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

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

RESERVATION OF LEADER TIME

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

PARTIAL-BIRTH ABORTION BAN ACT OF 2003

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

The legislative clerk read as follows:

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

The PRESIDING OFFICER. The Senator from Pennsylvania.

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

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

ROCKFORD HEALTH SYSTEM, DIVISION OF MATERNAL-FETAL MEDICINE,

Rockford, IL, March 12, 2003.

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

DEAR SENATOR SANTORUM: I am writing to contest the letter submitted to Senator Feinstein by Philip D. Darney, MD supporting the ''medical exemption''; to the proposed restriction of the partial birth abortion (or as abortionists call it ''intact D&E'').

I am a diplomate board certified by the American Board of Obstetrics and Gynecology in general Obstetrics and Gynecology and in the sub-specialty of Maternal-Fetal Medicine. I serve as a Visiting Clinical Professor in Obstetrics and Gynecology, University of Illinois at Chicago, Department of Obstetrics and Gynecology, College of Medicine at Rockford, Rockford, Illinois; as an Adjunct Professor of Obstetrics and Gynecology, at Midwestern University, Chicago College of Osteopathic Medicine, Department of Obstetrics and Gynecology; and as an Adjunct Associate Professor of Obstetrics and Gynecology Uniformed Services University of Health Sciences, F. Edward Herbert School of Medicine, Washington, D.C. I have authored over 50 peer review articles in the obstetrics and gynecologic literature, presented over 100 scientific papers, and have participated in over 40 research projects,

In my over 14 years as a Maternal-Fetal Medicine specialist I have never used or needed the partial birth abortion technique to care for my complicated or life threatening conditions that require the termination of pregnancy. Babies may need to be delivered early and die from prematurity, but there is never a medical need to perform this heinous act.

I have reviewed both cases presented by Dr. Darney, and quite frankly, do not understand why he was performing the abortions he indicates, yet alone the procedure he is using. If the young 25 year old woman has a placenta previa with a clotting disorder, the safest thing to do would be to place her in the hospital, transfuse her to a reasonable hematocrit, adjust her clotting parameters, watch her closely at bed rest, and deliver a live baby. If the patient had a placenta previa, pushing laminaria (sterile sea weed) up into her cervix, and potentially through the previa, is contraindicated. It is no surprise to anyone that the patient went, from stable without bleeding, to heavy bleeding as they forcibly dilated her cervix to 3 centimeters with laminaria. The use of the dangerous procedure of blinding pushing scissors into the baby's skull (as part of the partial birth abortion) with significant bleeding from a previa just appears reckless and totally unnecessary.

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

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of the second medical practices that result in a live baby and an unharmed mother.

Sincerely,

BYRON C. CALHOUN, MD.

MARCH 13, 2003.

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

DEAR SENATOR SANTORUM: I have reviewed the letter from Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional ''medical exemption'' for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Program in Human Rights in Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emptying the uterus before fetal viability then I will utilize a medically appropriate method of delivery, including intact D&E.

Though they are certainly complicated, the two cases described by Dr. Darney describe situations that were not initially emergent. This is demonstrated by the use of measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is itself risky and can lead to life-threatening hemorrhage. There may be extenuating circumstances in Dr. Darney's patients but most obstetrical physicians would not attempt dilation of the cervix in the presence of these complications. It is my understanding that the proposed partial birth abortion ban already has an exemption for situations that are a threat to the life of the mother. This would certainly allow all measures to be taken if heavy bleeding, infection, or severe preeclampsia required evacuation of the uterus.

The argument for an additional medical exemption is redundant; furthermore, its inclusion in the legislation would make the ban virtually meaningless. Most physicians and citizens recognize that in rare life-threatening situations this gruesome procedure might be necessary. But it is certainly not a procedure that should be used to accomplish abortion in any other situation.

Passage of a ban on partial birth abortion with an exemption only for life-threatening situations is reasonable and just. It is in keeping with long-standing codes of medical ethics and it is also in keeping with the provision of excellent medical care to pregnant women and their unborn children.

Sincerely,

STEVE CALVIN, MD.

REDMOND, WA,
March 12, 2003.

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

DEAR SENATOR SANTORUM: The purpose of this letter is to counter the letter of Dr. Philip Darney, M.D. to Senator Diane Feinstein and to refute claims of a need for an exemption based on the health of the mother in the bill to restrict ''partial birth abortion.''

I am board certified in Maternal-Fetal Medicine as well as Obstetrics and Gynecology and have over 20 years of experience, 17 of which have been in maternal-fetal medicine. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such were performed due to the risk of caesarean delivery (also called hysterotomy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead baby. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

The presence of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney placed those mothers at extremely high risk for catastrophic life-threatening hemorrhage with any attempt at vaginal delivery. Bleeding from placenta previa is primarily maternal, not fetal. The physicians are lucky that their interventions in both these cases resulted in living healthy women. I do not

agree that D&X was a necessary option. In fact, a bad outcome would have been indefensible in court. A hysterotomy (caesarean delivery) under controlled non-emergent circumstances with modern anesthesia care would be more certain to avoid disaster when placenta previa occurs in the latter second trimester.

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

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

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

Sincerely,

SUSAN E. RUTHERFORD, MD.

UNIVERSITY OF SOUTHERN CALIFORNIA, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY,
Los Angeles, CA, March 12, 2003.

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

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

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

I have had occasion to review the cases described by Dr. Philip Darney, offered in support of the position that partial birth abortion, or intact D&E, was the best care for the patient in those situations. Mindful of Dr. Darney's broad experience with surgical abortion, I nevertheless disagree strongly that the approach he describes for these two cases was best under the circumstances. Such cases are infrequent, and there is no single standard for management. However, it would certainly be considered atypical, in my experience, to wait 12 hours to dilate the cervix with laminaria while the patient was actively hemorrhaging, as was described in his first case. Similarly, the approach to presumed placenta acreta, described in the second case, is highly unusual. Although the mother survived with significant morbidity, it is not clear that the novel approach to management of these difficult cases is the safest approach. It is my opinion that the vast majority of physicians confronting either of these cases would opt for careful hysterotomy as the safest means to evacuate the uterus.

Although I do not perform abortions, I have been involved in counseling many women who have considered abortion because of a medical complication of pregnancy. I have not encountered a case in which what has been described as partial birth abortion is the only choice, or even the better choice among alternatives, for managing a given complication of pregnancy.

Thank you for your consideration of this opinion.

Sincerely,

T. MURPHY GOODWIN, M.D,
Chief, Division of Maternal-Fetal Medicine.

Mr. SANTORUM. Madam President, I ask unanimous consent that a letter from Dr. Daniel J. Wechter be printed in the RECORD.

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

SYNERGYMEDICAL EDUCATION ALLIANCE,
Saginaw, MI, March 13, 2003.

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

DEAR SENATOR SANTORUM, I am writing in response to the letter from Dr. Phillip Darney which was introduced by Senator Feinstein.

I have cared for pregnant patient patients for almost 29 years, and have worked exclusively in the field of Maternal-Fetal Medicine (high risk pregnancy) for over 15 years. I am board certified in Obstetrics & Gynecology, and also in the subspecialty of Maternal-Fetal Medicine. I am an assistant professor in Obstetrics & Gynecology for the Michigan State College of Human Medicine, and co-director of Maternal-Fetal Medicine in Saginaw Michigan.

I have never seen a situation in which a partial birth abortion was needed to save a mother's life. I have never had a maternal death, not ever.

I am familiar with Dr. Darney's letter describing two of his cases. My comments are not meant as a criticism of Dr. Darney as a person or as a physician. I have great respect for anyone in our field of medicine, which is a very rewarding specialty but which requires difficult decisions on a daily basis. We are all working to help mothers and their children make it through difficult pregnancies. Still, I do disagree with his stand that the legal freedom to do partial birth abortions is necessary for us to take good care of our patients. For example, in the second case he describes, I believe that patient could have carried the pregnancy much further, and eventually delivered a healthy child by repeat caesarean section followed by hysterectomy. Hemorrhage is always a concern with such patients, but we have many effective ways to handle this problem, which Dr. Darney knows as well as I. Blood vessels can be tied off at surgery, blood vessels can be occluded using small vascular catheters, cell-savers can be used to return the patients own blood to them, blood may be given from donors, pelvic pressure packs can be used for bleeding following hysterectomy, and other blood products (platelets, fresh frozen plasma, etc) can be given to treat coagulation abnormalities (DIC). His approach of placing laminaria to dilate the cervix in a patient with a placenta praevia is not without it's own risk.

If Dr. Darney performed the partial birth abortion on this patient to keep from doing another c-section, or even to preserve her uterus, I'm hopeful he counseled the patient that if she becomes pregnant again, she will once again have a very high risk of having a placenta praevia and placenta accreta.

Lastly, I believe that for some abortionists, the real reason they wish to preserve their ''right'' to do partial birth abortions is that at the end of the procedure they have only a dead child to deal with. If they were to abort these women by either inducing their labor (when there is no placenta praevia present), or by doing a hysterotomy (c-section), they then need to deal with a small, living, struggling child—an uncomfortable situation for someone who's intent was to end the child's life.

Sincerely,

DANIEL J. WECHTER, M.D.,
Co-Director of Maternal-Fetal Medicine,
Synergy Medical Education Alliance.

Mr. BURNS. Mr. President, the Partial-Birth Abortion Ban Act of 2003 is not about a woman's right to choose to have an abortion. Regardless of one's views on abortion in general, the partial-birth abortion procedure should have no place in a civilized society such as ours. Partial-birth abortion is an undeniably abhorrent procedure, and most physicians believe it is never medically necessary. The American Medical Association, the largest association of doctors in the United States, and the medical community at large, has endorsed banning this late-term abortion procedure. It is time for the Congress to follow suit.

Since 1995, at least 31 States have enacted laws banning partial-birth abortion. On June 28, 2000, the U.S. Supreme Court invalidated a Nebraska statute that prohibited the performance of partial-birth abortions. The Supreme Court determined that the Nebraska statute was unconstitutional because it failed to include an exception to protect the health of the mother, and because the language defining the prohibited procedure was too vague. We must not allow the Partial-Birth Abortion Ban Act to be diluted by amendments that would limit the application of this bill to a time after a child is determined to be viable. Such language would allow this procedure to continue being performed as late as the sixth month of pregnancy. Additionally, such amendments would create loopholes allowing this cruel procedure to be used even as late as the third trimester of pregnancy, a time at which many babies can sustain life outside the womb.

Passing the Partial-Birth Abortion Ban Act would prohibit any physician or other individual from knowingly performing a partial-birth abortion, except when necessary to save the life of a mother who is endangered by a physical disorder, illness, or injury. Experts have estimated that the partial-birth abortion procedure is used 3,000–5,000 times annually, and that the vast majority of these procedures are performed on a healthy mother and a healthy fetus. The Physicians' Ad Hoc Coalition on Truth—PHACT—a group of over 600 physicians-specialists—has spoken out to dispute the claims that some women need partial-birth abortions to avoid serious physical injury. In September 1996, former Surgeon General C. Everett Koop and other PHACT members said:

Partial-birth abortion is never medically necessary to protect a mother's health or her

future fertility. On the contrary, this procedure can pose a significant threat to both.

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

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

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

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

Then, in 2000, the Supreme Court considered and struck down as unconstitutional the Nebraska State law making partial-birth abortion illegal. In Stenberg v. Carhart, the Court believed that the Nebraska law (1) did not contain an exception for the health of a mother, and (2) was too broad and could be construed to cover other types of procedures. The bill before us specifically addresses the Supreme Court's concerns.

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

My constituents want a ban on partial-birth abortions:

A woman from Tabor, IA, wrote, ''I'm horrified that under current law, thousands of partial-birth abortions are committed in America every year.''

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

A woman from Nora Springs wrote, ''Abortions are actually murder because even though the child may not be out of the womb, it's still developing into a person.''

A woman from Waverly, IA, wrote, ''Partial-birth abortions are never medically necessary.''

A young man in the 6th grade from West Union, IA, wrote, ''A child might die, and in the future that small child could grow up to create a cure for a disease, or be a fireman and save many lives. Just think, you could have been aborted.''

It's time for us to stand up against such an extreme medical practice that stops the beating heart of an unborn child.

Most medical professionals would agree that this specific abortion procedure is outrageous. In fact, the American Medical Association supported a ban in 1999.

You will hear many on the other side argue about a woman's health and reproductive rights. As the bill states, the physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome. His testimony waters down their theory that this procedure is necessary in certain situations to preserve the mother's health.

If we know that the procedure can pose a threat to both a woman's immediate health and future reproductive capacity, why do you want to expose women to the risks?

Condoning partial-birth abortion is bad medicine, and bad policy.

When abortion advocates say that abortion is a matter just between a woman and her doctor, they are rejecting the rights of an innocent human being.

The unborn baby is alive from the moment of fertilization, the unborn baby has a heartbeat at 3 weeks and brain waves at 6 weeks, the unborn baby has 46 chromosomes in the cells of his or her body, the unborn baby is a living human being.

Dr. Seuss said it just right: A person is a person, no matter how small.

Let's pass this bill to protect the innocent and unborn.

Mr. CORZINE. Mr. President, I rise in opposition to this legislation because I believe it is unconstitutional, and because its language is so broad that it effectively would ban standard and safe abortion procedures. I am concerned that, if approved, this bill would not only undermine a woman's right to choose, but it would endanger the lives of thousands of women who no longer would have access to safe abortion procedures when their health or their life is in jeopardy.

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

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

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

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

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

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

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

If we really are interested in reducing the number of abortions in this country, we should ensure that all women have access to the full array of family planning services, including prescription contraception, emergency contraception, and prenatal care. We also should support an expansion of comprehensive sex education. I fully support the amendment offered by Senator MURRAY and REID that would have addressed these issues.

Every week, 8,500 children in our country are born to mothers who lacked access to prenatal care. Too many of these children are born with serious health problems because their mothers lacked adequate care during their pregnancies. As a result, 28,000 infants die each year in the United States. That, Mr. President, is the real tragedy. And we ought to act immediately to address this issue by expanding access to prenatal care, as several of my colleagues and I have proposed.

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

For these reasons, I urge my colleagues to oppose this bill.

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

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

PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH,
New York, NY, March 12, 2003.

Hon. JON S. CORZINE,
U.S. Senate,
Washington, DC.

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

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

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

While we can argue as to why this legislation is dangerous, deceptive and unconstitutional—and it is—the fact of the matter is that the text of the bill is so vague and misleading that there is a great need to correct the misconceptions around abortion safety and technique. It is wrong to assume that a specific procedure is never needed; what is required is the safest option for the patient, and that varies from case to case.

THE FACTS

(1) So-called ''partial birth'' abortion does not exist.

There is no mention of term ''partial birth'' abortion in any medical literature. Physicians are never taught a technique called ''partial birth'' abortion and therefore are unable to medically define the procedure.

What is described in the legislation, however, could ban all abortions. ''What this bill describes, albeit in non-medical terms, can be interpreted as any abortion,'' stated one of our physician members. ''Medicine is an art as much as it is a science; although there is a standard of care, each procedure—and indeed each woman—is different. The wording here could apply to any abortion patient.'' The bill's language is too vague to be useful; in fact, it is so vague as to be harmful. It is intentionally unclear and deceptive.

(2) Physicians need to have all medical options available in order to provide the best medical care possible.

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

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

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

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

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

THE SCIENCE

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

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

From the years 1972–76, labor induction procedures carried a maternal mortality rate of 16.5 (note: all numbers listed are out of 100,000); the corresponding rate for D&E was 10.4. From 1977–82, labor induction fell to 6.8, but D&E dropped to 3.3 From 1983–87, induction methods had a 3.5 mortality rate, while D&E fell to 2.9. Although the difference between the methods shrank by the mid-1980s, the use of D&E had already quickly outpaced induction.

Morbidity trends indicate that dilation and evacuation is much safer than labor induction procedures and for women with certain medical conditions, labor induction can pose serious risks. Rates of major complications from labor induction, including bleeding, infections, and unnecessary surgery, were at least twice as high as those from D&E. There are instances of women who, after having failed inductions, acquired infections necessitating emergency D&Es as a last resort. Hysterotomy and hysterectomy, moreover, carry a mortality rate seven times that of induction techniques and ten times that of D&E.

There is a psychological component which makes D&E preferable to labor induction; undergoing difficult, expensive and painful labor for up to two days can be extremely emotionally and psychologically difficult, much more so than a surgical procedure that can be done in less than an hour under general or local anesthesia. Furthermore, labor induction does not always work: Between 15 and 30 percent or more of cases require surgery to complete the procedure. There is no question that D&E is the safest method of second-trimester abortion.

There is also a technique known as dilation and extraction (D&X). There is a limited medical literature on D&X because it is an uncommonly used variant of D&X. However, it is sometimes a physician's preferred method of termination for a number of reasons: It offers a woman the chance to see the intact outcome of a desired pregnancy, to speed up the grieving process; it provides a greater chance of acquiring valuable information regarding hereditary illness or fetal anomaly; and D&E provides a decreased risk of injury to the woman, as the procedure is quicker than induction and involves less use of sharp instruments in the uterus, providing a decreased chance of uterine perforations or tears and cervical lacerations. The American College of Obstetricians and Gynecologists addressed this in their statement in opposition to so-called ''partial birth'' abortion when they said that D&X ''may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman's particular circumstances, can make this decision.

It is important to note that these procedures are used at varying gestational ages. both D&E and D&X are options for surgical abortion prior to viability. D&E and D&X are used solely based on the size of the fetus, the health of the woman, and the physician's judgment, and the decision regarding which procedure to use is done on a case-by-case basis.

THE LEGISLATION

Because this legislation is so vague, it would outlaw D&E and D&X (and arguably techniques used in the first trimester). Indeed, the Congressional findings—which go into detail, albeit in non-medical terms—do not remotely correlate with the language of the bill. This legislation is reckless. The outcome of its passage would undoubtedly be countless deaths and irreversible damage to thousands of women and families. We can safely assert that without D&E and D&X, that is, an enactment of S. 3, we will be returning to the days when an unwanted pregnancy led women to death through illegal and unsafe procedures, self-inflected abortions, uncontrollable infections and suicide.

The cadre of physicians who provide abortions should be honored, not vilified. They are heroes to millions of women, offering the opportunity of choice and freedom. We urge you to consider scientific data rather than partisan rhetoric when voting on such far-

reaching public health legislation. We strongly oppose legislation intended to ban so-called ''partial birth'' abortion.

Sincerely,

Nassim Assefi, MD, Attending, Women's Clinic and Adult Medicine, Harborview Medical Center, Seattle, WA.

Jonathan D. Berman, MD, Columbia River Mental Health Services, Vancouver, WA.

Elizabeth Bianchi, MD, Spokane, WA.

Paul D. Blumenthal, MD, MPH, Associate Professor, Department of Gynecology and Obstetrics, Johns Hopkins University, Director, Contraceptive Research and Programs, Johns Hopkins Bayview Medical Center, Baltimore, MD.

Fredrik F. Broekhuizen, MD, Professor Obstetrics and Gynecology, Medical College of Wisconsin, Madison, WI.

Herbert Brown, MD, Clinical Associate Professor, Obstetrics and Gynecology, University of Texas Health Science Center at San Antonio, San Antonio, TX.

Wendy Chavkin, MD, MPH, Professor of Clinical Public Health and Ob-Gyn, Columbia University, School of Public Health.

Philip A. Corfman, MD, Consultant in Reproductive Health, Bethesda, MD.

Anne R. Davis, MD, MPH, Assistant Clinical Professor of Obstetrics and Gynecology, Columbia College of Physicians and Surgeons, Columbia University, New York, NY.

Quentin B. Deming, MD, Jacob A. and Jeanne E. Barkey, Professor of Medince, Emeritus, Albert Einstein College of Medicine, New York, NY.

Paul M. Fine, MD, Medical Director, Planned Parenthood of Houston and Southeast Texas, Houston, TX.

Marilynn C. Frederiksen, MD, Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago, IL.

Susan George, MD, Family Physician, Portland, ME.

Richard W. Grady, MD, Assistant Professor, Children's Hospital and Regional Medical Center, Seattle, WA.

Laura J. Hart, MD, Alaska Urological Associates, Seattle, WA

Paula J. Adams Hillard, MD, Professor, OB-Gyn and Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH.

Sarah Hufbauer, MD, Country Doctor Community Clinic, Seattle, WA.

Robert L. Johnson, MD, FAAP, Pediatrician and Adolescent Medicine Specialist, Orange, NJ.

Harry S. Jonas, MD, Past President, The American College of Obstetricians and Gynecologist, Lee's Summit, MO.

Deborah E. Klein, MD, Swedish Physician Division, Seattle, WA.

Julie Komarow, MD, Covington Primary Care, Covington, WA.

Kim Leatham, MD, Clinical Instructor, University of Washington, Dept. of Family Medicine, Medical Director, Virginia Mason Winslow, Bainbridge Island, WA.

David A. Levine, MD, Associate Professor of Clinical Pediatrics, Morehouse School of Medicine, Atlanta, GA.

Sara Buchdahl Levine, MD, MPH, Resident, Social Pediatrics, Children's Hospital at Montefiore, Bronx, NY.

Scott T. McIntyre, MD, Seattle Family Medicine, Aurora Medical Services, Planned Parenthood of Western Washington Medical Advisory Committee, Seattle, WA.

Catherine P. McKegney, MD, MS, Hennepin Count Medical Director, Department of Family Practice, Minneapolis, MN.

Deborah Oyer, MD, Medical Director, Aurora Medical Services, Clinical Assistant Professor in Family Medicine, University of Washington, Seattle, WA.

Warren H. Pearse, MD, Ob/Gyn, Mitchellville, MD.

Natalie E. Roche, MD, Assistant Professor of Obstetrics and Gynecology, New Jersey Medical College, Newark, NJ.

Roger A. Rosenblatt, MD, MPH, Professor and Vice Chair, Department of Family Medicine, Rural Underserved Opportunity Program Director—School of Medicine University of Washington School of Medicine Seattle, WA.

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

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

Steven B. Tamarin, MD, St. Luke's/Roosevelt Medical Center, Attending Assistant, Department of Pediatrics, New York, NY.

Katherine Van Kessel, MD, Attending Physician, Harborview Medical Center, Department of OB/Gyn, University of Washington Medical Center, Seattle, WA.

Gerson Weiss, MD, Professor and Chair, Department of Obstetrics, Gynecology and Women's Health, New Jersey Medical College, Newark, NJ.

Beverly Winikoff, MD, MPH, President, Gynuity Health Projects, New York, NY.

And the board of Physicians for Reproductive Choice and Health.

MARCH 5, 2003.

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

DEAR SENATOR BOXER: I understand that you will be considering Senate S. 3, the ban on abortion procedures, soon and would like to offer some medical information that may assist you in your efforts. Important stakes for women's health are involved: if Congress enacts such a sweeping ban, the result could effectively ban safe and common, pre-viability abortion procedures.

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

The proposed ban on abortion procedures criminalizes abortions in which the provider ''deliberately and intentionally vaginally delivers a living fetus . . . for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus . . .'' The criminal ban being considered is flawed in a number of respects:

It fails to protect women's health by omitting an exception for women's health;

It menaces medical practice with the threat of criminal prosecution;

It encompasses a range of abortion procedures; and

It leaves women in need of second trimester abortions with far less safe medical options: hysterotomy (similar to a caesarean section) and hysterectomy.

The proposed ban would potentially encompass several abortion methods, including dilation and extraction (d&x, sometimes referred to as ''inact d&e), dilation and evacuation (d&e), the most common second-trimester procedure. In addition, such a ban could also apply to induction methods. Even if a physician is using induction as the primary method for abortion, he or she may not be able to assure that the procedure could be effected without running afoul of the proposed ban. A likely outcome if this legislation is enacted and enforced is that physicians will fear criminal prosecution for any second trimester abortion—and women will have no choice but to carry pregnancies to term despite the risks to their health. It would be a sad day for medicine if Congress decides that hysterotomy, hysterectomy, or unsafe continuation of pregnancy are women's only available options. Williams Obstetrics, one of the leading medical texts in Obstetrics and Gynecology, has this to say about the hysterotomy ''option'' that the bill leaves open: ''Nottage and Liston (1975), based on review of 700 hysterotomies, rightfully concluded that the operation is outdated as a routine method for terminating pregnancy.'' (Cunningham and McDonald, et al, Williams Obstetrics, 19th ed., (1993), p. 663.)

Obviously, allowing women to have a hysterectomy means that Congress is authorizing women to have an abortion at the price of their future fertility, and with the added risks and costs of major surgery. In sum, the options left are less safe for women who need an abortion after the first trimester of pregnancy.

I'd like to focus my attention on that subset of the women affected by this bill who face grievous underlying medical conditions. To be sure, these are not the majority of women who will be affected by this legislation, but the grave health conditions that could be worsened by this bill illustrate how sweeping the legislation is.

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

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

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

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

Sincerely,

FELICIA H. STEWART, M.D.

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

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The bill having been read the third time, the question is, Shall the bill pass? The clerk will call the roll.

The legislative clerk called the roll.

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

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

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

The result was announced—yeas 64, nays 33, as follows:

[Rollcall Vote No. 51 Leg.]

YEAS—64

Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Dorgan	Miller
Bayh	Ensign	Murkowski
Bennett	Enzi	Nelson (NE)
Bond	Fitzgerald	Nickles
Breaux	Frist	Pryor
Brownback	Graham (SC)	Reid
Bunning	Grassley	Roberts
Burns	Gregg	Santorum
Byrd	Hagel	Sessions
Campbell	Hatch	Shelby
Carper	Hollings	Smith
Chambliss	Hutchison	Specter
Cochran	Inhofe	Stevens
Coleman	Johnson	Sununu
Conrad	Kyl	Talent
Cornyn	Landrieu	Thomas
Craig	Leahy	Voinovich
Crapo	Lincoln	Warner
Daschle	Lott	
DeWine	Lugar	

NAYS—33

Akaka	Durbin	Lieberman
Baucus	Feingold	Mikulski
Bingaman	Feinstein	Murray
Boxer	Graham (FL)	Nelson (FL)
Cantwell	Harkin	Reed
Chafee	Inouye	Rockefeller
Clinton	Jeffords	Sarbanes
Collins	Kennedy	Schumer
Corzine	Kohl	Snowe
Dayton	Lautenberg	Stabenow
Dodd	Levin	Wyden

NOT VOTING—3

Biden	Edwards	Kerry

CHANGE OF VOTE

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

The PRESIDING OFFICER. Without objection, it is ordered.

(The foregoing tally has been changed to reflect the above order.)

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

S. 3

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Partial-Birth Abortion Ban Act of 2003''.

SEC. 2. FINDINGS.

The Congress finds and declares the following:

(1) A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion—an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a Sharp instrument, and sucks the child's brains out before completing delivery of the dead infant—is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

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

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

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

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

(6) Despite the dearth of evidence in the Stenberg trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not ''clearly erroneous''. A finding of fact is clearly erroneous ''when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed''. Anderson v. City of Bessemer City, North Carolina (470 U.S. 564, 573 (1985)). Under this standard, ''if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently'' (Id. at 574).

(7) Thus, in Stenberg, the United States Supreme Court was required to accept the very questionable findings issued by the district court judge—the effect of which was to render null and void the reasoned factual findings and policy determinations of the United States Congress and at least 27 State legislatures.

(8) However, under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in Stenberg under the ''clearly erroneous'' standard. Rather, the United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence.

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

(10) Katzenbach's highly deferential review of Congress's factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the ''bail-out'' provisions of the Voting Rights Act of 1965, (42 U.S.C. 1973c), stating that ''congressional fact finding, to which we are inclined to pay great deference, strengthens the inference that, in those jurisdictions covered by the Act, state actions discriminatory in effect are discriminatory in purpose''. City of Rome, Georgia v. U.S. (472 F. Supp. 221 (D. D. Col. 1979)) aff'd City of Rome, Georgia v. U.S. (46 U.S. 156 (1980)).

(11) The Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992. See Turner Broadcasting System, Inc. v. Federal Communications Commission (512 U.S. 622 (1994) (Turner I)) and Turner Broadcasting System, Inc. v. Federal Communications Commission (520 U.S. 180 (1997) (Turner II)). At issue in the Turner cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be ''seriously jeopardized''. The Turner I Court recognized that as an institution, ''Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here'' (512 U.S. at 665–66). Although the Court recognized that ''the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,' '' its ''obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'' (Id. at 666).

(12) Three years later in Turner II, the Court upheld the ''must-carry'' provisions based upon Congress' findings, stating the Court's ''sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.' '' (520 U.S. at 195). Citing its ruling in Turner I, the Court reiterated that ''[w]e owe Congress' findings deference in part because the institution 'is far better

equipped than the judiciary to ''amass and evaluate the vast amounts of data'' bearing upon' legislative questions,'' (Id. at 195), and added that it ''owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power.'' (Id. at 196).

(13) There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a ''health'' exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care. Congress was informed by extensive hearings held during the 104th, 105th, and 107th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These findings reflect the very informed judgment of the Congress that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

(14) Pursuant to the testimony received during extensive legislative hearings during the 104th, 105th, and 107th Congresses, Congress finds and declares that:

(A) Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, ''there are very few, if any, indications for . . . other than for delivery of a second twin''; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.

(B) There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

(C) A prominent medical association has concluded that partial-birth abortion is ''not an accepted medical practice,'' that it has ''never been subject to even a minimal amount of the normal medical practice development,'' that ''the relative advantages and disadvantages of the procedure in specific circumstances remain unknown,'' and that ''there is no consensus among obstetricians about its use''. The association has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is ''ethically wrong,'' and ''is never the only appropriate procedure''.

(D) Neither the plaintiff in Stenberg v. Carhart, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

(E) The physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.

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

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

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

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

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

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

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

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

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

(O) For these reasons, Congress finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

SEC. 3. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.

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

''CHAPTER 74—PARTIAL-BIRTH ABORTIONS

''§ 1531. Partial-birth abortions prohibited

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

''(b) As used in this section—

''(1) the term 'partial-birth abortion' means an abortion in which—

''(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and

''(B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus; and

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

''(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the

fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

''(2) Such relief shall include—

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

''(B) statutory damages equal to three times the cost of the partial-birth abortion.

''(d)(1) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

''(2) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

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

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

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

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

(a) FINDINGS.—The Senate finds that—

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

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

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

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

(2) such decision should not be overturned.

Mr. SANTORUM. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

Mr. HATCH. Madam President, I rise today to applaud this body for passing S. 3, the Partial-Birth Abortion Ban Act of 2003. I know the people of my home State of Utah share my sentiments because they recognize, as I do, that the practice of partial-birth abortion is immoral, offensive and impossible to justify. This procedure is so heinous that even many that consider themselves pro-choice cannot defend it.

While we have passed a similar measure before, it was never certain to be signed into law. Today it is. It saddens me that this legislation was even necessary, and even more that it took 7 years to achieve. I thank the Senator from Pennsylvania for his outstanding leadership in bringing this about. I hope he knows he has my admiration and respect.

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

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

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

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

This is what happens, when we continue to devalue human life.

William Raspberry argued in a column in the Washington Post several years ago that ''only a short distance [exists] between what [these teenagers] have been sentenced for doing and what doctors get paid to do.'' How right he is.

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

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

Mr. DASCHLE. Madam President, few issues divide our country more markedly than the issue of abortion. This debate is a difficult one, and I commend those on both sides of the issue who have given their time on the floor to express their very deeply held views on this matter. While the debate has had some unfortunate low points, it has also had some very high ones.

In particular, I commend those on the Democratic side Senators BOXER, MURRAY, DURBIN, HARKIN, and FEINSTEIN—who have helped manage the floor this week. Each of them has worked diligently to ensure these difficult issues were given the honest, constructive attention they deserve. I know very well how thankless that job can be, and I am grateful for their efforts.

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

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

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

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

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

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

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

Like many of my colleagues, I would prefer to ban all post-viability abortions, regardless of the procedure used. In 1997, in an effort to find a constitutional compromise that would actually stop far more abortions than the bill we have been debating today, I offered

a broader ban much like the one offered by the Senator from Illinois yesterday.

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

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

The sponsors of S. 3 answer the Supreme Court's concern that their legislation is too vague to meet constitutional muster by claiming that their legislation bans only one procedure and that it is clearly defined. They also claim that the ban does not restrict a woman's Court-affirmed right to choose because all other abortion procedures are allowed under S. 3. Finally, they claim their legislation avoids the Court's concerns about protecting the life and health of the mother because the procedure described in their legislation is never necessary to protect the mother; thus, other available procedures could be employed interchangeably.

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

If our true desire is to protect viable fetuses whenever possible, I think we can do better than S. 3.

An across-the-board ban on all post-viability procedures with a constitutional life and health exception is the only way to achieve that broader goal, and I deeply regret that the Senate has yet again failed to do so. It is a principle that would win the support of the American people and the Supreme Court, and it would actually reduce the number of abortions in this country. Yesterday's outcome is one I will never understand.

There is yet another reason S. 3 may fail to meet its objective. The Supreme Court has struck down what many experts claim is a ''legally identical'' bill, the Nebraska law banning this procedure. In previous Congresses, I have expressed my concern that this legislation may not withstand an inevitable constitutional challenge.

Now that the Court has ruled in the Nebraska case, that concern is even greater. But the sponsors of this bill have chosen to take that gamble, claiming their ''20 word changes'' have resolved the constitutional concerns. Those 20 words, by the way, are allegedly powerful enough to change the outcome in the Supreme Court, but not significant enough to merit a hearing in the Judiciary Committee.

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

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

Finally, I want to say a few words about the women whose lives are impacted by our actions this week. One of the saddest aspects of this debate is the suggestion that countless women, for frivolous reasons, are choosing unnecessary abortions in the last few weeks of their pregnancies. That just isn't true.

Anyone willing to listen has heard the tragic stories of women and families who have had to terminate their pregnancies either because their own health was threatened, or their child was the victim of severe fetal anomalies often inconsistent with life outside the womb. These are not unwanted pregnancies, and these are not abortions of convenience.

Regardless of one's ultimate decision on this legislation, I hope that in the future the Senate will show greater respect for these women and the tragic circumstances they have faced. As they have so poignantly said, you or someone you love could face similar circumstances, and you would deserve better than these women and their families have gotten.

Mr. HARKIN. Madam President, I wanted to discuss my votes on S. 3 and its amendments. I have long supported a ban on late term abortions. However, S. 3 would not do that because it would be struck down by the U.S. Supreme Court because it does not contain a health exception. Both in 1973 and in 2001, the Supreme Court ruled that a government may regulate late term abortions with an exception to both life and health of the woman. The Court specifically ruled in the 2001 decision in Carhart—that Nebraska's law was too vague and did not contain the required health exception. Therefore, I supported the amendments offered by Senator FEINSTEIN and Senator DURBIN to ban late term abortions because they both contained the requisite health exceptions, and which I believe the Supreme Court would uphold.

I am also pleased the Senate passed my amendment, 52 to 46, affirming Roe v. Wade. A woman's constitutional right to make a private decision in these matters is no more negotiable than the freedom to speak or the freedom to worship. As a father, I have struggled with this issue. However, I do not believe that it is appropriate to insist that my personal views be the law of the land.

So what should Congress do? Pass a late term abortion ban that the Supreme Court will uphold; increase funding for family planning and abstinence-only education and mandate insurance coverage for contraception. All of these fall within the rules under Roe v. Wade—that established a woman's fundamental right to choose.

Mr. DODD. Mr. President, the Senate had an opportunity this week to find common ground on an issue that has too often been an ideological battleground: abortion.

As the Senate debated the partial Birth Abortion Ban Act of 2003, I cosponsored a bipartisan amendment authored by Senator Durbin that could have actually reduced the number of abortions in our country while at the same time protecting a woman's life, health, and her constitutional right to choose. While the amendment was defeated, I remain hopeful that it will ultimately prevail someday as the most sound and moderate approach to addressing the troubling issue of late-term abortions.

The Durbin amendment struck a reasonable middle-ground approach on an issue that has frequently been dominated by the extremes. There are those who would universally ban all abortions. Others would universally allow all abortions. I respect the views of the people in each camp, but I disagree with them both.

Abortions ought to be legal, safe, and rare. That is my fundamental view, and it's the view that the Supreme Court has affirmed and reaffirmed for the past three decades since its decision in Roe vs. Wade. Abortions have never been—and should not be— available at any time for any reason. As Roe held, once a fetus achieves the point of viability, abortions may be regulated, but States must allow abortions to preserve a woman's life or health.

Forty-one States have already enshrined this standard, or one like it, into their State statutes. The Durbin amendment would have written it into Federal law. It would have respected a woman's constitutional right to choose while appropriately curbing choice after the point of viability where abortions are only necessary to preserve a woman's life or health.

This proposal was reasonable, it was constitutional and sensitive to the wrenching circumstances that families typically face when they must contemplate a late-term abortion. Unfortunately, it was adamantly opposed by those seeking a ban on so-called partial-birth abortions. Their proposal had two serious flaws that made it impossible for me to support.

First, the ban on partial-birth abortions bans just one medical procedure. It will not stop all late-term abortions from being performed, because an alternative procedure might be found. The Durbin amendment, on the other hand, would have limited all constitutionally-unprotected abortions without regard to a specific procedure. Why?

Because the wisdom of using a given medical procedure is best left with medical professionals. We are legislators, not doctors.

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

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

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

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

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

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

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

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

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

EXECUTIVE SESSION

NOMINATION OF THOMAS A. VARLAN, OF TENNESSEE, TO BE UNITED STATES DISTRICT JUDGE FOR THE EASTERN DISTRICT OF TENNESSEE

The PRESIDING OFFICER. Under the previous order, the Senate will now go into executive session and proceed to vote on Executive Calendar No. 53, which the clerk will report.

The legislative clerk read the nomination of Thomas A. Varlan, of Tennessee, to be United States District Judge for the Eastern District of Tennessee.

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is, Will the Senate advise and consent to the nomination of Thomas A. Varlan, of Tennessee, to be United States District Judge for the Eastern District of Tennessee?

The clerk will call the roll.

The assistant legislative clerk called the roll.

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

I further announce that, if present and voting, the Senator from North Carolina (Mr. EDWARDS) and the Senator from Massachusetts (Mr. KERRY) would each vote ''aye''.

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

The result was announced—yeas 97, nays 0, as follows:

[Rollcall Vote No. 52 Ex.]

YEAS—97

Akaka	Dole	Lugar
Alexander	Domenici	McCain
Allard	Dorgan	McConnell
Allen	Durbin	Mikulski
Baucus	Ensign	Miller
Bayh	Enzi	Murkowski
Bennett	Feingold	Murray
Bingaman	Feinstein	Nelson (FL)
Bond	Fitzgerald	Nelson (NE)
Boxer	Frist	Nickles
Breaux	Graham (FL)	Pryor
Brownback	Graham (SC)	Reed
Bunning	Grassley	Reid
Burns	Gregg	Roberts
Byrd	Hagel	Rockefeller
Campbell	Harkin	Santorum
Cantwell	Hatch	Sarbanes
Carper	Hollings	Schumer
Chafee	Hutchison	Sessions
Chambliss	Inhofe	Shelby
Clinton	Inouye	Smith
Cochran	Jeffords	Snowe
Coleman	Johnson	Specter
Collins	Kennedy	Stabenow
Conrad	Kohl	Stevens
Cornyn	Kyl	Sununu
Corzine	Landrieu	Talent
Craig	Lautenberg	Thomas
Crapo	Leahy	Voinovich
Daschle	Levin	Warner
Dayton	Lieberman	Wyden
DeWine	Lincoln	
Dodd	Lott	

NOT VOTING—3

Biden	Edwards	Kerry

The nomination was confirmed.

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

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