishes research on the topic in medical journals.

Hern performs between 1,500 and 2,000 abortions a year. About 500 are on women 20 to 25 weeks pregnant. Of those, about one-quarter involve abnormal fetuses. He does between 10 and 25 abortions each year on women more than 26 weeks pregnant, and all of them involve fetal abnormalities or serious maternal disease, he said.

''It is true that a significant proportion of the community is offended by any abortion after 26 weeks that is not medically indicated,'' he said. ''We practice medicine in a social context. So that is why I will not perform an abortion after 26 weeks just because a woman has decided she does not want to carry the pregnancy to term.''

Women seeking an abortion late in pregnancy ''are often young, frequently not married, and many have a child already, or more,'' said Steve Lichtenberg, a obstetrician-gynecologist in Chicago who does abortions up to 22 weeks of development. Many are poor, have not completed school or established themselves in the work force, he said, and are in excellent health.

* * * * *

''The number who volunteer that information is substantially smaller than the number who've actually been subjected to social or sexual violence.''

Herbert Wiskind is the administrator of the 19-bed Midtown Hospital in Atlanta, whose four doctors perform about 25 abortions a week on women at least 18 weeks pregnant. In his experience many of the late procedures occur simply because of denial.

''You have a young girl who becomes pregnant, someone 15 or 16 years old,'' he said. ''She doesn't know how to tell her parents or her boyfriend. So she puts herself on a diet and tries to deny she's pregnant.''

However, Wiskind said, some fetal defects aren't diagnosed until late in pregnancy for unavoidable reasons. Amniocentesis, one technique of fetal genetic screening is done between weeks 15 and 17 of pregnancy. Several weeks can then pass before test results are known, and when they indicate a problem it often takes a woman several more weeks to decide about abortion, he said. In addition, many deformities can only be diagnosed through sonograms and were not apparent until the midpoint of pregnancy or later.

Thomas J. Mullin does abortions through the 24th week of gestation, as calculated by sonographic measurement of the fetus's head. He practices in the New York area.

Of the procedures Mullin does in weeks 20 through 24, about one-third are for fetal abnormalities, he said. In about 10 percent of cases, the woman has an illness, such as severe diabetes or painful uterine fibroids, that is not necessarily life-threatening but is clearly made worse by pregnancy.

''The remainder of them are just errors,'' he said. ''Many are young patients—12 to 20 years old—who are not in touch with their reproductive system as well as they should be, so they get stuck later than they want in pregnancy. They get surprised, basically.''

Jaroslav Hulka, a professor of obstetrics and gynecology at the University of North Carolina, supervises a teaching program whose physicians do 250 to 300 abortions a year on women carrying fetuses between 13 and 22 weeks old.

''Ninety-five percent of those are normal—that's fair to say,'' he said. Occasionally, fetuses up to 24 weeks old are aborted if they have a condition incompatible with life. The physicians use the dismemberment technique—an arduous and potentially risky procedure.

''The technique that the Congress is concerned about [intact D&E] is a level of skill above this,'' Hulka said. ''They are doing what we're all supposed to do—namely, minimize the risk to the patient.''

Practitioners of the intact procedure argue that their method is the least traumatic among the many variants of dilation and evacuation abortions used and is not—as their critics claim—the most barbarous. In testimony submitted last year to a congressional subcommittee, the late James McMahon wrote:

''In a desired pregnancy, when the baby is damaged or the mother is at risk, the decision to abort may be intellectually obvious, but emotionally it is always a personal anguish of enormous proportions . . . For the physician who is willing to help the patient in this dilemma, choices are few. Intact D&E can often be the best among a short list of difficult options. . . . Dealing with the tragic situations that I confront daily makes me constantly aware that I can only limit the hurt by doing gentle surgery and giving sympathetic counsel.''

Mr. SANTORUM. Mr. Brown talks about the different reasons—and a lot of the reasons given by physicians are reasons that are not medical necessities. Dr. Markman from California, I believe, performed nine abortions on third-trimester abortions on babies. The fetal abnormality? Cleft palate.

Dr. Pamela Smith sums it up best in a letter written October 28, last year, to CHARLES CANADY, who carried this bill over in the House. The last paragraph:

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

I think Mr. Cohen and the doctors I will refer to later have hit the nail on the head on what is going on with this whole debate.

I came to the floor last year and spoke on this issue. It is the first time in 6 years as a Senator and Congressman that I had ever taken to the floor of either body and utter the word ''abortion.'' I am pro-life. I feel very strongly about that. But I have never felt moved before to stand up and do something about it until I saw this.

I thought eventually in this country if we go out, as I have tried to do and talk to people, and try to change hearts by talking to people, young people, and talk about abortion, talk about how it is a scourge on our country, and that 1.5 million of these are performed every year in this country. It is not a healthy thing for women who have them. It is certainly not a healthy thing for our society that so many are done. I thought if we just kept vigilant we would see what the President said he would like to see—that abortions are safe, legal, and rare.

To me, this bill and the President's veto of this bill showed me that the rhetoric—how appealing it is, that abortions be rare—is just rhetoric. You cannot, you cannot, in your heart want abortions to be rare and allow this to happen in this country. What are you saying? What are you saying to those young people who are home from school and maybe made the mistake of plopping on C–SPAN 2 for a few seconds and they hear someone stand up and say you can deliver a baby and you can kill it. What are you saying to people who actually have to deal with this issue, saying we can kill, not as Mr. Cohen says, a few weeks old inch-long embryo, but a fully formed viable baby, viable baby, inches away from that first breath. What kind of a message does that send? What kind of a country are we?

If we knew of a procedure that had dogs delivered and then we performed that procedure on puppies, do you know how many letters from animal rights activists we would be getting now—and some of the very same people who would argue to keep this legal would argue to ban the other. What does that say about us?

You have the President of the United States who works very hard in the language of his veto message to try to cast the debate in a different light, talking about issues that really are not

substantive here. I will read again and again until the cows come home, ''there is absolutely no obstetrical situation encountered in this situation which requires a partially delivered human fetus to be destroyed to preserve the health of the mother.'' Yet the President vetoed it. Why? To preserve the health of the mother. It does not happen that way.

We try to form the debate around things that people can feel comfortable with. This issue is an issue that a lot of people do not feel comfortable with. We do not like to talk about it. But we have to talk about this because we are defined not by what the President of the United States would like us to feel comfortable with, not by the language that we can hide behind and not think about, but by what goes on every day in this country.

A lot of folks in Washington would like us to be cast in what we say. What we say is what we really are. I think in our hearts we know what we do is what we really are.

I have a lot of faith in the U.S. Senate. I have a lot of faith in the people who sit here and serve here, that they will take that time and will gather that evidence and look at the United States of America and say in the greatest civilization known to man—will we allow this to happen here?

I believe, even though all the media reports says we will never override the President's veto here, we are way short—well, we may have been, but I truly believe that my colleagues will study this issue well, will take all the new information that is available and will look at where we are in America and what signal we are going to send to this generation and future generations of Americans about what we will become.

If this is not wrong, I do not know what wrong is. This is wrong, and I believe the U.S. Senate will stand up in the next few days and tell the American public, ''We heard you.'' Tell those babies we understand now we are not going to let this happen any more under our watch.

I see the Senator from California is here and I asked her a question. I will ask it again because she did not answer it the two times previously when I asked, so I will ask one more time.

A partial birth abortion is performed when a baby is delivered feet first, as the Senator from Ohio described, the baby is delivered feet first through the birth canal. Everything is delivered—arms, shoulders, torso, legs, all delivered outside of the womb, outside of the mother completely except for the head. As nurse Brenda Shafer said, ''A pair of curved scissors, surgical scissors, are then inserted into the base of the skull and the brains removed.''

My question to the Senator from California is, what would her position be if, when the shoulders were delivered, that accidentally the head was also delivered; would the woman and her doctor—and I hear so often it is the woman and her doctor's right to choose—would the woman and the doctor in that situation where the head is delivered and the baby is completely outside of the womb, would the doctor be permitted, then, to kill the baby?

I will be happy, then, to yield the floor and await her answer.

Mrs. BOXER. Mr. President, I know the Senator from Florida is here to talk on another matter. Could I ask unanimous consent that I be allowed to speak for 10 minutes, immediately followed by the Senator from Florida for 15 minutes?

The PRESIDING OFFICER. Is there objection?

Mr. DEWINE. Reserving the right to object, I would like to inquire as to the amount of time we have remaining. My understanding is we will go to a vote at 5 o'clock.

Is that our cutoff time?

Mrs. BOXER. I say to the Senator, if you would like me to add the Senator, following Senator GRAHAM, I am delighted.

Mr. DEWINE. I do not think I will object. I want to see where we are.

The PRESIDING OFFICER (Mr. THOMPSON). We were scheduled to resume the pending business at 4:30, with half an hour of debate and then a series of votes at 5 o'clock.

Granting the Senator's request would delay those times.

Mr. SANTORUM. If the Senator will withhold we will see what the situation is. We will be happy to accommodate the Senator from Florida if we can.

Mrs. BOXER. I renew my request. The Senator spoke for 20 minutes. I would like to speak for 10 minutes. I would be happy to make as part of that request that the Senator from Ohio follow.

Is the Senator objecting to my getting 10 minutes?

Mr. SANTORUM. We are scheduled to go to debate on the bill and votes at 5 o'clock. This unanimous consent would push that back, and because Members are scheduled later this evening, they do not want to do that. That is the problem.

Mrs. BOXER. In trying to accommodate everybody, it seems to me—it is 20 after 4. We go to the bill at 4:30. Then I would ask for the normal 5 minutes to see where we go.

I am going to try this, Mr. President: That we delay going to the bill by 7 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. SANTORUM. I object.

The PRESIDING OFFICER. Objection is heard.

Mrs. BOXER. The reason I have been rather insistent is that for many hours today my name has been mentioned on the floor perhaps not directly but ''the Senator from California.'' And every time I go back to do business with being ''the Senator from California'' I hear another misstatement on the floor and the repeated question about how I feel about perfectly healthy babies and a perfectly healthy birth being aborted.

Not one United States Senator who is pro-choice believes that there should be an abortion allowed on a perfectly healthy pregnancy in the late term. I repeat that again. It is my position certainly in the late term—this is in concert with Roe v. Wade—that these abortions not happen on a healthy baby. And I want to say to my friend when he keeps posing that, he has never given birth. I have had the honor and the privilege to do so twice. One of my babies was born in a breach fashion.

So when the Senator asks me how I feel about that, I get a little upset because the way I felt about that at the time was God help me have a healthy baby. And she was premature, and I prayed every minute of the way.

So I do not want anyone to come to this Senate floor—and I ask you, I plead with you, not to do this anymore—and talk about ''the Senator from California's position.''

I am a grandmother. It is the greatest thing that has ever happened to my husband and myself. I prayed for healthy babies, and, no, I do not support the abortion of a healthy pregnancy—not one Senator does—despite the fact that my colleague makes it sound as if we do.

We could walk hand in hand down this aisle of the U.S. Senate and pass a bill in 60 seconds that outlawed this procedure except for life of the mother and serious adverse health impact. We could be together. But instead we have to face a debate that no doubt will show up on 30-second commercials.

I know that my colleague referred to the President as Mr. Clinton. Mr. Clinton met with mothers who have this procedure. He said, ''Why didn't he meet with other people on the other side?'' He has talked about this issue. He has looked at this issue. He has come to the conclusion that he would definitely sign a bill that made that life and health exception.

I quote from his letter.

> I urge that you vote to uphold my veto of H.R. 1833. My views on this legislation have been widely misrepresented.

And I might say to the President, they are being misrepresented as we speak by Members on the other side of this issue.

He says:

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

So here you have a President who has indicated that he would sign a bill outlawing this procedure with an exception for life and health. But no. The other side does not want that. They would rather come down and demagog the issue.

If I might say, I hear about Mr. Cohen's article. Good for Mr. Cohen.

He has taken a lot of different positions on a lot of subjects.

How about listening to the women who have gone through this like Maureen? Maureen is a 30-year-old Catholic mother of two, and lives in Massachusetts. On February 17, 1994 Maureen and her husband were joyously awaiting birth of their second child. On that date when she was 5 months pregnant a sonogram determined that her daughter had no brain and was nonviable. Her doctor recommended termination of the pregnancy.

On February 18, 1994, a third-degree sonogram at New England Medical Center in Boston confirmed the diagnosis that the baby had no brain and was nonviable.

Maureen and her family sought counsel from their parish priest, Father Greg, who supported the decision to terminate the pregnancy.

Mr. President, may I have order.

The PRESIDING OFFICER. The Senate will come to order.

Mrs. BOXER. Maureen found out that her baby had no brain. She is a practicing Catholic, and she went to her priest, Father Greg. On the record he supported her decision to terminate the pregnancy.

They named their daughter Dahlia. She had a Catholic funeral and is buried at Otis Air Force Base in Cape Cod, MA.

And Senators in this Chamber want to insert themselves into that family, insert themselves into the dialog between her priest, her God, and her family?

President Clinton will sign a bill that outlaws this procedure with an exemption for life and health. Throughout this debate I will bring up example after example.

And I urge my colleagues. This is not about 30-second commercials. This is about the life of women.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Mrs. BOXER. We will continue this debate, Mr. President.

I yield the floor.

Is it time now to go to the bill at hand?

The PRESIDING OFFICER. Under the previous order, it would be time to go to the bill.

Mr. SANTORUM. Mr. President, I ask unanimous consent for 5 minutes, and I would be happy to share that time, half and half.

Mrs. BOXER. If there is no objection, I save my 2½ minutes until after the Senator is finished.

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

Mr. SANTORUM. Mr. President, the Senator from California makes a point—again, it is a good one—that the President will sign the bill with the exception for the life and health of the mother. That is what the President said.

I have two amendments. One, the health of the mother exception has been consistently held even though it has been narrowly drawn by many State legislatures, the health of the mother exception has been interpreted by courts unanimously as being anything—financial health is the health of mother; social interaction, health of the mother; her age, health of the mother; maturity; emotional health; mental health; physical health. Yes. It is a limitation without limit. It is no limitation at all. And the Senator from California knows that. More importantly, the President of the United States knows that very well.

It is all how to frame the issue. It makes a lot of people feel comfortable that the President really does want to limit these things. It is only these serious health consequences, and that is reasonable until you understand that health consequences is not a limit on the procedure. It is not a limit on the procedure.

So to make a limitation that does not have a limit is just what I described before which is someone who wants to be judged by what they say to you that sounds so nice instead of what the reality of what their words would be which means partial-birth abortions would continue to go on in this country without limitation if we passed a bill that had a health limitation. That is not RICK SANTORUM, the Senator from Pennsylvania speaking. That is court after court after court after court interpreting language that you would believe would be rock solid. But with the judges it is not. So I would just say go ahead and continue to use it, as I am sure you will—that we could agree on this rhetoric. But I can guarantee you we cannot agree on this rhetoric. We cannot agree on a limitation that is a phony limitation; to a procedure that is infanticide and nothing more.

The second thing I would say is you have doctor after doctor who has written to us and said that this procedure is never medically necessary to save the life or health of the mother.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from California.

Mrs. BOXER. Thank you very much. Mr. President, once more I want to put on the table what the Members of the U.S. Senate could agree to at any moment. We would say this procedure cannot be used unless the woman's life is at stake because there is no true life exception in this extreme bill before us, or to spare her serious adverse health consequences.

And let me just say to my colleague in all due respect—and as collegial as I can be in the moment here—if you are suggesting that anyone in this U.S. Senate is talking about financial health of the woman, let me just say it is an absolute outrage if you would think that is what we are talking about. We are talking about infertility for life. We are talking about paralysis. We are talking about bleeding to death.

Vikki Stella, mother of two, was in the third trimester of her pregnancy when she discovered 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. The doctor told her the baby would never live outside the womb. She said, ''The only option that would assure that my daughters would not grow up without a 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 son Nicholas was born in December 1995.''

Senators in this Chamber would stand up to this woman and tell her, ''Too bad, even though your doctor said it was necessary to have this procedure so you could have another child; too bad.''

You know, I will tell you something. For people who say they want to get Government out of the lives of the people, this is extraordinary to me. Let us leave these tragic situations to the mother, to the father, to the doctor, to the priest, to the rabbi, to God. Let us think seriously. If it was your wife, if it was your daughter, and the doctor looked in your eye and said, ''Your wife might die if I do not use this procedure,'' at that moment would you want him or her to use the procedure that would save that life?

The PRESIDING OFFICER. The time of the Senator has expired.

Mrs. BOXER. Thank you.

MARITIME SECURITY ACT

The PRESIDING OFFICER. Under the previous order, the hour of 4:30 p.m. having arrived, the Senate will now resume consideration of H.R. 1350, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 1350) to amend the Merchant Marine Act, 1936, to revitalize the United States-flag merchant marine, and for other purposes.

The Senate resumed the consideration of the bill.

Pending:

Grassley amendment No. 5393, to clarify the term fair and reasonable compensation with respect to the transportation of a motor vehicle by a certain vessel.

Grassley amendment No. 5394, to prohibit the use of funds received as a payment or subsidy for lobbying or public education, and for making political contributions for the purpose of influencing an election.

Grassley amendment No. 5395, to provide that United States-flag vessels be called up before foreign flag vessels during any national emergency and to prohibit the delivery of military supplies to a combat zone by vessels that are not United States-flag vessels.

Inouye (for Harkin) amendment No. 5396 (to amendment No. 5393), to provide for payment by the Secretary of Transportation of certain ocean freight charges for Federal food or export assistance.

Mr. STEVENS. Mr. President, what is the parliamentary situation now with regard to time?