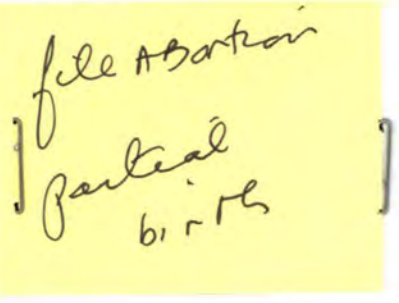
Partial Birth

Women's Domestic Issues

file Abortion
Partial
Birth

PHOTOCOPY
PRESERVATION


file ABortion
partial
birth

# ACOG *Statement of Policy*

As issued by the ACOG Executive Board

## STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; **and**
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

continued. . .

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, DC 20090-6920 Telephone 202 638 5577

**STATEMENT ON INTACT DILATATION AND EXTRACTION** (continued)
Page Two

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
January 12, 1997

NATIONAL CONFERENCE OF CATHOLIC BISHOPS

Secretariat for Pro-Life Activities
3211 Fourth Street, N.E. Washington, DC 20017-1194 (202) 541-3070 FAX (202) 541-3054

January 16, 1997

The Honorable William J. Clinton
The White House
Washington, D.C. 20500

Dear Mr. President:

As you begin your second term, I wish to assure you of my prayers. Good counsel and wisdom will be needed to resolve the difficult issues facing our nation.

One such issue is partial-birth abortion. It is my understanding that Congress is likely to consider this matter again. It is my sincere hope that the forthcoming discussion will avoid the worst aspects of last year's debate. I pray that time will not be wasted debating claims that have been proven to be false.

It is reported that Senator Daschle, with your approval, is crafting a bill to ban third-trimester abortions with exceptions for "life or health." Such a bill would prevent neither partial-birth abortions, nor late-term abortions in general. The vast majority of partial-birth abortions are performed in the second trimester of pregnancy, a fact confirmed by independent investigations and by the doctor whose paper initiated this debate.

In regard to third-trimester abortions, an exception for "health" (or "serious adverse health" or any similar formulation) eviscerates the ban. The Supreme Court has interpreted "health" so broadly in the abortion context that it includes abortions for almost any social or emotional reason. Those who perform partial-birth abortions have admitted publicly that they have done so for reasons of the woman's "youth" or "depression" or even the child "cleft palate."

Furthermore, the evidence that partial-birth abortion is ***never*** necessary to preserve a woman's health or fertility is overwhelming. I urge you to consult with the Physicians' Ad-Hoc Coalition for Truth (PHACT), a group of nearly 400 physicians who have spoken out on this.

Mr. President, I believe it would be beneficial if you and I, perhaps with a doctor from PHACT, were to discuss this matter. I would welcome such an opportunity.

Sincerely yours in Christ,

Bernard Cardinal Law

Bernard Cardinal Law
Chairman

NATIONAL CONFERENCE OF CATHOLIC BISHOPS

Secretariat for Pro-Life Activities
3211 Fourth Street, N.E. Washington, DC 20017-1194 (202) 541-3070 FAX (202) 541-3054

January 16, 1997

The Honorable William J. Clinton
The White House
Washington, D.C. 20500

Dear Mr. President:

As you begin your second term, I wish to assure you of my prayers. Good counsel and wisdom will be needed to resolve the difficult issues facing our nation.

One such issue is partial-birth abortion. It is my understanding that Congress is likely to consider this matter again. It is my sincere hope that the forthcoming discussion will avoid the worst aspects of last year's debate. I pray that time will not be wasted debating claims that have been proven to be false.

It is reported that Senator Daschle, with your approval, is crafting a bill to ban third-trimester abortions with exceptions for "life or health." Such a bill would prevent neither partial-birth abortions, nor late-term abortions in general. The vast majority of partial-birth abortions are performed in the second trimester of pregnancy, a fact confirmed by independent investigations and by the doctor whose paper initiated this debate.

In regard to third-trimester abortions, an exception for "health" (or "serious adverse health" or any similar formulation) eviscerates the ban. The Supreme Court has interpreted "health" so broadly in the abortion context that it includes abortions for almost any social or emotional reason. Those who perform partial-birth abortions have admitted publicly that they have done so for reasons of the woman's "youth" or "depression" or even the child "cleft palate."

Furthermore, the evidence that partial-birth abortion is *never* necessary to preserve a woman's health or fertility is overwhelming. I urge you to consult with the Physicians' Ad-Hoc Coalition for Truth (PHACT), a group of nearly 400 physicians who have spoken out on this.

Mr. President, I believe it would be beneficial if you and I, perhaps with a doctor from PHACT, were to discuss this matter. I would welcome such an opportunity.

Sincerely yours in Christ,

Bernard Cardinal Law

Bernard Cardinal Law
Chairman

TALKING POINTS ON FITZSIMMONS STORY

- Nothing that Mr. Fitzsimmons now says contradicts or undermines the President's position, which is that so-called partial-birth abortions should be banned except when they are necessary to save the life of a woman or prevent serious harm to her health.

- The President has never claimed that partial-birth abortions are used only, or even primarily, to prevent death or serious harm. What he has said is that when (but only when) the procedure is necessary for these reasons, a doctor must be allowed to perform it.

- The President has recognized that some doctors may use the procedure for elective reasons and has called for an end to this practice. He has stated on several occasions: "The procedure may well be used in situations where a woman's serious health interests are not at issue. But I do not support such uses, I do not defend them, and I would sign appropriate legislation banning them."

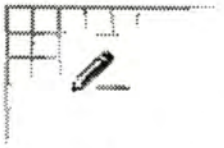
- The President's position today remains what it has always been: that he will sign a bill banning partial-birth abortions, but only if it has an exception that will protect those women -- even if few in number -- who need this procedure to save their lives or prevent serious harm to their health.

**Background**

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said this week that partial birth abortions are (1) performed more frequently than pro-choice groups have acknowledged and (2) often performed on healthy women with healthy fetuses.

There are no good statistics on these questions, and it would be a great mistake to challenge Fitzsimmons on the facts. The important point is that even if true, Fitzsimmons's claims do not undermine the President's position, as explained above.

To: Melanne
Fr: Tracey 5/1/97



Record Type: Record

To:

cc:
Subject: Late-term

Daschle met with about 24 Senators in his office last night to talk through his alternative. Attached is updated materials including more info on mental health (Daschle let Members see the language but did not let them take copies). I understand they spent quite a bit of time talking about how they could possibly draw a narrow mental health exception and the talks were quite inconclusive. The sense was that there was general uneasiness -- even among some of the pro-choicers -- with the mental health language. Members are concerned that they are going to vunerable to chargers that the standard to not tight enough and conditions like mild depression could be covered. They're gonna keep talking next week.

POTUS may get asked about this at the Senate retreat.

Message Sent To:

**AGENDA**
**Late-Term Abortion Meeting**
**April 30, 1997**

I. Problems with S. 6/H.R. 1122

- Unconstitutional
- No health exception
- Ineffective

II. Goals of Alternative

- Constitutionality
- Protection of women's health
- Effectiveness

III. Health Definition

IV. Penalties

V. Schedule and Floor Strategy

- After Supplemental Appropriations bill
- Message/Participation
- Amendments

## Bipartisan Alternative to S. 6/H.R. 1122

S. 6, the Partial Birth Abortion Ban, would outlaw the procedure physicians call dilatation and extraction (D&X) at any stage of pregnancy -- with no exception for the health of the mother -- but allow other, sometimes more dangerous abortion procedures to be used in its place.

The bipartisan alternative to S. 6 would ban all abortions after fetal viability (when the fetus can sustain survivability outside the womb with or without life support) unless the mother's life or health is truly endangered. The health exception to the comprehensive ban is being written to cover only very rare situations (1) that arise from complications of the pregnancy itself, such as serious heart damage (cardiomyopathy), severe hypertension (preeclampsia); dangerous aggravation of pre-existing conditions, such as complications from diabetes (blindness, amputation); and, as in the cases of some women carrying severely deformed fetuses, uterine rupture and other injuries; or (2) where termination of the pregnancy is necessary to allow medically necessary treatment of life-threatening conditions, including aggressive cancers (acute leukemia or breast cancer).

### Constitutional Parameters Limiting Government Restriction of Abortion

*Right To Terminate Pregnancy Prior To Viability:* Roe v. Wade held that the Constitution protects "a woman's decision whether or not to terminate her pregnancy." This holding was reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey, in which the Supreme Court held that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy."

*Viability Defined:* According to the Court, "viability is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." Although the actual point of viability varies with each case, it is generally reached between the 23rd and the 28th week.

*Government May Ban Abortion After Viability:* In Casey, the Supreme Court reiterated Roe's determination that after viability, the State may ban abortion. Many states have done so, and post-viability abortions comprise less than 0.5% of all abortions (99% occur in the first 20 weeks).

*Ban Must Have An Exception When A Woman's Life Or Health Is At Risk:* According to Roe and Casey, although the State has a legitimate interest in preserving potential life, and may promote this interest by prohibiting abortion once the fetus attains viability, it may not do so when preventing an abortion would endanger the life or health of the mother. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

***Would S. 6 prevent abortions?*** No. S. 6 would not stop a single abortion; it would merely result in abortion by a different method, such as induction, hysterotomy (pre-term c-section), or dilatation and evacuation (D&E) -- all of which pose a greater risk to the mother's health in certain cases.

***Can S. 6 become permanent law?*** No. Even if Congress overrides a Presidential veto, S. 6 is clearly unconstitutional, so it will be struck down by the courts and have no ultimate effect.

***Can something be done to stop unnecessary abortions of viable fetuses?*** Yes. Congress can pass the bipartisan, comprehensive post-viability abortion ban with a narrow life and health exception that will outlaw these very late-term abortions. This will actually reduce the number of abortions in this country without putting women at unacceptable risk. This ban would be constitutional, and the President would sign it.

# Memorandum

Re: Constitutional Issues Involved in Drafting Health Exception to Late Term Abortion Ban

---

To follow up on your meeting yesterday, we wanted to address more precisely the constitutional problems associated with a pre-viability restriction on abortion and on limiting the health exception to physical health alone.

**Is it constitutional to ban one procedure before viability?**

No. There are two reasons why a ban on a procedure before viability would be unconstitutional. First, before viability, the States may restrict abortions only when the purpose of the restrictions is to protect the health of the mother (or to "inform the choice") and may not impose restrictions that are intended simply as an obstacle to getting an abortion. Second, limiting a woman's access to one type of procedure could force the woman to risk her health, since in some cases that procedure may be the safest.

Restrictions Before Viability -- Only for Informed Choice & Women's Health: The Supreme Court made it extremely clear in Planned Parenthood of Southeastern Pennsylvania v. Casey, that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy." In Casey, the court held that prior to viability, restrictions on abortion must not constitute an "undue burden" on a woman's right to terminate her pregnancy. An undue burden is one that has "the purpose or the effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."

Regulations that have been upheld under the Casey formulation include informed consent provisions and parental notification and have been characterized by the Court as not intended to burden the right but intended to inform the choice. A ban on a procedure could not be characterized as intended to do anything but limit the right to seek abortions. In addition, criminalizing a procedure used prior to viability, particularly since there are strong similarities between various procedures, would likely have a chilling effect on doctors who perform abortions. Such a chilling effect also could be seen by the Court as burdening a woman's constitutional right to choose to abort a nonviable fetus.

Under the Supreme Court's jurisprudence, blocking a woman's access to what a doctor might believe to be the safest abortion procedure would pose an undue burden to the right to choose to terminate a pregnancy.

Restricting Access to One Procedure Could Harm Women's Health: The Supreme Court has stated repeatedly that maternal health cannot be compromised in favor of the fetus. In Colautti v. Franklin, the Supreme Court criticized a Pennsylvania statute, which provided that a physician must employ an "abortion technique . . . that . . . would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary . . . to preserve the life or health of the mother." The Court found the provision very "problematic." The Court noted that the provision "does not clearly specify . . . that the woman's life and health must always prevail over the fetus's life and health when they conflict," and also found that the term "necessary" meant "that a particular technique must be indispensable to the woman's life or health -- not merely desirable -- before it may be adopted." The Court stated that the statute's ambiguity concerning "whether it requires the physician to make a `trade-off' between the woman's health and additional percentage points of fetal survival" posed "[s]erious . . . constitutional difficulties."

More recently, in Thornburgh v. American College of Obstetricians and Gynecologists, the Court struck down a statute that "failed to require that maternal health be the physician's paramount consideration" and forced her to "bear an increased medical risk in order to save her viable fetus."

While people differ over whether the so-called "partial birth" procedure is sometimes necessary to protect a woman's life or health, mainstream gynecologists and obstetricians would agree that it may often be the most appropriate or safest procedure among those available. The American College of Obstetricians and Gynecologists (ACOG) recently issued a position statement, stating that it could not establish that the procedure "would be the only option to save the life or preserve the health of a woman." According to ACOG, "[a]n intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision."

The fact that mainstream gynecologists and obstetricians believe there are times when the procedure would best protect a woman's life or health, would make a ban on a specific procedure unconstitutional, as it could have a detrimental impact on women's health.

**Would it be unconstitutional to ban post-viability abortions for mental health reasons?**

Yes. First, it is clear that, even after viability, women must be allowed access to abortion to protect their health. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

While the Supreme Court has never been faced directly with the breadth of the health exception after viability, the Court has indicated that it considers mental health to be an integral part of health. For example, in Casey, the Court stated that "[i]t cannot be questioned that psychological well-being is a facet of health." Similarly, in United States v. Vuitch, the Court noted that "the general usage and modern understanding of the word 'health' . . . includes psychological as well as physical well-being."

Following the Supreme Court's lead, the Third Circuit in American College of Obstetricians & Gynecologists v. Thornburgh stated that Pennsylvania's abortion law would have been unconstitutional if it had declared that "potential psychological or emotional impact on the mother" could not be considered a medical risk to the mother.

Even more recently, the District Court for the Southern District of Ohio became the first court in the nation to face post-viability health definitions head on. In the context of a facial challenge (that is, challenging the statute as unconstitutional not just in a particular case but for all or most applications), the court struck down the ban because the court believed that the statute did not make an exception for abortions necessary for mental or emotional health reasons. Women's Medical Professional Corp., v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995).

Based on these precedents, it is very likely that the Court would rule that an exception drafted to cover only physical health problems is unconstitutional.

# MEMORANDUM

Re: Mental health conditions and pregnancy

Upon a review of psychiatric journals and after discussions with the American Psychiatric Association, as well as independent psychiatrists, it appears that we were correct in our initial determination that the health definition would only cover extremely rare cases. Pregnancy may prohibit successful treatment of, or seriously worsen, some psychiatric diseases, such as schizophrenia and manic depression psychoses. For these reasons, it appears a mental health inclusion is necessary in order to comprehensively protect women's health.

## Difficulty of treating Psychiatric Disease during Pregnancy

According to the American Academy of Family Physicians, approximately 16 percent of pregnancies are accompanied by some type of psychiatric dysfunction. Most of these women do not experience severe depression or psychosis, but some may require anti-depressant medication. Often, such medication is not prescribed for pregnant women because of the risk of teratogenic (developmental malformations) effects on the fetus. In some cases, depriving the woman of medication may lead to suicide or total functional breakdown.

It should be noted that for many women with serious psychiatric conditions (such as suicidal tendencies), abortion would not provide successful treatment. However, in extreme situations where a woman does not respond to aggressive treatment, pregnancy termination may be necessary to avoid a severe psychotic break. Obstetrics manuals list such cases as indications for pregnancy termination.

## Suggested Mental Health Response

When discussing the health exception, we should continue to refer to the severity standard, and we can correctly point out that this excludes almost all psychiatric conditions. In addition, it is important to note that the debate over mental health parity highlighted the connection between many mental illnesses and their physical manifestations or causes. Even though we may not be able to anticipate the types of serious psychiatric conditions that may require pregnancy termination for treatment, we should not exclude mental health as a category simply because it is perceived as "less serious" than physical health. The following is a reprint of the suggested response to questions about the inclusion of mental health:

Mental illness, when diagnosed as a psychiatric disease, is not ruled out in this definition. However, mild depression or other less-than-severe conditions are not covered by this definition, just as a minor illness or other mild "physical" conditions are not covered. And remember that the Senate voted just last year to insist on equitable health coverage for mental illness, based largely on the fact that mental illnesses are diseases of the brain and can be just as serious as "physical" conditions.

Our exception turns on the severity, not the type, of condition dealt with by a woman late in pregnancy. These severe conditions fall under the two categories in our definition (either a disease or impairment caused by the pregnancy, or inability to treat a life-threatening condition). We are providing legal guidelines for physicians to supplement their existing understanding of medical indications for pregnancy termination. It is the physicians themselves who must make the ultimate determination about which conditions and circumstances meet that severity standard.

It may well be that the exception for mental illness or psychiatric disease will never be used. If at all, it would be an extremely rare case, and it should be noted that in the case of most psychiatric diseases, treatment could be administered without the need for pregnancy termination.

In the end, no matter how tight we make this definition, some will always argue that it's too loose -- that there's a loophole that women and doctors could use to allow unnecessary abortions. But don't forget to counterbalance that concern with consideration for protecting the women for whom termination of pregnancy is truly a medical necessity. And don't forget there are certain constitutional parameters within which we must operate. Excluding mental health categorically would almost certainly make the law unconstitutional, and I am not willing to arbitrarily rule out coverage of diseases that could, in fact, put women at unacceptable risk.

This should not be considered an exhaustive list of serious maternal health conditions. These are merely examples of conditions listed in obstetrical textbooks as possible medical indications for pregnancy termination.

## Disease or Impairment Caused by Pregnancy

### Preeclampsia (with accompanying renal, kidney, or liver failure)

onset of severe hypertension during pregnancy

"Preeclampsia often occurs early and with increased severity. Deterioration of maternal renal function or uncontrolled hypertension is an indication for pregnancy termination."° Preeclampsia occurs in 5-10% of pregnancies and is severe in less than 1%. Eclampsia (complication characterized by seizures) occurs in approximately 0.1% of pregnancies.

### Peripartal cardiomyopathy

heart failure in late pregnancy

"Characterized by its occurrence...in women with no previous history of heart disease and in whom no specific [origin] of heart failure can be found, peripartal cardiomyopathy is a distinct, well-described syndrome of cardiac failure in late pregnancy."°

### Pregnancy-aggravated hypertension

acceleration of existing hypertension

"Maternal indications include organ failure such as renal failure, seizures associated with the development of eclampsia [progression from hypertension/preeclampsia characterized by seizures and can result in cerebral hemorrhage], and uncontrollable hypertension."* Complications develop in 10-40% of patients with chronic hypertension.

### Primary pulmonary hypertension

complication of existing hypertension (abnormally high blood pressure)

"The natural course of the disease terminates either by sudden death or by the development of intractable congestive heart failure resistant to therapy. Maternal mortality with primary pulmonary hypertension approaches 50%."°

### Amniotic fluid embolism

results from a mass of amniotic fluid in the maternal circulation

Typically caused by invasive third-trimester obstetric procedures or by blunt abdominal trauma. Amniotic fluid lodges in the circulation system and leads to respiratory failure and cardiovascular collapse, shock, or coma.*

Sources:


* Clinical Manual of Obstetrics, ed. David Shaver and Frank Ling (University of Tennessee College of Medicine), Sharon Phelan (University of Alabama Department of Obstetrics and Gynecology), and Charles Beckmann (University of Wisconsin Department of Obstetrics and Gynecology)

° Manual of Obstetrics: Diagnosis and Therapy, ed. Kenneth Niswander and Arthur Evans, University of California, Davis, School of Medicine

# Life-Threatening Conditions Requiring Immediate Treatment

## Bone Marrow Failure

severe form of anemia

"The role of pregnancy termination [in bone marrow failure treatment] is unclear. Therapeutic abortion is inconsistently associated with remission. It may be necessary, however, in order to treat the patient with anabolic steroids."° Additionally, "bone marrow transplant has become the treatment of choice. Termination of the pregnancy would be necessary if a suitable donor could not be found."° It should be noted that bone marrow transplant is also a treatment for other conditions such as leukemia.

## Cardiac Arrest

heart failure

Most incidents of cardiac arrest are secondary to other acute events, such as anesthetic complications, trauma, or shock. According to several obstetrics manuals, pregnancy termination -- whether by delivery or abortion -- is often recommended.*° CPR can generally be expected to generate only 30 percent of normal cardiac output, and during pregnancy the uterus obstructs this cardiac output even further.

## Cancer

Cancer complicates approximately 1 out of every 1000 pregnancies. Issues that must be addressed in pregnancies affected by cancer include the effect of pregnancy on the malignancy, the need for pregnancy termination, and the timing of therapy. Radiation and chemotherapy may be contraindicated during pregnancy due to documented risks of fetal mutation. Additionally, pregnancy inhibits a woman's ability to fight off cancer because the immune system is often depressed, and her nutritional intake is divided between herself and the fetus.

## Lymphoma

cancer of the lymphatic system

"High-grade Non-Hodgkin's lymphoma is a rapidly progressive disease with a median survival of six months. Since cure rates approach 50%, it is imperative therapy not be delayed."* In this situation, delay of therapy could mean the loss of an opportunity to cure the mother. Because both radiation and chemotherapy present mutation risks for the fetus, termination of the pregnancy is suggested in order to begin treatment for lymphoma.

## Breast Cancer

especially breast cancer diagnosed during pregnancy

"Factors in pregnancy that could adversely affect this malignancy include...increased estrogen and prolactin stimulation [both factors that exacerbate breast cancer], and depression of the immune system."° The frequency of breast cancer in pregnancy is second only to cancer of the cervix, occurring in 1 out of every 3,000 pregnancies. In addition, adequate nutrition is a serious problem.

Sources:

* Clinical Manual of Obstetrics, ed. David Shaver and Frank Ling (University of Tennessee College of Medicine), Sharon Phelan (University of Alabama Department of Obstetrics and Gynecology), and Charles Beckmann (University of Wisconsin Department of Obstetrics and Gynecology)

° Manual of Obstetrics: Diagnosis and Therapy, ed. Kenneth Niswander and Arthur Evans, University of California, Davis, School of Medicine

**DATE:** 5/2/97

**FAX TO:**

| | |
|---|---|
| Pam Cicetti | x69412 |
| Ann Stock | x66235 |
| Alice Pushkar | x65199 |
| Patti Solis-Doyle | x62317 |
| Marsha Berry | x67805 |
| Melanne Verveer | x66244 |
| Mike McCurry | x66423 |
| Ann Walker* | |
| David Shipley* | |
| Brenda Costello* | |

**FROM:** Carrie Greenstein

---

4/30/97 HRC Column

Creators Syndicate ☎ 310-337-7003 4/30/97 10:05 AM 2/3

TALKING IT OVER
BY HILLARY RODHAM CLINTON
FOR IMMEDIATE RELEASE

The memorial to President Franklin Delano Roosevelt that is opening this month on the mall in Washington sparked controversy over whether or not the former President should be shown in a wheelchair. Some people may have been surprised when my husband recently supported the idea of an additional statue of FDR with his disability in full view. It was no surprise to me, however, because I have seen Bill deal with the temporary disability he has had to live with in the aftermath of his own injury.

He heard the pop when he tore the tendons connecting his quadricep muscle to his right knee as he missed a step. Although he was in severe pain, he did not realize how serious the damage was until he heard the doctor's verdict: "It would have been better for you if you had broken a bone or even your kneecap." The doctor meant that a broken bone could be immobilized and put in a cast for healing, which, although cumbersome, would not require surgery or as long a period of recuperation.

The operation to repair the tendons took about two hours because the surgeons found that more than 80 percent of the tendons had been torn on an angle. I was a nervous wreck during the surgery and in the hours immediately after. I hated to see him in pain. But I became really concerned when the morning after the surgery, the doctors, nurses and physical therapists came into the room to announce they would start moving the injured leg. They planned to have Bill out of bed learning to use crutches and how to get in and out of a wheelchair a few hours later.

Learning to move again after the kind of operation Bill had is not easy. I felt relieved when he agreed to use a wheelchair for several days after he left the hospital, including for his summit in Helsinki with President Yeltsin. The accident happened the day before Chelsea and I were scheduled to leave for Africa, and my first reaction was that we should cancel the trip. But Bill wouldn't hear of any postponement longer than a day. He expected to be at home by then and assured me he would be fine.

I spent the time before we left preparing the White House for Bill's return. With the help of the medical staff, I looked for anything that might be a hazard to someone on crutches. Boy, did I learn a lot about what people with physical

disabilities go through every day. We taped down carpets and removed furniture, like chairs on wheels, and rearranged our bedroom to eliminate obstacles. We installed railings and handles for him to use in the bathroom.

Chelsea and I called Bill from Africa every chance we had to check on his progress. We heard about his daily physical therapy, in which his leg was being bent and moved to increase its strength and mobility. He also had to do weight training for his upper body and aerobic exercise.

In the six weeks since his accident, Bill has taken physical therapy twice a day and made slow but steady progress bending his leg and becoming more mobile on his crutches. He will soon "graduate" to a cane. But he has at least four more months of hard work to rehabilitate his leg so he can run and -- most important -- play golf again.

As I have watched my strong, seemingly indestructible husband struggle in the morning to put on his clothes or carefully lower himself into a chair, I've sometimes had to stop myself from rushing to help him, since I know he wants to be as independent as possible. He and I have talked about the small daily challenges that people in wheelchairs or on crutches face that we never fully understood before. While he's been coping with them, he's been working every day as President, too.

One night, we were marveling about the daily burdens President Roosevelt endured as he dressed, moved or performed any of the other mundane tasks most of us do without thinking. When I refurbished the Map Room on the ground floor of the White House, where President Roosevelt reviewed troop positions during World War II, I asked a man who had worked with the President to describe to an artist how the room looked then. Based on his description, the artist drew Roosevelt sitting in his wheelchair reviewing maps.

Bill and I now regard President Roosevelt even more highly because of all he did every day to carry out his obligations. And if he could plan America's victory in war from his wheelchair, we should share that story with the world.



April 29, 1997

Late Term language

# Office of Senate Democratic Leader Tom Daschle

DATE: 5/8/97

TO: Tracy Thornton

Fax#:

FROM: Laura Petrou (Petrou)

NOTES:

Number of Pages, Including Cover Sheet: 24

If problems with transmission, contact 202–224–5556

**DRAFT -- NOT FOR DISTRIBUTION**

**Findings**

(1) As the Supreme Court recognized in Roe v. Wade, the government has an "important and legitimate interest in preserving and protecting the health of the pregnant woman . . . and has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grow in substantiality as the woman approaches term and, at a point during pregnancy, each becomes compelling";

(2) In delineating at what point the government's interest in fetal life becomes "compelling," Roe v. Wade held that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability," a conclusion reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey;

(3) Planned Parenthood v. Casey also reiterated Roe's holding that the government's interest in potential life becomes compelling with fetal viability, stating that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother";

(4) According to the Supreme Court, viability "is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman";

(5) The Supreme Court has thus indicated that it is constitutional for Congress to ban abortions occurring after viability so long as the ban does not apply when a woman's life or health faces a serious threat;

(6) Even when it is necessary to terminate a pregnancy to save the life or health of the mother, every medically appropriate measure should be taken to protect a viable fetus so long as the mother's health is not put at greater risk;

(7) It is well established that women may suffer serious health conditions during pregnancy, such as breast cancer, preeclampsia, uterine rupture or non-Hodgkin's lymphoma, among others, that may require the pregnancy to be terminated;

(8) While such situations are rare, not only would it be unconstitutional but it would be unconscionable for Congress to ban abortions in such cases, forcing women to endure severe damage to their health and, in some cases, risk early death;

(9) In cases where the mother's health is not at such high risk, however, it is appropriate for Congress to assert its "compelling interest" in fetal life by prohibiting abortions after fetal viability;

(10) While many States have banned abortions of viable fetuses, in some States it continues to be legal for a healthy woman to abort a viable fetus;

(11) As a result, women seeking abortions may travel between the States to take advantage of differing State laws;

(12) To prevent abortions of viable fetuses not necessitated by severe medical complications, Congress must act to make such abortions illegal in all States;

**(more)**

**DRAFT -- NOT FOR DISTRIBUTION**

(13) Congress finds that abortion of a viable fetus should be prohibited throughout the United States, unless a woman's life or health is threatened and that, even when it is necessary to terminate the pregnancy, every measure should be taken, consistent with the goals of protecting the mother's life and health, to preserve the life and health of the fetus.

**Prohibition of Post-Viability Abortions**

(a) In General. It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health.

"Grievous injury" shall be defined as:
(a) a severely debilitating disease or impairment specifically caused by the pregnancy; or
(b) an inability to provide necessary treatment for a life-threatening condition.

(b) "Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.

**Penalties**

(a) Action by Attorney General: the Attorney General may commence a civil action under this Act in any appropriate United States District Court.

(b) Relief.

(1) First offense: In any action under subparagraph (_), the court shall order the suspension or revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding $100,000, or both.

(2) Second offense: If the respondent has been convicted on a prior occasion for a violation of this Act, the court shall order the revocation of respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding $250,000, or both.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General shall certify to the court that at least 30 calendar days previously --

(1) he or she has notified in writing to the Governor or chief executive officer and attorney general or chief legal officer of the appropriate State or political subdivision of the alleged violation of this section, and

(2) he or she believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

No woman who has had an abortion after fetal viability may be prosecuted under this section for a conspiracy to violate this section or for an offense under section 2, 3, 4, or 1512 of this title.

**(more)**

**DRAFT -- NOT FOR DISTRIBUTION**

## State Regulations

Each State shall establish regulations for certification by the physician under subsection (), including appropriate penalties for falsification of information, and to enforce the penalties associated with the suspension or revocation of respondent's medical license, certificate, or permit under subsection ().

In the certification to be submitted under subsection (), the physician shall certify that, in his or her best medical judgment, continuation of the pregnancy would threaten the mother's life or risk grievous injury to her health, as defined in subsection (), and describe the medical indications supporting his or her judgment.

In addition, each State shall establish regulations to ensure the confidentiality of all information submitted pursuant to certification by the physician, as required by subsection ().

## Rule of Construction

Nothing in this chapter shall be construed to prohibit State or local governments from regulating, restricting, or prohibiting post-viability abortions to the extent permitted by the Constitution of the United States.

# Life-Threatening Conditions Requiring Immediate Treatment

## Bone Marrow Failure

severe form of anemia

"The role of pregnancy termination [in bone marrow failure treatment] is unclear. Therapeutic abortion is inconsistently associated with remission. It may be necessary, however, in order to treat the patient with anabolic steroids."° Additionally, "bone marrow transplant has become the treatment of choice. Termination of the pregnancy would be necessary if a suitable donor could not be found."° It should be noted that bone marrow transplant is also a treatment for other conditions such as leukemia.

## Cardiac Arrest

heart failure

Most incidents of cardiac arrest are secondary to other acute events, such as anesthetic complications, trauma, or shock. According to several obstetrics manuals, pregnancy termination -- whether by delivery or abortion -- is often recommended.*° CPR can generally be expected to generate only 30 percent of normal cardiac output, and during pregnancy the uterus obstructs this cardiac output even further.

## Cancer

Cancer complicates approximately 1 out of every 1000 pregnancies. Issues that must be addressed in pregnancies affected by cancer include the effect of pregnancy on the malignancy, the need for pregnancy termination, and the timing of therapy. Radiation and chemotherapy may be contraindicated during pregnancy due to documented risks of fetal mutation. Additionally, pregnancy inhibits a woman's ability to fight off cancer because the immune system is often depressed, and her nutritional intake is divided between herself and the fetus.

## Lymphoma

cancer of the lymphatic system

"High-grade Non-Hodgkin's lymphoma is a rapidly progressive disease with a median survival of six months. Since cure rates approach 50%, it is imperative therapy not be delayed."* In this situation, delay of therapy could mean the loss of an opportunity to cure the mother. Because both radiation and chemotherapy present mutation risks for the fetus, termination of the pregnancy is suggested in order to begin treatment for lymphoma.

## Breast Cancer

especially breast cancer diagnosed during pregnancy

"Factors in pregnancy that could adversely affect this malignancy include...increased estrogen and prolactin stimulation [both factors that exacerbate breast cancer], and depression of the immune system."° The frequency of breast cancer in pregnancy is second only to cancer of the cervix, occurring in 1 out of every 3,000 pregnancies. In addition, adequate nutrition is a serious problem.

Sources:

* Clinical Manual of Obstetrics, ed. David Shaver and Frank Ling (University of Tennessee College of Medicine), Sharon Phelan (University of Alabama Department of Obstetrics and Gynecology), and Charles Beckmann (University of Wisconsin Department of Obstetrics and Gynecology)

° Manual of Obstetrics: Diagnosis and Therapy, ed. Kenneth Niswander and Arthur Evans, University of

## Bipartisan Alternative to S. 6/H.R. 1122

S. 6, the Partial Birth Abortion Ban, would outlaw the procedure physicians call dilatation and extraction (D&X) at any stage of pregnancy -- with no exception for the health of the mother -- but allow other, sometimes more dangerous abortion procedures to be used in its place.

The bipartisan alternative to S. 6 would ban all abortions after fetal viability (when the fetus can sustain survivability outside the womb with or without life support) unless the mother's life or health is truly endangered. The health exception to the comprehensive ban is being written to cover only very rare situations (1) that arise from complications of the pregnancy itself, such as serious heart damage (cardiomyopathy), severe hypertension (preeclampsia); dangerous aggravation of pre-existing conditions, such as complications from diabetes (blindness, amputation); and, as in the cases of some women carrying severely deformed fetuses, uterine rupture and other injuries; or (2) where termination of the pregnancy is necessary to allow medically necessary treatment of life-threatening conditions, including aggressive cancers (acute leukemia or breast cancer).

### Constitutional Parameters Limiting Government Restriction of Abortion

*Right To Terminate Pregnancy Prior To Viability:* Roe v. Wade held that the Constitution protects "a woman's decision whether or not to terminate her pregnancy." This holding was reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey, in which the Supreme Court held that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy."

*Viability Defined:* According to the Court, "viability is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." Although the actual point of viability varies with each case, it is generally reached between the 23rd and the 28th week.

*Government May Ban Abortion After Viability:* In Casey, the Supreme Court reiterated Roe's determination that after viability, the State may ban abortion. Many states have done so, and post-viability abortions comprise less than 0.5% of all abortions (99% occur in the first 20 weeks).

*Ban Must Have An Exception When A Woman's Life Or Health Is At Risk:* According to Roe and Casey, although the State has a legitimate interest in preserving potential life, and may promote this interest by prohibiting abortion once the fetus attains viability, it may not do so when preventing an abortion would endanger the life or health of the mother. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

***Would S. 6 prevent abortions?*** No. S. 6 would not stop a single abortion; it would merely result in abortion by a different method, such as induction, hysterotomy (pre-term c-section), or dilatation and evacuation (D&E) -- all of which pose a greater risk to the mother's health in certain cases.

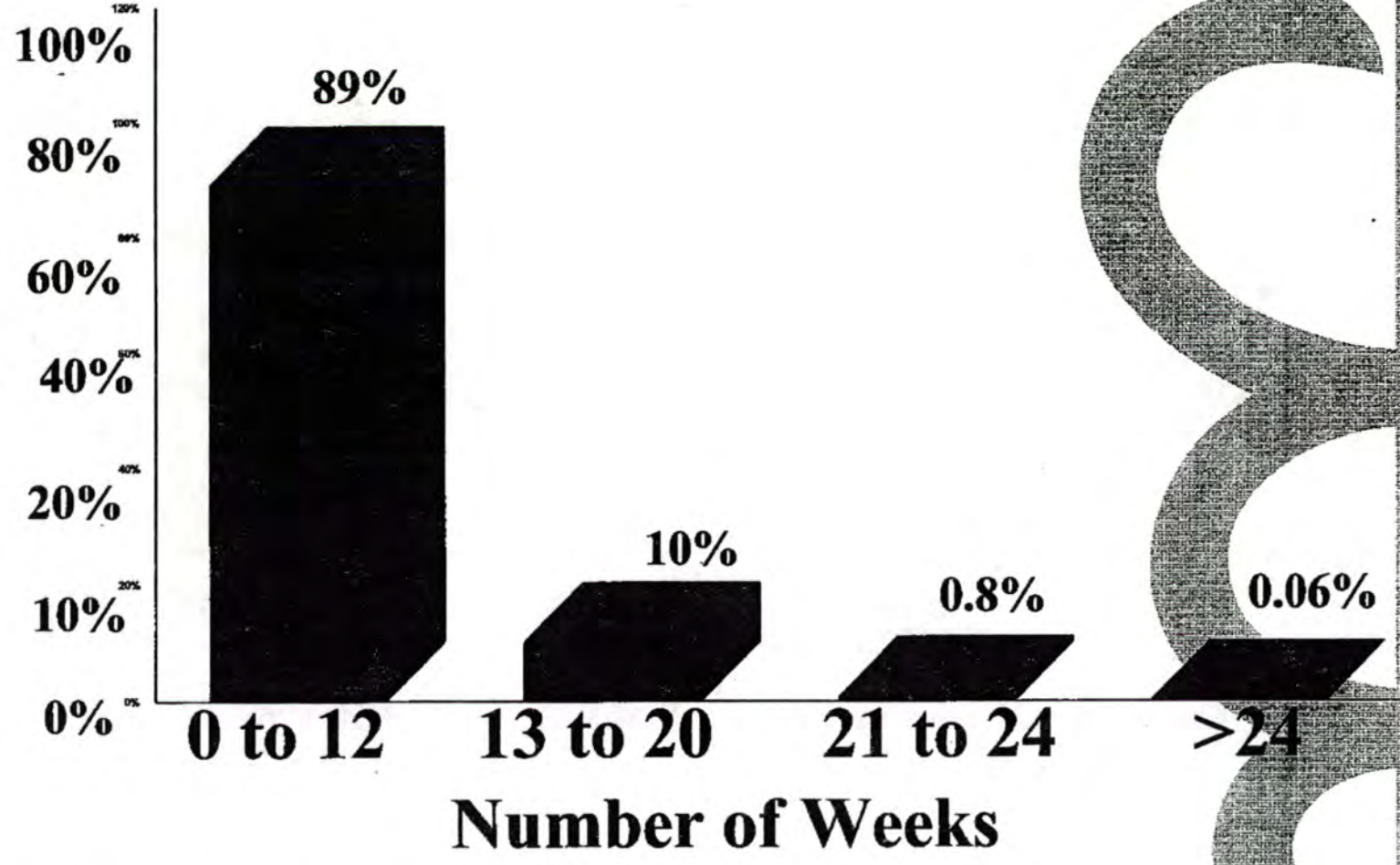
***Can S. 6 become permanent law?*** No. Even if Congress overrides a Presidential veto, S. 6 is clearly unconstitutional, so it will be struck down by the courts and have no ultimate effect.

***Can something be done to stop unnecessary abortions of viable fetuses?*** Yes. Congress can pass the bipartisan, comprehensive post-viability abortion ban with a narrow life and health exception that will outlaw these very late-term abortions. This will actually reduce the number of abortions in this country without putting women at unacceptable risk. This ban would be constitutional, and the President would sign it.

# Abortion

## Time to Reassess?

# Truth: When Abortions Occur




*Source: The Alan Guttmacher Institute*

# The Real Issue

**When, and under what circumstances, should the government restrict abortion?**

# Truth: the Constitution

**Roe v. Wade (1973):** protects ***"a woman's decision whether or not to terminate her pregnancy."***

**Colautti v. Franklin (1979):** ***"a fetus is considered viable if it is potentially able to live outside the womb, albeit with artificial aid."***

**Planned Parenthood v. Casey (1992):** prohibits restrictions that place ***"a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus."***

# Truth: the Science

## Viability:

- Ability to sustain survivability outside the womb, with or without life support.
- Usually 23-28 weeks.
- Determined by physician on a case-by-case basis.

# Key Questions Posed by S. 6/H.R. 1122

- Should just one, or all, post-viability abortion procedures be banned?
- Should a mother's health be protected throughout pregnancy?
- Should a woman's Constitutional right to choose <u>before</u> viability be preserved?

# Two Approaches

| S. 6/H.R. 1122 | The Alternative |
| --- | --- |
| ► Bans only <u>one</u> procedure; allows others in its place. | ► Bans <u>all</u> post-viability abortions. |
| ► Violates a woman's Constitutional right to have her health protected. | ► Preserves exceptions for life & health of the mother. (narrowly defined) |
| ► Violates a woman's Constitutional right to choose before viability. | ► Protects a woman's Constitutional right to choose before viability. |

# Viability

99% of abortions are performed within the first 20 weeks.

0 — ***Viability*** *(23-28 weeks)* — 40

Right to Choose
Constitutionally protected.

S. 6/H.R. 1122:

The Alternative:
bans D&X
and all other
procedures

# Post-Viability

## S. 6/H.R. 1122

- Bans only:
  Dilatation & Extraction
  (D&X or "Intact D&E")

- No exception to protect health of the mother.

## The Alternative

- Bans all:
  Dilatation & Evacuation (D&E)
  Dilatation & Extraction (D&X)
  Induction
  Hysterotomy
  Hysterectomy

- Preserves exception for health of the mother.
  (narrowly defined)

# National Right to Life on Alternatives to D&X:

**S. 6**

*(source: NRL Web Page as of 5/1/97)*

no ban → D&E "...may cause cervical laceration. Bleeding...may be profuse."

no ban → Induction [with prostaglandins] "...risks...cervical trauma, infection, hemorrhage...cardiac arrest and rupture of the uterus....Death is not unheard of."

no ban → Hysterotomy (C-section) "...highest risk to the health of the mother...potential for rupture during subsequent pregnancies..."

banned → D&X No maternal health risks cited.

# Who Should Decide...

- ...Which Procedure is Medically Appropriate in an Individual Case?

**A Woman and her Doctor.**

or

**The Government.**

# Health Consequences: the Constitution

**Roe v. Wade (1973):** protects a mother's health throughout pregnancy.

**Planned Parenthood v. Danforth (1975):** Cannot force *"a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed."*

**Thornburgh v. American College of Ob/Gyns (1986):** Cannot force a mother *"to bear an increased medical risk...to save her viable fetus."*

# Health Consequences: Physicians say...

***American College of Obstetricians & Gynecologists***

"An intact 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 upon the woman's particular circumstances can make this decision. **The intervention of legislative bodies into medical decision making is inappropriate, ill-advised, and dangerous.**"

# Complications Caused by the Pregnancy

- Primary pulmonary hypertension: *Sudden death or intractable congestive heart failure. Maternal mortality approaches 50%.* (this or other complications occur in 10 to 40% of patients with chronic hypertension)
- Preeclampsia: *Severe hypertension & accompanying renal/kidney or liver failure.* (5 to 10% of pregnancies)
- Cardiomyopathy: *Occurs late in pregnancy in women with no history of heart disease as "a distinct, well-described syndrome of cardiac failure."*

# When Pregnancy Complicates Treatment

- Cancers: (1 in 1000 pregnancies)

  *Pregnancy depresses mother's immune system; radiation and chemotherapy are harmful to fetus.*

- Lymphoma: *50% cure rate with immediate treatment; likely death in 6 months if delayed; radiation & chemotherapy risk fetal mutation.*

- Breast Cancer: (1 in 3000 pregnancies)

  *Increased estrogen and lactose production during pregnancy accelerates cancer; immune system depressed.*

# Health Exception

It shall be unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health. "Grievous injury" shall be defined as:

(a) a severely debilitating disease or impairment specifically caused by the pregnancy; or

(b) an inability to provide necessary treatment for a life-threatening condition.

"Grievous injury" does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated.

# Who Should Decide...

► ...When Medical Risks are Serious Enough?

**A Woman and her Doctor.**

or

**The Government.**

# S. 6/H.R. 1122

- **Clearly Unconstitutional.**
- **Doesn't Stop a Single Abortion.**

# The Alternative

- **Before Viability:** A woman's Constitutional right to choose is protected.

- **After Viability:** All procedures banned with exceptions only when the life or health of a mother are seriously threatened.

**NARAL** *Promoting Reproductive Choices*

**DATE:** 5/15/97

**TO:** Melanne Verveer

**OFFICE:** Ofc of First Lady 202/456-2806

**FROM:** Kate Michelman **PHONE:** 202/973-3001

**THIS IS PAGE ONE OF** 4 **PAGES**

**COMMENTS:**

*URGENT*

Please forward immediately.

Thank-you!

National Abortion
and Reproductive Rights
Action League

1156 15th Street, NW
Suite 700
Washington, DC 20005

Phone (202) 973-3000
Fax (202) 973-3096
E-Mail: naral@naral.org

# HARVARD UNIVERSITY
## LAW SCHOOL

LAURENCE H. TRIBE
*Ralph S. Tyler, Jr. Professor of Constitutional Law*

HAUSER HALL 420
CAMBRIDGE, MASSACHUSETTS 02138
(617) 495-4621

May 15, 1997

Ms. Kate Michelman
President, NARAL

Dear Kate:

I've been surprised to learn that some people are evidently confused about whether the health exception contained in Senator Daschle's proposed legislation complies with the constitutional requirements set forth in *Roe* and *Casey*. You've asked me to put in writing my explanation of why the Daschle exception is constitutionally insufficient, and I'm glad to do so.

Both *Roe* and *Casey* unambiguously hold that a state may not prohibit any post-viability abortion that is "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." The Daschle language would forbid abortion of a viable fetus unless the physician certifies that continuing the pregnancy "would threaten the mother's life or risk grievous injury to her physical health," and goes on to explain that even this narrowed health exception — which impermissibly excludes medically diagnosable risks, however severe, to the woman's *mental* health and which requires the physician to certify that the physical injury to the woman would be "grievous" — is inapplicable unless the "severely debilitating disease or impairment" that the physician believes requires termination of pregnancy is "specifically caused by the pregnancy." Thus, although a pregnancy may be terminated without violating Daschle if its continuation would cause what the proposed statute calls "an inability to provide necessary treatment for a *life-threatening* condition," a pregnancy may *not* be terminated without violating Daschle if its continuation would cause only an inability to provide necessary treatment for a *severely debilitating* but not life-threatening condition.

The upshot is that the Daschle language would criminalize at least three categories of post-viability abortions that, under *Roe* and *Casey*, may not be prohibited:

- First, abortions that are regarded by the woman and her physician as necessary to avoid medically diagnosable injury to mental health, including suicidal depression that might result from having to carry to term a fetus so severely deformed (as in a

case of anencephaly, for instance) that it would be born only to die hours later after a brief and painful life;

- Second, abortions that are required because, in the judgment of the woman and her physician, continuing the pregnancy would seriously and permanently threaten the woman's physical and/or mental health but not by bringing about what the physician could certify is a "severely debilitating disease or impairment specifically caused by the pregnancy;"

- Third, and to some degree encompassed within the second point above, abortions that are medically required because continuing the pregnancy would preclude the provision of necessary treatment for a condition that, although not life-threatening, would indeed amount to a "severely debilitating impairment" — such as, for instance, permanent inability to bear children in the future, or permanent impairment of some important bodily capacity or function such as, e.g., vision — but not an impairment that is "specifically caused by the pregnancy."

I should stress the arbitrariness of the exclusion, from the Daschle language, of impairments in the latter category. If a woman is pregnant with a viable fetus in circumstances where the pregnancy itself, unless terminated, would cause a severe impairment (say, to kidney function), the Daschle bill would permit her to obtain an abortion. If the same woman is pregnant with the same viable fetus where the pregnancy itself causes no impairment but where the continuation of that pregnancy would make impossible the use of certain drugs or procedures (because those drugs or procedures would cause severe deformity in the fetus, for instance, as is often the case with chemotherapy or radiation therapy) without which the woman would suffer an even more severe impairment (say, to kidney and liver function and future reproductive capacity), the Daschle bill would make it a crime for her doctor to perform the same abortion. This arbitrary distinction would in all likelihood violate the Due Process Clause of the Fifth Amendment even apart from *Roe* and *Casey*, but in any event it seems undeniable that it would violate the principles laid down in those decisions, which quite pointedly focus on whether the *abortion* is necessary to preserve "the life or health of the mother," *not* on the (quite irrelevant) issue of whether the *pregnancy* itself endangers her life or health.

The Daschle bill recognizes that the key question is the necessity of the *abortion* and not what the *pregnancy itself* might cause when it comes to what it calls "life-threatening" conditions, making clear that a pregnancy may be terminated if it causes an "inability to provide necessary treatment" for such conditions. The glaring omission of any parallel provision for terminating a pregnancy that causes an inability to provide necessary treatment for severely debilitating even if not life-threatening conditions, or an inability to provide procedures that would prevent the development of such conditions, cannot be squared with the requirements of *Roe* and *Casey*.

For these reasons, I cannot understand how anyone could doubt the inconsistency of the Daschle language with the requirements of the Constitution as construed in *Roe* and *Casey*. I can

readily understand the political temptation of some to sign onto a measure that seems less drastic and dangerous from some perspectives than Santorum, and this letter is not intended to address the political pros and cons of various positions. I think it would be a tragedy, however, for Senators, or the White House, to proceed on the basis of demonstrably indefensible readings of the Daschle language or of *Roe v. Wade* or both.

Sincerely yours,

Laurence H. Tribe

**NARAL** *Promoting Reproductive Choices*

June 6, 1997

Melanne Verveer
Deputy Chief of Staff, Office of the First Lady
Old Executive Office Bldg., Rm 100
Washington, DC 20500

Dear Melanne:

There has been a great deal of concern expressed within the pro-choice community about the impact of the current debate on late-term abortion on our movement as a whole There is a near universal desire among pro-choice advocates to get "back on track" and "on message" in terms of the public debate on abortion. While it is essential that we protect the right to choose against current Congressional attacks, we cannot allow that battle to paralyze our strategic thinking. We must have an offensive as well as a defensive plan for the future.

Along these lines, I've taken the time to prepare a brief discussion paper that puts our current challenge in an historical context and makes some suggestions for the future.

I welcome your reactions to the ideas I've put forward. Together we can craft a strategy for moving a pro-active agenda that best serves women's reproductive health and freedom.

Thank you.

Sincerely,

Kate Michelman

Kate Michelman
President

National Abortion
and Reproductive Rights
Action League

1156 15th Street, NW
Suite 700
Washington, DC 20005

Phone (202) 973-3000
Fax (202) 973-3096
E-Mail: naral@naral.org

**NARAL** *Promoting Reproductive Choices*

**CONFIDENTIAL**

TO: Interested Parties
FROM: Kate Michelman
RE: Pro-Choice Strategy
DATE: June 6, 1997

---

**Overview**

In recent years, pro-choice forces have had to adjust to new political realities: a Congress firmly under anti-choice control, complacency among pro-choice voters, and a re-energized and well-financed anti-choice movement. In addition, the difficult and protracted battle over late-term abortion has left pro-choice organizations on the defensive and off message.

It is time to get back on track. We believe, and NARAL's research shows, that the pro-choice movement has the winning messages and issues to shift the debate back to more favorable ground. The pro-choice arsenal contains powerful and effective messages that resonate with Americans -- messages that were overshadowed by the fight over late-term abortion. There are several strategic advantages to emphasizing our core message of keeping politicians out of private reproductive health decisions ("Who Decides?") and to broadening the message to include early prevention and an expansion of women's reproductive choices ("Make Abortion Less Necessary"). These messages will help us resume our conversation with mainstream America, return pro-choice organizations to more proactive ground, and put opponents of choice on the defensive. At this juncture in the fight over late-term abortion, we must move quickly to seize the initiative. We cannot afford to wait.

National Abortion
and Reproductive Rights
Action League

1156 15th Street, NW
Suite 700
Washington, DC 20005

Phone (202) 973-3000
Fax (202) 973-3096
E-Mail: naral@naral.org

**History**

After extensive public opinion research, NARAL developed the "Who Decides?" message in conjunction with the pro-choice mobilization around the Supreme Court's 1989 decision, *Webster v. Reproductive Health Services*. NARAL's "Who Decides?" public education campaign in 1989 and 1990 shifted the debate from the question of whether abortion is right or wrong to the question of who makes the abortion decision -- politicians or the individual woman with her physician. Pollster Harrison Hickman wrote at the time:

> "When the issue is presented as a question of the proper role of government and whether or not current laws on abortion should be changed to make abortion illegal, the majority support our pro-choice position....This is why reducing the issue to one simple policy-based question ("Who decides?") works so well: It frames the very complex matter of abortion rights on the dimension where voters most readily accept our view."[1]

In 1991, NARAL field tested its hypothesis that placing abortion along a continuum of reproductive choices, including pregnancy prevention, would create an even broader pro-choice constituency. Our public-opinion research found overwhelming support for this expanded mission:

> "For NARAL and other pro-choice forces, the advantages of moving in a broader thematic direction are numerous. Strategically, this adjustment moves NARAL toward a more mainstream position and, in the process, helps expose some of the most unpopular, extremist elements of the anti-choice movement. Politically, this makes it easier to attract public and elite support for our proposals and, in time, to develop and pass a more expansive and attractive legislative agenda. . . . [T]his thematic approach grounds our arguments for abortion rights in a larger context, giving our supporters something to fight for in addition to continuing the fight **against** encroachments on abortion rights."[2]

That poll found that 89 percent of pro-choice voters and 73 percent of swing voters (the "mushy middle") on abortion strongly support reducing the number of unplanned pregnancies

through increased access to sexuality education and birth control.

Based on its research, NARAL began a limited advertising campaign in 1991 aimed at the 40 percent of the electorate who are swing voters on choice. One ad stated:

> "[T]o us, being pro-choice means having real choices. It means working to improve our nation's reproductive health care policies. It means working to reduce the need for abortion. . . . That's why we're working for better sex education, more effective birth control, improved methods of contraception and pre- and post-natal care."[3]

While attempts were made to raise the resources to launch a national "Real Choices" advertising campaign, other major developments captured public attention and prevented the campaign from moving beyond its initial stage. In 1991, pro-choice organizations were forced to respond to the nomination of Clarence Thomas to the U.S. Supreme Court and the threat posed by an increasingly hostile judiciary.

This was also the period when choice became a major electoral issue. Beginning with the 1989 victories of governors Doug Wilder and James Florio and continuing in the 1990 and 1991 elections, pro-choice forces organized and delivered the votes of Americans who understood the legal and political threats to a woman's freedom to choose. These electoral efforts culminated in the 1992 election of a pro-choice President. "Who Decides?" messages motivated pro-choice voters, while then-Governor Clinton appealed to women voters across party lines with the theme of making abortion "safe, legal and rare." According to a major academic study of the 1992 election:

> "Abortion had a stronger influence on candidate choice than any other policy issue included in the study, including affirmative action, social welfare, defense spending, the Gulf War, and the death penalty."[4]

Victory, however, came at a tremendous cost. President Clinton's election led voters to

believe -- erroneously -- that the right to choose was secure. The salience of the issue diminished, and Americans curtailed their financial contributions to pro-choice organizations. These factors made it virtually impossible to sustain a "Real Choices" campaign.

Nevertheless, the demonstrated power of the "Real Choices" direction led NARAL in early 1994 to officially adopt a broadened mission and name change. If there was any doubt about how a more comprehensive pro-choice agenda would be received, it vanished when both the New York Times and the Washington Post lauded the efforts of NARAL and Planned Parenthood in this area:

> "Today nearly one out of three American babies is born to an unwed mother. For parent and child the economic and educational prognosis is grim -- reason enough to believe that NARAL and Planned Parenthood, which announced a similar initiative last year, have picked a good time to begin making sure that women have real choices."[5]

But, once again, political developments led NARAL to suspend its "Real Choices" campaign. In 1994, anti-choice forces, capitalizing on pro-choice complacency, organized, mobilized and turned out their supporters in the mid-term elections. Congress fell firmly under anti-choice control.

Today, anti-choice stalwarts chair almost every committee with jurisdiction over women's reproductive health and press their advantage by successfully attaching anti-choice riders to spending bills. With only 33 fully pro-choice Senators and 135 fully pro-choice House members in the most anti-choice Congress since *Roe v. Wade*, abortion opponents maintain a crucial advantage in shaping the public debate on abortion. The late-term abortion issue is a prime example.

Proponents of a ban on late-term abortion shifted the focus of the debate from the woman

to the abortion procedure and from early pregnancy termination to second and third trimester abortion. Late-term abortion has become the anti-choice movement's lead assault against a woman's freedom to choose, dominating the legislative debate and news media coverage of abortion.

The agenda-setting and opinion-shaping nature of the late-term abortion debate has had a significant impact. Its effect is analogous to the mid-80s film, the "Silent Scream," which used ultrasound to depict the developing fetus. Both the "Silent Scream" and late-term abortion focused new attention on the fetus. However, in the 80s, anti-choice forces were unable to capitalize on their momentum to pass legislation because the House remained under pro-choice control and the Senate returned to pro-choice control in 1986.

**Legislative and Public Education Strategy**

Pro-choice forces urgently need to reclaim the upper hand in the abortion debate. NARAL's research and analysis demonstrate that a proactive legislative and public education campaign to protect choice and to make abortion less necessary is both sound public policy and a vehicle to return us to more favorable pro-choice ground.

NARAL's research, including focus groups conducted in April, 1997, underscores the continued support for safe, early abortion and programs to prevent unplanned pregnancy, especially emergency contraception. The analysis of the focus groups found:

> "[M]embers and nonmembers alike respond positively to initiatives that broaden the issue on our terms -- emergency contraception and RU-486 are the most obvious examples. These issues and initiatives help them -- and NARAL -- move back to a pro-active posture rather than simply trying to hold back the advance of the other side."[6]

A pro-choice legislative and public education campaign should include early

reproductive choices that help reduce the high rate of unintended pregnancy, as well as working to defend the fundamental right to choose. The components can include: improving awareness of, and access to, emergency contraception; mandating insurance coverage for contraception and ensuring adequate funding for family planning programs; increasing resources for contraceptive research and development, and promoting comprehensive sexuality education in the nation's schools. These initiatives will improve reproductive health, expand reproductive choices, help reduce unintended pregnancy, and promote the value of personal responsibility.

These efforts will resonate with mainstream Americans who want to see fewer abortions. They will allow us to speak in a way that has the broadest possible consensus and that addresses the moral concerns of swing voters. And they will reveal the true intentions of opponents of choice, who want to deny women control of reproductive decisions and access to reproductive health services.

While in the short-term we may be unable to enact legislation because of the current makeup of Congress, our campaign will lay the groundwork for success in a more hospitable Congress. Moreover, this approach can rejuvenate pro-choice activists and supporters working toward a common, positive goal at the state and federal levels. Pro-choice organizations will be able to broaden their message, reclaim support among the majority of Americans, and establish the context for subsequent pro-choice electoral work.

A high impact public education campaign is critical to refocusing the abortion debate. Indeed, the anti-choice movement has used this strategy to its advantage. NARAL's research shows that the "Life, What a Beautiful Choice" advertising campaign by the DeMoss Foundation helped lay the groundwork for the anti-choice legislative assault on late-term abortion and is

having an impact on public attitudes about reproductive choice. The NARAL Foundation, with a grant from the Packard Foundation, is conducting critical new research for an effective and proactive advertising campaign that will articulate the values underlying the pro-choice position. The campaign is intended to give the "mushy middle" on reproductive choice a moral and ethical framework in which to ground their pro-choice beliefs and to recoup some of the erosion of public support for the freedom to choose. Another critical audience for the pro-choice message is the post-*Roe* generation, the first to come of age with abortion as a constitutionally protected right. The Pro-Choice Education Project is taking the lead in devising a public education effort specifically targeted to young women. We must begin to lay the groundwork now and build toward a more intensive public education campaign in January 1998 on the 25th anniversary of *Roe v. Wade*.

**Electoral Strategy**

Conventional wisdom notwithstanding, abortion remains a potent factor electorally. In the 1992 presidential campaign, Bill Clinton won 17 percent of Republican voters because of his support for the freedom to choose.[7] A 1996 NARAL poll found that 39 percent of voters considered abortion to be the single most or one of the most important issues for them.[8] Voters must be educated, however, about the candidate's position on choice.

A NARAL focus group this year found that voters were surprised to learn that the House and the Senate are both solidly anti-choice. And they said that their election decisions would be influenced by their concern that their Member of Congress might vote to restrict abortion rights. Aside from late-term abortion, most voters do not know about the 53 congressional votes taken on choice during the 104th Congress. Despite efforts by individual pro-choice Members, the

Democratic leadership has been unwilling to use the abortion issue -- as they have used the environment and Medicare -- to dramatize the impact of radical right control of Congress.

In the 1998 mid-term elections, anti-choice forces will attack pro-choice Members' opposition to a ban on late-term abortion. It is critical for pro-choice candidates to begin using messages now that resonate with the pro-choice majority and not wait to be attacked on late-term abortion. Pro-choice candidates must quickly establish their support for the right to choose and for pregnancy prevention, and they must characterize their opponent's positions on these issues as extreme.

Emphasizing positive messages early and often and staying focused on that agenda will enable pro-choice candidates to set the terms of the political debate. By stressing the importance of keeping politicians out of women's reproductive lives ("Who Decides?") and prevention ("Make Abortion Less Necessary"), pro-choice candidates can deliver messages that will find overwhelming support among their constituents.

Finally, a "Real Choices" prevention campaign will expose the fissure in the anti-choice community between those who support contraception and those who oppose it. Tactics that help derail the anti-choice movement will speed pro-choice efforts to get back on track. The time to begin is now.

**Endnotes**

1. Hickman, H. (1991, May). [Confidential working paper 1991-1]. Unpublished memorandum to National Abortion and Reproductive Rights (NARAL) Strategy Group, Washington, D.C.

2. *Ibid.*

3. NARAL. "Real Choices." The Washington Post. July 7, 1991. P. A7 (advertisement).

4. Abramowitz, A. I. (1995, February). It's Abortion, Stupid: Policy Voting in the 1992 Presidential Election. The Journal of Politics, Vol. 57, No. 1, pp. 176-86.

5. Expanding the meaning of choice (1994, January 17). The New York Times, A16.

6. Hickman, H. (1997, April). Unpublished memorandum to NARAL, Washington, D.C.

7. Abramowitz, A. I. It's Abortion, Stupid. pp. 176-86.

8. Hickman, H. (1996, August). Unpublished memorandum to NARAL, Washington, D.C.