Jennifer Barbera

May 1997

TO: Delegates and Alternate Delegates
Executive Directors
State Medical Associations
National Medical Specialty Societies.

FROM: Nancy W. Dickey, MD
Chair, Board of Trustees

Included in this package is the Report of the Board of Trustees on Late-Term Abortion responding to Substitute Resolution 208. This report represents the cumulative work of many groups and individuals over the last several months. It should be evaluated as the science based treatise it was intended to be.

However, everyone is aware of the pending and peripherally related legislation. I am writing you this memorandum to share with you the thinking of the Board on this issue and to ask you to evaluate the legislative/political questions separately from, though very impacted by, the science issues.

Legislation addressing abortion procedures is currently pending in many state legislatures as well as the Congress. Action in the US Senate could come within the next two weeks. The Board's report on late-term abortion, developed by an expert panel, with representatives from AMA councils (Scientific Affairs, Ethical and Judicial Affairs, Medical Education, and Legislation), recognized medical specialty societies with expertise in this area (the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics), the AMA Board of Trustees and state medical associations, recommends severe restrictions on the use, at any time, of the abortion procedure known as intact dilation and extraction (intact D&X). In addition, the Report recommends that physicians "generally" not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because abortion is rarely necessary to preserve the life or health of the mother at this stage.

Generally, AMA policy calls for opposition to legislation controlling or criminalizing medical practice or procedures. However, AMA has supported legislation where the procedure(s) was narrowly defined, and not medically indicated such as prohibition of female genital mutilation.

For the AMA to support any legislation impacting medical decision-making the legislation would have to:

- Provide a formal role for medical peer determination (through the appropriate state medical licensing bodies or some similar process) in any enforcement proceedings under a bill.

- Retain for physicians the ability, using their best clinical judgment at the time, to use the procedure in an extraordinary circumstance where the patient would otherwise be seriously endangered.

- Use correct medical terminology so that it is clear on the face of the legislation what act is to be prohibited.

The AMA Board has determined that legislation regarding intact D&X would have to meet the above requirements to be supported. However, the strong concerns about intact D&X provided in the scientific report leave little basis for opposition if the legislative requirements were met. The widely debated, strongly supported, fast moving legislation in this area leads AMA to urge Congressional leaders on both sides of the debate to move forward and develop legislation consistent with these views.

pertinent medical specialty organizations to develop clinical practice guidelines appropriate for late term pregnancy termination.

As of April, 1997, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have not issued formal policies on late-term abortion. Both organizations, however, sent representatives to the study group convened by the American Medical Association in April, 1997.

The American College of Obstetricians and Gynecologists was the first medical specialty society to oppose the "Partial Birth Abortion Act of 1995" and to develop formal policy on intact dilatation and extraction. In November, 1995, ACOG released a statement in which it expressed its disappointment that the Congress "has attempted to regulate medical decision-making today by passing a bill on so-called "partial-birth" abortion."53 The statement noted that "the College finds it very disturbing that any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community---demonstrating why Congressional opinion should never be substituted for professional medical judgment."53

In January, 1997, ACOG released a Statement of Policy on Intact Dilatation and Extraction. According to the College, intact dilatation and extraction (intact D&X) contains four elements: "Deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus."19 The policy notes that "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."19 The policy further states that "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 on the patient's individual circumstances. . . 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."19

RECOMMENDATIONS

The Board of Trustees recommends the adoption of the following statements of policy and that the remainder of this report be filed:

1. The American Medical Association reaffirms current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995 (see page 3). In summary:

the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate

facilities;

abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;

support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures;

neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.

2. The term 'partial birth abortion' is not a medical term. The American Medical Association will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

3. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

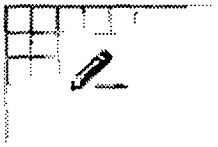
4. The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

5. In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

6. The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines will address indications and contra-indications for such procedures, identify techniques which conform to standards of good medical practice and, whenever possible, should be evidence-based and patient-focused.

7. The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

8. The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment and education. Such measures should help women who elect to terminate a pregnancy through induced abortion to receive those services at the earliest possible stage of gestation.



To: Jennifer
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

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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

THE WHITE HOUSE

WASHINGTON

May 13, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
ELENA KAGAN

SUBJECT: DASCHLE AND FEINSTEIN AMENDMENTS

As you know, the Senate is taking up the Partial Birth Abortion Act (HR 1122) this afternoon. We expect Senator Daschle and Senator Feinstein to offer substitute amendments during the course of the debate. We recommend that you send a letter to Congress indicating that you would accept either of these substitute proposals. John Hilley and Rahm strongly agree, believing that a letter of this kind will help prevent a veto override on this issue. The proposed letter is attached; if you agree to send it, we will put it into final form for your signature.

Background

Both the Feinstein and the Daschle amendments prohibit post-viability abortions generally. They thus differ in two crucial ways from HR 1122: (1) they apply to all procedures, including but not limited to the "partial birth" procedure, and (2) they apply only to abortions performed after the fetus has become viable.

Both amendments impose civil, rather than criminal, penalties. Feinstein's would fine the physician up to $10,000 for a violation. Daschle's would result in a fine of up to $100,000, or suspension or revocation of the doctor's medical license (and in the case of a second or subsequent offense, $250,000 or revocation of the license).

Most critically, both amendments contain a health exception, though of different kinds. The Feinstein legislation would exempt an abortion if, "in the medical judgment of the attending physician, the abortion is necessary to . . . avert serious adverse health consequences to the woman." This language is essentially identical to the language you have used in calling for a health exception to the Partial Birth Act. The Daschle language is more stringent. It exempts an abortion when the physician "certifies that continuation of the pregnancy would . . . risk grievous injury to [the mother's] physical health." "Grievous injury" is then defined as "a severely debilitating disease or impairment specifically caused by the pregnancy, or an inability to provide necessary treatment for a life-threatening condition."

The five women you spoke with before your last year's veto would fall within even the Daschle exception, assuming the truth of their accounts. Each said that her doctor advised her that an abortion was necessary to prevent a risk of grave physical harm -- for example, of serious

damage to her reproductive system. Daschle himself believes that his bill protects such women, and is willing to refer to these women when he offers his amendment. You should be aware, however, of a slight chance that one of the choice groups will persuade one or more of these women to oppose the Daschle bill on the ground that it would not protect women in her situation.

The American College of Obstetricians and Gynecologists today endorsed the Daschle amendment, stating that it "provides a meaningful ban [on post-viability abortions] while assuring women's health is protected." (ACOG took no position on the Feinstein amendment, which the group rightly views as a less serious proposal.) The AMA has refused to take a position on any of the pending legislative proposals, but yesterday issued a study (1) expressing skepticism about the need to use the "partial birth" procedure, but stating that doctors must retain discretion to use medical judgment in selecting procedures, and (2) stating that post-viability abortions are almost never necessary to save a woman's life or prevent serious harm to her health, given the alternative at this stage of delivering the fetus.

The choice groups (somewhat reluctantly) support the Feinstein language, but oppose the Daschle proposal. They argue that the stringency of Daschle's health exception -- including its limitation to cases of physical harm -- undermines the comprehensive protections announced in Roe regarding the health of the woman. The Office of Legal Counsel of the Justice Department similarly believes that both the Daschle and the Feinstein amendments, properly read, violate Roe because they countenance tradeoffs involving women's health. (OLC thinks, however, that a court might be able to interpret the Feinstein amendment so narrowly as to avoid this problem.)

John Hilley believes that a letter from you supporting the Daschle amendment is of crucial importance in sustaining a veto. He worries that if the Daschle amendment goes down to a decisive defeat, many Senators who previously supported you will switch and vote for HR 1122. He thinks a letter of endorsement from you will strengthen the prospects for the Daschle amendment.

Recommendation

We recommend that you endorse the Daschle amendment in order to sustain your credibility on HR 1122 and prevent Congress from overriding your veto. You have spent many months calling on Congress to pass a bill that contains a sufficiently protective, but also appropriately confined, health exception -- as you said in a letter to the Cardinals, not a health exception that "could be stretched to cover most anything," but a health exception that "takes effect only where a woman faces real, serious adverse health consequences." Especially given ACOG's endorsement of the Daschle amendment, it will be difficult for you to make the case that Daschle's language does not adequately safeguard women's health. In these circumstances, declining to support the amendment will weaken your position and increase the chance that Congress will override your veto.

DRAFT

Dear Senators Daschle and Feinstein:

I am writing to express support for your amendments prohibiting late-term abortions. If Congress were to substitute either of these amendments for the current H.R. 1122, I would sign the legislation.

As you know, I have long opposed late-term abortions, and I continue to do so except where necessary to save the life of a woman or prevent serious harm to her health. When I was Governor of Arkansas, I signed into law a bill that barred third-trimester abortions, with an appropriate exception for life or health. And last year, I made clear that I would sign such a bill at the federal level.

Your amendments, though differing in detail, both meet the standards I have set for such legislation. The amendments contain exceptions that will adequately protect the lives and health of the small group of women in tragic circumstances who need an abortion at a late stage of pregnancy to avert death or great injury. At the same time, the amendments prohibit any late-term abortions performed for elective reasons. This balance is an appropriate one, which I -- and, I believe, most Americans -- would gladly make the nation's law.

Sincerely,

THE WHITE HOUSE

WASHINGTON

Senator Chafee
224-2921

MAY 14, 1997

RECOMMENDED TELEPHONE CALL

TO: SENATOR BOXER

DATE: ON OR BEFORE NOON MAY 15, 1997

RECOMMENDED BY: SUSAN BROPHY, LEGISLATIVE AFFAIRS
TRACEY THORNTON, LEGISLATIVE AFFAIRS

PURPOSE: TO THANK THE SENATOR FOR HER LEADERSHIP IN OPPOSING THE SANTORUM BILL ON "PARTIAL-BIRTH ABORTION" AND TO ASK HER TO CONSIDER VOTING FOR DASCHLE IF HER ALTERNATIVE DOES NOT PREVAIL

BACKGROUND: On March 20, 1997, the House of Representatives passed a bill identical to the one you vetoed last year by a vote of 295-136, a veto-proof margin. The Senate will vote on the Daschle substitute tomorrow as well as a Feinstein-Boxer substitute to the underlying bill sponsored by Senator Santorum (R-PA).

Both substitutes would ban all post-viability abortions with exceptions for life and health of the mother. The differences between them go to the definition of health. The Daschle alternative contains a very strict definition of health making it 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 health. Grievous injury does not include any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated. Senator Daschle intends to cover a mental health condition only when it manifests itself in some serious physical way. The Feinstein-Boxer exception covers "serious adverse health consequences to the woman".

Senator Daschle's approach is not supported by the pro-choice movement because of its narrow health definition. Senator Boxer has privately indicated her very strong reservations about the Daschle alternative but she has not said that she will vote against it. She is concerned that the women who were here when you vetoed the bill may not be covered under Daschle. We have told her that we believe they would be and have asked Daschle to make that clear in his remarks on the floor.

TOPICS OF DISCUSSION:

1. Tell Senator Boxer that you are very grateful for her work to protect a woman's right to choose. Say that we would not have been able to hold the line as we have so far were it not for her courage and the strength of her convictions. Ask for her assessment of the vote situation in the Senate.

2. She may tell you that Daschle is leaning towards voting for Santorum if Daschle's alternative does not pass. Let her know that you had a conversation with Senator Daschle earlier today and he did not raise that possibility with you. Tell her that you are concerned about the veto override vote and that you know how difficult this matter is for many of her colleagues. Tell her that you think it is important to pass either her alternative or Daschle's so that at least there are two different bills, one in the Senate recognizing the need to protect the mother's health and the other an extreme House measure that will be vetoed. Tell her she should vote for Daschle's alternative if her's does not pass.

CONTACT PERSON AND TELEPHONE NUMBERS(S): Senator Boxer
202-547-1015 or White House Operator

DATE OF SUBMISSION: May 14, 1997

ACTION:

Feinstein Am →

May 20, 1997

The Honorable Rick Santorum
United States Senate
Senate Russell 120
Washington, DC 20510

Dear Senator Santorum:

After months of intense deliberation, the American Medical Association (AMA) is writing to support HR 1122, "The Partial-Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122 now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

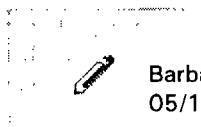
The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,

P. John Seward, M.D

P. John Seward, MD



Barbara D. Woolley
05/12/97 07:04:23 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: AMA Report - Late Term

AMA's Board of Trustees quietly released to selected Members of Congress today a new study reviewing the scientific literature on abortion and making 5 recommendations.

The following are highlights.

* AMA reaffirms current policy regarding abortion: the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgement, the patient's informed consent.

* The term 'partial birth abortion' is not a medical term and won't be used by the AMA. They will use the term "intact dilatation and extraction."

* According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X The D&X procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgement, acting within standards of good medical practice and in the best interest of the patient.

* The viability of the fetus and the time when viability is achieved may vary with each pregnancy.

* That abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viabiltiy of the fetus argues for ending the pregnancy by appropriate delivery/

* The AMA will work with ACOG, AAP to develop clinical guidelines for induced abortions after the 22nd week of gestation.

* AMA urges CDC and state health dept to develop expanded, ongoing data surveillance systems of induced abortions.

* AMA will work with appropriate medical specialty societies, government agencies, private foundation, and other interested groups to educate the public regarding pregnancy prevention strategies.

Barbara D. Woolley
05/13/97 12:48:28 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: ACOG Position

ACOG is endorsing the legislative language of Daschle's substitute amendment preferable to HR.1122. I have a copy of the letter.

* It provides a meaningful ban, while allowing an exception when it is necessary for a women's health. It preserves the ability of physicians to make judgements about individual patients.
* The amendment does not dictate to physicians which abortion procedures can or cannot be performed.

Message Sent To:

Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Tracey E. Thornton/WHO/EOP
Maria Echaveste/WHO/EOP
John Podesta/WHO/EOP
Robyn Leeds/WHO/EOP
William P. Marshall/WHO/EOP

THE WHITE HOUSE
WASHINGTON

JANE TERM 5/9/97

Please see new language on penalties. We're checking to make sure women present during veto are all covered under Daschle.

Tracey
1:30pm

Robin Leeds
6-7339

Mary-Dorothy Line
Claudia Adeg
Vicki Stella
Coreen Costello

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)

Penalties

(a) Action by Attorney General. The Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by 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 notify the State medical licensing authority in order to effect the suspension or revocation of respondent's medical license, 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 shall notify the State medical licensing authority in order to effect the revocation of respondent's medical license, or shall assess a civil penalty against the respondent in an amount not exceeding $250,000, or both.

(3) Hearing on penalties: The State medical licensing authority shall be given notification of and an opportunity to be heard at a hearing to determine penalties under this Title.

(c) Certification Requirements. At the time of the commencement of an action under this section, the Attorney General, the Deputy Attorney General, the Associate Attorney General, or any Assistant Attorney General or United States Attorney specifically designated by 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, as well as the State medical licensing board or other appropriate State agency, 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.

Regulations

In the certification to be submitted under subsection (), the physician shall certify that, in his or her best medical judgment, an abortion was medically necessary pursuant to subsection (), and describe the medical indications supporting his or her judgment.

The Department of Health and Human Services shall establish regulations for certification by the physician under subsection (), unless the State has its own certification procedure for abortions after fetal viability.

In addition, Department of Health and Human Services shall establish regulations to ensure the confidentiality of all information submitted pursuant to certification by the physician, as required by subsection ().

Each State shall ensure that the State medical licensing authority develops regulations to effect the revocation or suspension of respondent's medical license under subsection (), or the State shall be subject to loss of funding under title XVIII.

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.