BORN-ALIVE INFANTS PROTECTION ACT OF 2001

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

ON

H.R. 2175

JULY 12, 2001

Serial No. 32

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://www.house.gov/judiciary

U.S. GOVERNMENT PRINTING OFFICE

73–696 PS WASHINGTON : 2001

For sale by the Superintendent of Documents, U.S. Government Printing Office
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BORN-ALIVE INFANTS PROTECTION ACT OF 2001

THURSDAY, JULY 12, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CONSTITUTION,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:43 p.m., in Room 2226, Rayburn House Office Building, Hon. Steve Chabot [Chairman of the Subcommittee] presiding.

Mr. CHABOT. Okay. The Committee will come to order. I am Steve Chabot, the Chairman of the Subcommittee on the Constitution of the Judiciary Committee. This is a hearing on H.R. 2175, the Born-Alive Infants Protection Act. This hearing will be followed, we hope immediately, by a markup on this particular bill. I want to apologize for not getting started at exactly one o'clock, but we had what I thought was going to be one vote, and then ultimately ended up being two votes. So—please accept our apology for starting a little bit late here.

I recognize myself for 5 minutes for the purpose of making an opening statement.

The purpose of the Born-Alive Infants Protection Act is to protect infants who are born alive by recognizing them as a person, human being, child or individual for purposes of Federal law.

This recognition would take effect upon the live birth of the infant regardless of whether or not the child's development is sufficient to permit long-term survival and regardless of whether the baby survived an abortion. The act also clarifies that nothing in the bill shall be construed to affirm, deny, expand, or contract any legal status or legal rights applicable to any unborn child.

This is a bill of compassion, a bill that says all of America's children are precious and should be protected. It has long been an accepted legal principle that infants who are born alive are persons and are entitled to the protections of the law. A live birth is considered to occur whenever an infant is expelled from his or her mother's body and displays any of several specific signs of life: breathing, heartbeat, or definite movements of voluntary muscles.

Thirty States and the District of Columbia have statutes that, with some variations, explicitly enshrine this principle as a matter of State law, and some Federal courts have recognized the principle in interpreting Federal criminal laws. But recent changes in the legal and cultural landscape appear to have brought that well-settled principle into question. For example, in *Stenberg* v. *Carhart*, the United States Supreme Court struck down a Nebraska law

banning partial-birth abortion, a procedure in which an abortionist delivers an unborn child's body until only the head remains inside the mother, punctures the back of the child's skull with scissors and sucks the child's brains out before completing the delivery. What was described in *Roe* v. *Wade* as a right to abort unborn children has now been extended by the Court to include the violent destruction of partially born children just inches from birth.

By failing to consider the legal significance of the location of an infant's body at the moment it is killed during an abortion, the Court's ruling opened the door for a future court and lower Federal courts to conclude that the location of an infant's body at the moment it is killed during an abortion has no legal significance. In fact, two members of the majority, Justices Stevens and Ginsburg, explicitly rejected the significance of an infant's location in their concurring opinions, stating that, quote, "The notion that partial-birth abortion is more akin to infanticide than any other abortion procedure is simply irrational."

If such a legal conclusion were to be accepted, a baby's entitlement to the protections of the law would become entirely dependent upon whether the mother intends to give birth; in other words, whether the baby has been marked for abortion prior to its birth.

In Planned Parenthood of Central New Jersey v. *Farmer*, the Third Circuit Court of Appeals explicitly adopted such reasoning, concluding that it is nonsensical for a legislature to conclude that an infant's location in relation to his or her mother's body has any relevance in determining whether that infant may be killed. The Court said that in contrast to an infant whose mother intends to give birth, an infant who is killed during a partial-birth abortion is not entitled to the protections of the law because, quote, "A woman seeking an abortion is plainly not seeking to give birth." Unquote.

The *Carhart* and *Farmer* rulings have essentially brought our legal system to the threshold of accepting infanticide itself, making it necessary to firmly establish the born-live principle in Federal law.

Under the logic of these rulings, it may ultimately become irrelevant whether that child emerges from the mother's womb as a live baby. That child may still be treated as a non-entity without rights under the law, no right to receive medical care to be sustained in life or receive basic comfort.

The Born-Alive Infant Protection Act draws a bright line between the right to an abortion, which the Supreme Court has now said includes the right to kill partially-born children, and infanticide or the killing of completely born children, a distinction that the *Carhart* court refuses to recognize.

[The prepared statement of Mr. Chabot follows:]

PREPARED STATEMENT OF THE HONORABLE STEVE CHABOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

The purpose of this bill is to protect infants who are born alive by recognizing them as a "person, human being, child or individual" for purposes of federal law. This recognition would take effect upon birth, regardless of whether or not the child's development is sufficient to permit long-term survival and regardless of whether the baby survived an abortion. The Act also clarifies that nothing in the bill shall be construed to affirm, deny, expand, or contract any legal status or legal

rights applicable to an unborn child. This is a bill of compassion, a bill that says all of America's children are precious and should be protected.

It has long been an accepted legal principle that infants who are born alive are persons and are entitled to the protections of the law. A live birth is considered to occur whenever an infant is expelled from his or her mother's body and displays any of several specific signs of life—breathing, heartbeat, or definite movements of voluntary muscles. Thirty states and the District of Columbia have statutes that, with some variations, explicitly enshrine this principle as a matter of state law, and some federal courts have recognized the principle in interpreting federal criminal laws. But recent changes in the legal and cultural landscape appear to have brought this well-settled principle into question.

For example, in *Stenberg v. Carhart,* the United States Supreme Court struck down a Nebraska law banning partial-birth abortion, a procedure in which an abortionist delivers an unborn child's body until only the head remains inside of the mother, punctures the back of the child's skull with scissors, and sucks the child's brains out before completing the delivery. What was described in Roe v. Wade as a right to abort "unborn children" has now been extended by the Court to include the violent destruction of *partially-born* children just inches from birth.

By failing to consider the legal significance of the location of an infant's body at the moment it is killed during an abortion, the Court's ruling opened the door for a future Court, and lower federal courts, to conclude that the location of an infant's body at the moment it is killed during an abortion has no legal significance. In fact, two members of the majority, justices Stevens and Ginsburg, explicitly rejected the significance of an infant's location in their concurring opinions, stating that "the notion that [partial-birth abortion] is more akin to infanticide than [any other abortion procedure] . . . is simply irrational."

If such a legal conclusion were to be accepted, a baby's entitlement to the protections of the law would become entirely dependant upon whether the mother intends to give birth—in other words, whether the baby has been marked for abortion prior to its birth.

In *Planned Parenthood of Central New Jersey v. Farmer,* the Third Circuit Court of Appeals explicitly adopted such reasoning, concluding that it is "nonsensical" for a legislature to conclude that an infant's location in relation to his or her mother's body has any relevance in determining whether that infant may be killed. The court said that in contrast to an infant whose mother intends to give birth, an infant who is killed during a partial-birth abortion is not entitled to the protections of the law because "[a] woman seeking an abortion is plainly not seeking to give birth." The *Carhart* and *Farmer* rulings have essentially brought our legal system to the threshold of accepting infanticide itself, making it necessary to firmly establish the "born alive" principle in federal law.

Under the logic of these rulings it may ultimately become irrelevant whether that child emerges from the mother's womb as a live baby. That child may still be treated as a non-entity, without rights under the law—no right to receive medical care, to be sustained in life, or receive basic comfort.

The Born-Alive Infants Protection Act draws a bright line between the right to an abortion—which the Supreme Court has now said includes the right to kill partially-born children—and infanticide, or the killing of completely born children; a distinction that the *Carhart* Court refused to recognize.

And I will now recognize the gentleman from New York, Mr. Nadler, for 5 minutes to make an opening statement.

Mr. NADLER. Thank you, Mr. Chairman.

Today, we consider legislation reaffirming an absolutely established principle which is enshrined in the law of all 50 States that an infant who is born and is living independently of the birth mother is entitled to the same care as any other child similarly diagnosed regardless of whether labor was induced or occurred spontaneously.

It was not and is not clear to me now why we need to legislate that which is obvious and clear in the law, that which most Members of Congress and the general public already assume to be the law, but if the majority is interested in a belts-and-suspenders approach, sobeit.

The same measure just passed recently as an amendment to the Patients' Bill of Rights legislation in the Senate by a vote of 98 to nothing, which is about as uncontroversial as something can get. Even such pro-choice Members as our junior—as our colleague, the junior Senator from California, spoke in favor of it.

Let me say here that last year, I thought that the genesis of this bill was a disingenuous attempt to trick the pro-choice Members of Congress into voting against it so that we could be labelled as in favor of infanticide. We saw the motive for the legislative—I think the whole motive for the legislation was to get people to vote against it, so we didn't, and I'm now pleased that the majority has now made a serious effort to make clear that this bill has nothing to do with matters related to abortion, at least no longer has anything to do with matters related to abortion, even going so far as to introduce Subsection (C) further clarifying that point.

Whatever concerns anyone may have had in the past that this might become a clever way to undermine the rights protected under *Roe* v. *Wade* have I think been addressed and it's now clear this has nothing to do with that. Unless someone attempts to disrupt this effort by dragging the abortion debate back into it, I have little doubt that this bill will be passed without much controversy.

I would like to address the concern—I would like to say, by the way, that the concerns expressed by the Chairman that recent court rulings about partial-birth abortion—so-called partial-birth abortion have called into question whether infanticide may be legal I think are rather farfetched. Infanticide is illegal under the laws of every State in the Union and remain so with or without this bill.

I would like to address the concern, which is the only legitimate concern I've had about—I've heard about this bill, a concern expressed by our Republican colleague, the gentlewoman from Connecticut, Nancy Johnson, who has annunciated this concern most eloquently; that is, that the standard of care employed by neonatologists when faced with a non-viable newborn or a clearly critically ill or massively deformed newborn may be affected by this bill.

These are difficult medical issues and horrendous circumstances which confront hopeful families every day. I am cognizant of the fact that these are complex issues which doctors, hospitals, families, and courts grapple with every day.

I would quote the Committee's report from the last Congress which makes clear that this legislation, and I now quote from the Committee report, quote, "would not mandate medical treatment where none is currently indicated. While there is a debate about whether or not to aggressively treat premature infants below a certain birth weight, this is a dispute about medical efficacy not regarding the legal status of the patient. That is, the standard of medical care applicable in a given situation involving a premature infant is not determined by asking whether the infant is a person. This legislation would not affect the applicable standard of care, but would only ensure that all born-alive infants, regardless of their age and regardless of the circumstances of their birth, are treated as persons for purposes of Federal law." End quote.

I do not want to trivialize the concerns regarding this bill held by neonatologists, but I assume and hope to have the assurance of

the Chair that the intent of this legislation has not changed, that Congress is not attempting to substitute congressional medical judgment for the judgment of doctors on the scene or interfering with the painful decisions that families must make under the most difficult and tragic of circumstances. We must respect families and not have the big hand of Government make their worst moments even more unbearable.

Finally, I wanted to note that this hearing—so in summary on that, I think that the report language of the last Congress, which I hope we'll put in again in this Congress, makes clear that the concerns that this affects—might affect the standard of care owed to critically ill newborns or non-viable newborns is not affected by this bill. That's not the intention of this bill. The law recognizes such newborns as people and the question is what is the efficacy of medical care, not what is the—whether they're legal. I hope we will reaffirm that determination so that we can satisfy the concern of Ms. Johnson and some—I was about to say some other neonatologists; she's not, of course; she's a Member of Congress—and of neonatologists.

Finally, I want to note that this hearing is unfortunately taking place at the same time that the leadership of the House has scheduled the campaign finance reform debate on the floor, which, unlike this bill, is very controversial and concerns the future of our democratic institutions. I may not be able to be present for the entire proceeding because I do want to—have to participate in the campaign reform discussions, but I want to assure everyone here that I remain very involved with this legislation and that I hope to work with the Chairman to ensure that it is not sidetracked by fringe agendas and that it remains very clear what the purpose of this bill is, that it has nothing to do either with hobbling neonatology judgments or with the abortion debate.

I do not anticipate any amendments, and with the Chairman's agreement that we are in accord, I do not see any need to particularly drag out the process.

Before we proceed, it has come to my attention that some of our colleagues and other interested parties may wish to submit comments and other materials for the record. I ask unanimous consent that all Members be permitted to submit additional statements and other materials for the record.

Mr. CHABOT. Without objection.

Mr. NADLER. Thank you, Mr. Chairman.

Mr. CHABOT. Thank you.

I would now recognize the gentleman from Indiana for the purpose of making an opening statement. And before he does, could I ask him to yield for just a moment?

Mr. HOSTETTLER. I yield to the Chairman.

Mr. CHABOT. I thank the gentleman for yielding.

Just—I would just like to note, the gentleman from New York mentioned about there is no question that infanticide is a crime in this country, but I would just note that the former Senator from his own State of New York, in describing the horrible procedure of partial-birth abortion equated that with in essence infanticide. That was his opinion and I agree with him on that particular respect.

So depending on what one's—what one thinks about partial-birth abortion, in essence the U.S. Supreme Court feels that that form of infanticide is still the law of this land, and many of us think that that ought to be changed.

Mr. NADLER. Would the gentleman yield?

Mr. CHABOT. It's the gentleman—I'll yield back to the gentleman from Indiana.

Mr. HOSTETTLER. I yield to the gentleman.

Mr. NADLER. Thank you.

First of all, let me thank the gentleman—the Chairman for waiting for my coming back from the vote. But second of all, let me simply comment. We're not engaged in a debate on so-called partial-birth abortion. The Supreme Court has said that the various laws that most States—some States have passed dealing with what I might call—with various forms of abortion which have been given the title of late-term abortion, that those laws are invalid. Some people may consider that infanticide. It is a different situation than an infant that has been born. There is no State in this Union where there is any question about the legal status of an infant that has been born, that is separated from the mother and that is alive. In any State of the Union, that baby is a person, it's considered a human being and the normal statutes of murder and everything else apply.

This bill I think is unnecessary, but, except with the possibility of that problem with neonatology, also harmless because it simply restates existing law.

What the law ought to be with respect to so-called partial-birth abortion is a completely separate debate. We've had that many times. There's no point going through that again. If anybody wants to hear it, they can go to the Library of Congress and hear the tape. But it is a separate debate and I don't see any reason to get involved with that in the discussion of this bill.

I thank the Chairman—I thank the gentleman. I yield back.

Mr. HOSTETTLER. I yield back, Mr. Chairman.

Mr. CHABOT. Okay. Thank you.

The gentleman from Virginia, Mr. Scott, is recognized if he would like to make an opening statement.

Mr. SCOTT. No statement.

Mr. CHABOT. Okay. Thank you very much.

Okay. We will at this time move to the—he just yielded back. Oh, I'm sorry. Ms. Hart, I apologize. Didn't even see you coming.

The gentlelady from Pennsylvania, and please accept my apology for not recognizing you there. The gentlelady is recognized for an opening.

Ms. HART. That's okay, Mr. Chairman. I actually had no intention of making an opening statement. Thank you for the offer and I yield back. [Laughter.]

Mr. CHABOT. Okay. Well, we thank the panel.

At this time, we will ask the witnesses to please come forward and take their places, and we'll have an introduction of them.

I want to thank them for coming today, and we will hear from Professor Hadley Arkes, the Edward Ney Professor of Jurisdiction and American Institution at Amherst College. Professor Arkes has been teaching at Amherst for 34 years and has also visited on leave

from Amherst at the Ethics and Public Policy Center, the Brookings Institution, the Woodrow Wilson Center at the Smithsonian Institution, and Georgetown University.

Professor Arkes has written several books and numerous articles on political philosophy, public policy and constitutional law, and we welcome you here this afternoon, Professor.

Our second witness will be Jill L. Stanek of—am I pronouncing this right?

Ms. STANEK. Yes.

Mr. CHABOT. Is it Mokena?

Ms. STANEK. Yes.

Mr. CHABOT. Mokena, Illinois.

Ms. Stanek is a registered nurse and will also be sharing her experiences as a nurse in the delivery ward of Christ Hospital in Oak Lawn, Illinois, and we again welcome you very much and thank you for being here today.

Our last witness will be Dr. Watson A. Bowes, Jr., M.D., Professor Emeritus at the University of North Carolina at Chapel Hill School of Medicine, where he also served as a full professor in the Department of Obstetrics and Gynecology from 1982 to 1999.

Before joining the faculty of North Carolina, Dr. Bowes was a member of the full-time faculty in the Department of Obstetrics and Gynecology at the University of Colorado for 14 years.

Dr. Bowes' major professional interests include high-risk obstetrics, pre-term birth, and all aspects of labor and delivery. From 1995 to 1999, he served on the Committee on Ethics of the American College of Obstetricians and Gynecologists, and was the last—and for the last 2 years of that time Chairman of the Committee.

Dr. Bowes received his medical degree from the University of Colorado in 1955.

Thank you all for being here this afternoon. I would ask that you please try to summarize your testimony if possible within 5 minutes or less. We have a light system there which you'll notice. The yellow light will come on when there's about a minute to go, and if you wouldn't mind wrapping up by the time a red light comes on.

Without objection, your written statements will be made a part of the permanent record. And again, we welcome you, Professor Arkes, for your testimony.

STATEMENT OF HADLEY ARKES, EDWARD NEY PROFESSOR OF JURISPRUDENCE AND AMERICAN INSTITUTIONS, AMHERST COLLEGE

Mr. ARKES. Thank you, Chairman Chabot, Members of the Committee. My name is Hadley Arkes, I am the Ney Professor of American Institutions at Amherst where, as the Chairman said, I taught for the past 35 years. I have an extended statement that will be made available in the record.

Mr. CHABOT. Without objection.

Mr. ARKES. Yes. I am here today in support of H.R. 2175, the Born-Alive Infants Protection Act introduced by Chairman Chabot. I would say of this act what I said of the earlier version last year, that this measure introduced by Chairman Chabot offers the gentlest and most modest first step of all in engaging the question

of abortion. It's a modest move, but it also runs to the root and offers the best chance of drawing all sides into a conversation, because even people who call themselves pro-choice think that abortions may rightly be restricted under some circumstances, and we ask why not begin here at the simplest level with a child who survives the abortion. No one is quibbling over whether we're dealing with a human being and the pregnancy has ended. We're not impairing rights of abortion.

Yet, even though this would seem to be the simplest case, it's no longer so easy for people to explain the grounds on which they would protect that child born alive. G.K. Chesterton once remarked that if we asked the modern man to explain what is wrong with the practice of cannibalism, the modern man is more likely to respond with a prejudice: We just don't do that here. The medieval schoolman could give you a reason. If we ask people why do we protect the child born alive, the answer isn't so clear any longer. We can't simply say, "Well, that's what the laws have always done," because that answer could have been tendered about why we protect the unborn child up until January 22nd, 1973. And that is why we have sought to add those findings to the bill.

We would suggest that it really would be incoherent for people to vote for this bill unless they imply that that child has a claim to the protection of the law that doesn't pivot on the question of whether anyone wants her. If that's wrong, we just invite people to say, what reasons they would put in its place? But if that's the case, we seem to imply that the child has an intrinsic dignity that doesn't—that can't be contingent, then, on her location or whether she serves the interest of other people.

Now, this understanding of starting in the gentlest way and planting premises in the law has been the understanding that has enveloped this scheme from the beginning, since I first wrote it about 13 years ago for the debating kit of the first George Bush. It's never been a matter of concealment; it's been proclaimed openly in print persistently, for our hope has been to draw the other side into a conversation reflecting even the sentiments of people who call themselves pro-choice. Our proposal has been to move step by step. And we fully recognize that if we don't persuade people on the other side, the movement stops.

But our consolation has been this, that from the volume of 1.3 million abortions performed every year, we might hold back and save a handful of lives, and what's to be disdained in that?

The real problem for our friends on the other side, I think, is in explaining how they could vote for this measure while they reject all of its premises. The matter has been complicated over the past year—let me remind you where it began, with that dictum of Judge Clement Haynsworth in *Floyd* v. *Anders* in 1977 when a child had survived an abortion for 20 days, and a surgery. And when the question was put, were we obliged to protect the life of that child, the answer tendered by Judge Haynsworth was no, that is not a child protected by the law; that is a fetus marked for termination. In other words, the right to an abortion is the right to an effective abortion or a dead child.

This problem has been complicated over the past year by the decision in the *Stenberg* case that Chairman Chabot alluded to. In

that case, Court essentially told us that we couldn't protect the life of a child at the point of birth. And, as the Chairman rightly referred to, Judge Barry's opinion in the *Farmer* case just 6 days after we held the hearing last year is an example of kind of post-modern jurisprudence where Judge Barry said a woman seeking an abortion is plainly not seeking to give birth. In other words, there are no objective facts; a woman has decided on an abortion and therefore there is no birth, there is nothing there to be born. I would suggest to my new friend, Congressman Nadler, that that is the thing that complicates the situation and makes it different from all the laws in place in other States.

With this legislation, the Congress could put up a firm barrier to infanticide by making it clear that we are rejecting decisively the claim that the right to an abortion is the right to an effective abortion or a dead child.

Our friends on the other side have muted their opposition I think in order not to draw more attention to the bill. But even so, they will have backed into a state of collaboration with us because they will have helped in passing this bill and confirm this momentous point: that the Congress does, indeed, have the authority to legislate a limit to abortion.

We could take the occasion to teach again some axioms of our constitution often forgotten. If the Supreme Court can articulate new rights, say, under the fourteenth amendment, in civil rights, or a right to abortion, the legislative branch must be capable of vindicating the same rights and in filling them out, marking their limits.

The one thing that should be untenable under the constitution is that the Court can articulate new rights and then assign to itself a monopoly of the legislative power in defining those rights.

Congressman Watt—to move to my conclusion, Congressman Watt raised the question with me last year about making changes in the meaning of persons when there are several thousand references. I address that question in my extended testimony, and I would address it also in the discussion. But may I say in closing that the ground on which we take this simplest of measures will clarify our understanding of the human person as the bearer of rights. If we can't draw the line on infanticide, we must wonder: what kind of a people have we become?

This is the simplest of steps to make, and to take a line from Lincoln, may the vast future not lament our having failed to take it now.

[The prepared statement of Mr. Arkes follows:]

PREPARED STATEMENT OF HADLEY ARKES

Chairman Chabot, Members of the Committee:

My name is Hadley Arkes. I am currently the Edward Ney Professor of Jurisprudence and American Institutions at Amherst College. I've taught at Amherst since 1966, with the exception of several years in which I have been in Washington on leave and visiting at places like the Brookings Institution and the Woodrow Wilson Center at the Smithsonian Institution. My main interests as a writer and a teacher have been focussed on political philosophy, public policy, and constitutional law. I have written, in that vein, several books, published by Princeton University Press, including *The Philosopher in the City* (1981), *First Things* (1986), *Beyond the Constitution* (1990), and *The Return of George Sutherland* (1994). I have had a strong interest in the so-called "life issues," of abortion and euthanasia, but those interests

spring from the central concern in my work, which involves the moral ground on which the laws would have to find their justification.

I had the privilege of testifying before this committee last year on this same bill, which passed the House by a vote of 380–15. I would say now again, with renewed conviction, that the bill introduced by Congressman Chabot, HR 2175, the "Born-Alive Infants Protection Act" offers the most modest and the gentlest step that is imaginable in dealing with the question of abortion; and at the same time it is the approach that goes most deeply to the root of things. That combination, of the gentlest measure, and the measure running deepest, offers the best chance we have seen, over the past 28 years, to draw all sides into a conversation, and achieve the kind of settlement of this issue in our politics that can only be achieved by the political branches.

The refrain has been heard, at every turn, that abortion is one of the most emotional and divisive issues in our politics. And yet, there has been, for years, a remarkable measure of consensus in this country on abortion, a consensus that draws in Democrats as well as Republicans, pro-choicers as well as pro-lifers. The surveys show that even people who call themselves "pro-choice" do not think that all abortions should be permitted. Indeed, they have expressed a willingness to restrict, through the law, a large number of abortions that are now permitted in the law. But that consensus has not been able to manifest itself in our laws, because the opinions of the public have not been allowed to shape the laws that the courts will permit. At the same time, I've made the argument over the years that our problems here would not be solved even if the elves could come in the middle of the night and remove *Roe v. Wade* from the records of our law. Even if that decision were overruled overnight, the distemper and rancor in our political life would not be removed. For many people would feel themselves dispossessed of something they have been encouraged to regard by now as one of their first freedoms under the Constitution.

Evidently, we would need a conversation before we could begin to legislate on this question. But what makes that conversation possible is the fact that there has been, as I say, a surprising degree of consensus that has not been allowed to manifest itself on this matter of abortion. The news that took years finally to break through to the American public is that the laws on abortion in this country, fashioned by the courts, permit abortion for any reason at all, through all stages of the pregnancy—and even, as we have seen, at the time of a live birth, with the partial-birth abortion. But the surveys have shown for years that only about 22–27 per cent of the public supports this policy of abortion on demand, for any reason, at any time. Even many people who call themselves pro-choice do not think that abortions should be performed in the late stages of pregnancy, and for less than weighty reasons. People may support a right to abortion under some circumstances (most notably, when the life of the mother is endangered), but many of them still hold that a human life should not be taken for the sake of removing financial strain in the family, removing barriers to the career of a woman, or serving the convenience of the parents.[1] Most people do not think that abortions should be performed because the child is likely to be deaf or blind, and the opposition to abortion for these reasons is often quite independent of the age of the unborn child. My own surmise here is that most people think it would be wrong to take the life of any person because he happens to be deaf or blind. And if they think this kind of killing would be wrong at any age of the victim, they may conclude that the principle would be indifferent, in the same way, to the age of the child in the womb.

I could go on, but these points have been documented well by now in the public surveys. And yet, this constellation of opinion, rather stable over 25 years, has had no significant impact on the laws on abortion, shaped and sustained by the courts. Congressman Chabot's bill offers the chance finally to let that opinion of the public manifest itself in our laws. It does that, also, in the gentlest and most powerful way by beginning the conversation at the place that should command the most overwhelming consensus across our political divisions: the place where we act simply to preserve the life of the child born alive, the child who survives an abortion. That moment marks the earliest possible time, associated with an abortion, when the interests of the pregnant woman can be separated entirely from the interests of the child. Even if *Roe v. Wade* articulated an unqualified right on the part of a woman

[1] See "Abortion and Moral Beliefs: A Survey of American Opinion," Washington, D.C., February 28, 1991, p. 38. The study was conducted in the field by the Gallup organization, and commissioned by Americans United for Life, a pro-life group. But the survey was designed by Profs. James Davis Hunter (University of Virginia), Carl Bowman (Bridgewater College), Robert Wuthnow (Princeton). And more recently, see CNN/USA Today/Gallup poll: April 30-May 2, 1999.

to end her pregnancy, the pregnancy would now be over. No right to end the pregnancy would require at this moment the death of the child.

And of course no one, at that moment, claims to be suffering any doubt that we are dealing with a human being—as though the offspring of homo sapiens could have been anything less than human at any phase in its life. This is the first moment then, under our current law, when we should be able to declare, with unchecked conviction, that the law may extend its protections over that child. Or to put it more precisely, that is a moment in which it could be said for that child engaged in an abortion what could be said for any other child, or person, in the country: namely, that the claim of the child to the protections of the law could not possibly pivot on the question of whether anyone happens to "want" her.

We would be in a condition truly miserable if we could not count on certain natural human sympathies at work to protect the child, and there seems to be a normal tendency on the part of parents and hospitals to supply that care to the child who surprises everyone by surviving the abortion. And yet, the law frequently comes into play precisely because parents do not always have this inclination to protect their children. As we have ample reason by now to know, some parents may be inclined to abuse or even kill their born children. In the case of abortion, the matter is complicated for us by the fact that the very logic of "abortion rights" seems to create a momentum in principle to let the child die. Jill Stanek, who is joining us today in this hearing, offers a report from a respectable hospitable in our own time where that logic has been allowed to play itself out in real cases. She reports on the so-called "live birth" abortions, where children are delivered and simply left unattended, to die. I take it as a blessing that we are still capable of reacting with shock when these cases spring up, but they should have ceased long ago to have caused surprise. For the very logic that attends the "right to abortion" prevents that right from being cabined, or confined, to the child in the womb. That logic must move outside the womb if the child happens to survive, and we ought to take account here of those decisions, rendered in the courts, that have now made this point chillingly clear to us. In a notable case from South Carolina in 1977, Judge Clement Haynsworth confronted the situation of a child marked for abortion, a child of 25 weeks gestation. The child had survived the abortion, undergone one surgery, and lived for 20 days before he died.[2] The question had been posed as to whether there had been an obligation to preserve the life of that child. And the answer, tendered by Haynsworth, was no. After all, the mother had decided on an abortion, and therefore, as Haynsworth said, "the fetus in this case was not a person whose life state law could protect." (*Floyd v. Anders,* 440 F. Supp. 535, at 539.) The right exercised by the mother could not be frustrated, or negated, by the accident that the child happened to live. Or to put it more baldly, the right to an abortion must entail nothing less than the right to an "effective abortion," or a dead child.

Several years later, in *Planned Parenthood v. Ashcroft* (1983), Justice Powell noted, in a footnote, a doctor who had made that argument quite explicitly: that the right to an abortion meant an effective abortion or a dead child. Justice Powell pronounced that opinion "remarkable."[3] From that comment, offered in passing in a footnote, even some pro-life lawyers have drawn the inference that the Supreme Court has rejected that argument.[4] But as any lawyer should know, to state that this claim is "remarkable" is not exactly the same as pronouncing it "wrong," and still less is it to explain the grounds of its wrongness.

And now, just last summer, only a few days *after* this Committee had met to consider the Born-Alive Infants Protection Act, a federal appellate court offered the most sobering confirmation that Haynsworth's judgment was not at all an aberration in the law. A panel of three judges in the Third Circuit struck down New Jersey's version of a law on partial-birth. That move was expected in the wake of the Supreme Court's decision a month earlier, in *Stenberg v. Carhart.* But Judge Barry, writing for the panel, gave the decision and added twist: With language rather colored, she expressed her contempt for the effort to draw a line between the child in the womb and the child at the point of birth. That distinction has been known to common sense for millennia, but the application of that distinction in these case,

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[2] 440 F. Supp. 535, at 539 (1977).

[3] 462 U.S. 476, at 485, n. 7 (1983).

[4] One lawyer also recalls, in this vein, that the Supreme Court actually reversed the holding in *Floyd v. Anders,* or rather sent the case back for a reconsideration. But in an opinion *per curiam*? the Supreme Court sent the case back on the ground that "the District Court may have reached [its] conclusion on the basis of an erroneous concept of 'viability,' which refers to potential, rather than actual, survival of the fetus outside the womb." In all strictness, none of these comments, or moves, marks an explicit rejection of the claim that the right to abortion entails the right to an "effective abortion."

she thought, involved "semantic machinations, irrational line-drawing, and an obvious attempt to inflame public opinion":

> the Legislature would have us accept, and the public believe, that during a "partial-birth abortion" the fetus is in the process of being "born" at the time of its demise. It is not. A woman seeking an abortion is plainly not seeking to give birth. (*Planned Parenthood v. Farmer*, 220 F.3d 127, at 143 [July, 2000])

If there was ever a decision that embodied the very vices it was decrying, this must surely be it, for the argument here now was that it was all, in the end, a matter of perceptions, of "semantics" and "line-drawing": There were no objective facts—no birth, no "child" being killed at the point of birth, because the mother, you see, had elected an abortion. Once she had made that choice, there was no child to be killed, no birth to take place. For as Judge Barry said, the pregnant woman was "plainly not seeking to give birth." This decision must mark the emergence of a kind of "postmodern" jurisprudence, where theories ever more imaginative simply displace objective facts or recast them to mean something else. But it also confirms what even many pro-life lawyers had refused to believe: Judge Haynsworth's opinion in *Floyd v. Anders* was not an anomaly or aberration; it expressed the understanding that had now become the operational doctrine among many federal judges.

At the same time, that understanding was merging in the most fearful way with the decision last year in *Stenberg v. Carhart*, where the Court began to lay the path, and prepare the public mind, for a certain blurring of the boundaries as abortion spills over into infanticide. In his opinion for the Court, Justice Breyer argued that the partial-birth abortion (Dilation and Extraction [D&X], as grisly as it is, could still be reckoned as safer for the pregnant woman than the more familiar method of dismembering the child in the womb. As Breyer explained:

> The use of instruments within the uterus creates a danger of accidental perforation and damage to neighboring organs. Sharp fetal bone fragments create similar dangers. and fetal tissue accidently left behind can cause infection and various other complications.[5]

Is the implication not obvious? The avoidance of the usual method of abortion now warrants killing a child with 70 per cent of the body dangling out of the birth canal. On the same premises, would it not be even safer to deliver the child whole and simply let it die? For the doctor could then wholly avoid the insertion of instruments into the uterus or the dismembering that would allow fetal parts to be left behind, where they could be the cause of infection. With these steps, the Court has brought us to the threshold of outright infanticide, and it takes but the shortest step to cross that threshold. One must wonder then whether the majority in *Stenberg v. Carhart* is preparing us for a holding even more advanced and astounding. But the point is that it will have ceased to be astounding if we offer no response and permit no line to be drawn finally at infanticide.

To our friends then who say that this bill is not needed, we would have to say: Look about you, and seen plainly what is there. People who share your position think there is not the slightest inconsistency in claiming that there is a right to a dead child, and that the child who survives the abortion has no claim to the protection of the law. The people who make this argument, unashamedly, think that it is not only consistent, but virtually entailed, or made necessary, by the logic of "abortion rights." As you look about you in this country, can we not see, in fact, a notable drift in the same direction, with hospitals such as Christ Hospital in Oaklawn, Illinois, or with the appointment of Prof. Peter Singer to Princeton University. That a leading university would appoint to a prestigious chair an outright defender of infanticide is but one sign in a drift of some parts of liberal opinion, to be far more accepting of infanticide, or at least to break down our lingering prejudices against the killing of infants. In his testimony to the Committee last year, Professor Robert George, the McCormick Professor at Princeton, noted that the appointment of Mr. Singer at Princeton was not an isolated, curious instance. It was part, rather, of a trend in evidence in other parts of the academy to make the public more suggestible to the notion of infanticide as a legitimate thing. The people who arranged the appointment of Professor Singer to a chair at Princeton were well aware of his views; indeed those views formed the main part of the attraction. His elevation was, for them, a means of making a dramatic point in public. And the point was: that we should recede from our adamant opposition to infanticide; that we should treat that aversion, not as commitment anchored in principle, but as a social

[5] Slip opinion, Section I B.

prejudice, and like all prejudices, subject to erosion with the advent of new and better reasons.

In the meantime, the evidence from abroad already gives warning as to how much that erosion is underway, even in the camp of people noted for their expansive social sympathies. Over the last few years, we have seen a controversy in Australia over the treatment of children who survive abortions, and we have seen the most jolting statement on this matter put out in South Africa by the Department of Health, the agency that oversees the practice of medicine in that country. In 1997, the Department put out new guidelines, instructing doctors and nurses that "if an infant is born who gasps for breath, it is advised that the foetus does not receive any resuscitation measures."[6] In Australia, in 1999, a controversy was ignited when doctors, and certain agencies, actually registered their opposition when an agency of the government advised that babies who survive abortions should be given medical care. Mr. Gab Kovacs, the chairman of Family Planning Australia, insisted that babies born at an early gestational age had no realistic chance of survival, and they should be left to succumb. Those are civilized countries, with legal systems based on the British model. But what seems to be at work in both places is a vibrant strand of opinion, holding that the logic of abortion rights entails that right to an "effective abortion" or a dead child.

This is a problem, then, for the liberal contingent in our politics. The new acceptance of infanticide is being absorbed now in the body of their doctrines and their commitments as a political party. If they think that the refusal of care to the child who survives the abortion is, as we say, "over the top," then it has become a matter of high urgency for them finally to say that—and to do something now, both modest and emphatic, to draw that line.

Of course, we are likely to hear the argument that a law is not really needed here: the cases are mercifully few, and the dominant inclination among nurses is to nurse, to take care of newborn infants. And yet, as any philosopher or social scientist would know, we can draw no inferences about the understandings that are animating people when we are told that "the dominant practice, among parents, doctors, and hospitals, is to preserve the life of a child who survives an abortion." The fact that they do this, or do it most of the time, does not reveal anything to us about the grounds on which they are acting, or the principles that actually govern their actions. That is the question posed in this simple move by Congressman Chabot: The bill gives us the chance to fix in the law the principle that actually protects the child. And if that is not in fact the principle that explains the motivations of people on all sides, then that is something quite important for all of us to learn.

For those of us who have advocated this bill, the principle would run, as I have suggested, in this way: We think that the inclination to protect the child with the law must imply that the child has a claim to the protection of the law that cannot pivot on the question of whether anyone "wants" her. In that case, we would imply that the child has an *intrinsic* dignity, which must in turn be the source of rights of an intrinsic dignity, which cannot depend then on the interests or convenience of anyone else. When parents commit infanticide with a child two or three years old, we no longer ask whether the child was straining the parents, or whether the child was unwanted. If we understand that we are dealing with a human being, reasons of convenience and self-interest become radically inadequate in supplying a "justification" for the killing of the child. We would think that the same understanding must come into place for the child who survives the abortion. Now if such a principle cannot be invoked on behalf of that child—if our friends on the other side of the issue of abortion would protect the child but not share these premises of ours—then we would earnestly invite them to explain the principle they would put in its place. If we haven't stated here the reasons that we cast over the child the protections of the law, then what would those reasons be?

We had sought to array those reasons in the form of "findings" attached to this bill. Justice Frankfurter once lamented the loss of those preambles attached to legislation, for those preambles would make explicit the premises behind the bill, and along with that, the rationale and the purpose of the legislation. This modest bill works mainly by planting premises in the law, and I rather regret that the Committee decided to delete the rather impressive chain of reasoning that the staff brought forth as the findings that explain and justify this bill. Nevertheless, those premises are still there; we can still state them, as I have stated them here, and we can make the point that they provide the only coherent grounds for voting this

[6] See "Abortion Babies 'Should be Left to Die,' by Angella Johnson, African New Service, March 17, 1997. One female doctor declared that the directive was "inhuman and against all my principles." Other reports suggested that as many as 50 per cent of the nurses and "health workers" in the country would refuse to comply.

bill in the first place. We can earnestly ask our friends on the other side to correct them, or amend them, if they think we have it wrong. Let us suppose, for example, that someone says, "I would protect the child because the child elicits in me a sense of sympathy." But if that were the ground, the explanation has to do more with *ourselves*, with our feelings, and with *our* sense of what is pleasing or satisfying to us, or agreeable to our own interests. By implication, of course, there would be no obligation to protect the child when that course of action did not serve *our* interests or convenience.

My own sense is that people on either side of the controversy over abortion would not be satisfied with that kind of rationale, and that they would see instantly that there is something deeply wrong in it. But if that is the case, does it not become clear, by implication, as to what we must say instead?: Must we not be moved to say that there is something of an intrinsic dignity in the child, or any other human being, something that compels our respect, quite apart from anything in our self-interest? If that cannot be said for the child, newborn, at these first moments, then what can be said for any of the rest of us at any other time, for any other right? If we cannot speak those words, we would seem to imply that none of us has a claim to be respected, or a claim to be the bearers of rights, unless our presence, or our rights, suit the interests of those around us. What would even a "right to abortion" mean under those circumstances? Would it not be then a "right" that depends on the sufferance of others—a right that can be abridged or removed when it no longer suits the interests of a majority, or of those who exercise power?

Frankly, I don't see how we can refuse to protect the child at this point without producing a revolution in our law and deciding that, from this day forward, we will treat as a nullity the laws on infanticide. And of course we cannot say, in an offhand way, that infanticide has ceased to be a big deal without backing into the claim that homicide itself has ceased to be a big deal. People may try to finesse the matter by saying that we should wait perhaps a few days, or a week or two, before we extend the protection of the law to the newborn. But that would simply be a thinly disguised way of saying that we will wait in protecting the child until we are clear that the child is acceptable to someone, that it is in someone's interest to keep or "want" that child.

If I am right, and there is no way of getting around this matter, then Rep. Chabot's modest bill does the service of compelling us to face this elementary question about the human person, the question that stands at the heart of the thing. I would not conceal my own hope or expectation here: Once this first premise is planted, it must project itself back into the situation of the child even while still in the womb. After all, if we come to the understanding that the child has an *intrinsic* significance as a human being; that her claim to be protected by the law does not pivot on whether anyone wants her; then how could that intrinsic significance be affected by anything as contingent or "extrinsic" as whether she is only two days or two weeks before birth, or whether she is attached by an umbilical cord to her natural mother? How could it hinge on the question of just where she happens for the moment to be lodged or where she is receiving her nourishment? Nothing in her intrinsic significance could be affected by things of this kind when she leaves the womb. By the same logic, none of these attributes could have any moral bearing on the standing of the child to receive the protections of the law when she is still in the womb.

I happen to think myself that, once that first premise is granted, the argument to justify abortion can probably be unraveled step by step. It would be my own purpose to keep taking those steps, one at a time, and keep putting the question to people on the other side, who would be reluctant to waive the right to abortion under any set of circumstances. I would indeed raise the question of the child in late term, or perhaps the child of the "wrong" sex, or the child afflicted with handicaps. But that is to say, I would earnestly press the question with people on the other side, and attempt to persuade them step by step. None of us can foresee just how far that process may run. It is still open to people on the other side to refuse to go along, to insist that they have not been persuaded. They may not in fact see that the willingness to protect the child at birth bears implications for the protection of the child even earlier. But if so, what can we do except keep the conversation going? Yet, with each step we would have succeeded in saving another cluster of lives, even a handful of lives. And for those lives that are saved, the whole project must be eminently worth doing.

May I say then, on this point, that there has never been the slightest concealment: This hope of working step by step, to pare back the doctrine in *Roe v. Wade*, is something I have proclaimed often in print from the first time, 13 years ago,

when I first offered this proposal in public.[7] In that case, it is hard to see any warrant for the objection cast up by certain adversaries that this is a "dishonest" bill.[8] There has not been a trace of concealment or dissembling on our side; and if the rules of a robust politics are in order, I would avail myself of the same privileges of rhetoric and suggest that the real dissembling is on the other side: The partisans of abortion rights were counseled to vote for this bill rather than to step into our "trap" and vote for infanticide. They were advised, in effect, to play "rope-a-dope"—to go with the punch, and vote for the bill, rather than give us a public argument and draw even more attention to this measure. But plainly, this counsel is one of pure tactics bordering on cynicism, for those who accept the deep logic of abortion rights cannot possibly vote for this bill on the premise that the child has a claim to the protection of the law, regardless of whether anyone happens to want her. In all strictness, the partisans of abortion rights should come out on this question where Judge Haynsworth came out: If a pregnant woman had been willing to give up a child who was so patently her own, she would have arranged for an adoption. If she had a "right" to destroy a child she did not want, nothing in her right could have been impaired by fact that the child came out, as it were, by accident. The right to abortion has been predicated on the premise that the child in the womb has no standing as a human being, and no rights, that the mother is obliged to respect. That the child happens to be born alive would not seem to add anything of moral significance in establishing, for the child, the claim to receive the protections of the law.

It is not our side then that has any explaining to do. The burden really falls to the defenders of abortion rights to say how they could in fact vote for this bill when they could not possibly share the premises or principles that would justify this measure. In contrast, it must be said that the most "honest" response on other side was the response of the National Abortion Rights Action League, who opposed this bill from the outset. In the name of prudence this group has been counseled now to mute its opposition, but its opposition to this bill in principle offers the most eloquent confirmation of the understanding behind our bill. NARAL is nothing if not clear-headed on the issues of principle, and it recognizes, more than its allies care to admit, that any move to recognize the child as a being with an intrinsic dignity, coming within the protection of the law, must plant a principle that would run all the way back. That small concession in principle would indeed threaten the rightness of abortion at the root of its moral claim.

In this respect, the people at NARAL see through all of the legal definitions and distinctions—and see right through to the heart of things. After all, if abortion were understood strictly, nothing in this bill could possibly threaten any rights articulated in *Roe v. Wade.* As Professor Gerard Bradley noted last year, in his testimony for this Committee, "The *Roe* Court often referred to 'potential life', and used that term interchangeably with the 'fetus', or the child in utero. All these terms were contrasted to the child born alive":

> *Maloy's Medical Dictionary for Lawyers* (3rd. 1960) defines pregnancy as "the state of being with young; preparing to bring forth" [581]; "birth" is "the act of coming into life, or being born". [104]. The *Oxford-English Dictionary* (2nd edition) defines "birth" as "the bearing of offspring"; "bringing forth". "Pregnant", according to the OED, is "with child or young".
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> Abortion, these sources and the cases make clear, refers exclusively to terminating a "pregnancy". Another way to terminate a "pregnancy", it is equally clear, is to give "birth". . . . The woman is not then prohibited, by this or any other act, from securing or completing an "abortion". From the moment of birth on, "abortion" is, according to standard medical usage, impossible. No "pregnancy" remains to be terminated.

To cast a protection over the child born alive is to cast up no restriction on abortion. The rights proclaimed in *Roe v. Wade* remain unimpaired. But NARAL sees, rightly, that the Born-Alive Infants Act recognizes the human standing even of the child marked for abortion. And once that child is recognized for what it is, at any stage, that recognition must call abortion into question, for it must raise grave questions about the taking of that innocent life, at any age, for reasons that are self-serving.

The opposition to this bill may be muted then, but it will not be stilled. Many members of Congress will be voting for this bill because they are uneasy over the notion of removing born children from the protection of the law, and yet they are

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[7] See my piece in National Review (October 28, 1988), pp. 30 ff., and "Anti-Abortion, But Politically Smart," Wall Street Journal (March 28, 1995), Editorial page.

[8] See the Congressional Record (September 26, 2000), p. H8157.

evidently fearful of having Congress act, even to establish the clear limits of that right to abortion. And so we encounter people who say, "We agree with you, but these are rare cases, and as modest as this measure is, it is the first step that allows the Congress to be legislating on abortion. It is the first step toward involving the government in these private questions of abortion."

There are several layers of fallacies involved in this argument, and I don't expect the least acknowledgement that arguments of this kind will emanate from some of the same people who were passionate, several years ago, in advocating the passage of Freedom of Choice Act. That was an effort to codify in our statutes the holding in *Roe v. Wade*. The political figures and professors who championed that measure apparently did not think that there was anything in the Constitution that barred the Congress from legislating on the matter of abortion, when it came to protecting and promoting abortion. Toward that end, the full resources of the federal government could indeed reach that private matter of abortion, whether it involved the performing of abortions in the military outposts of this country, or providing counseling and support of abortion in private facilities with federal funds.

But there is a curious screening that comes along with this argument when we turn to restrictions on abortion. And what is screened out, most notably, are the powers of Congress and the very design of the Constitution in the separation of powers. When people argue that the federal government should not be involved in these decisions, I usually ask whether they mean that some effort should be made under Art. III, Section 2, to keep the federal courts from intervening in these questions. But that is not what they mean, and one nearly has the impression that the federal courts are somehow not part of the federal government. The federal courts intervened decisively in this matter of abortion in the early 1970's, and in *Roe v. Wade* the Supreme Court virtually swept away the laws that restricted abortion in the fifty States. Was that not an intervention of the federal government?

The federal courts have addressed the question of abortion in all of its dimensions, from the use of prostaglandins, and the methods of abortion, to the facilities in which these surgeries may be performed. But we may earnestly ask: How could the judicial branch of the government have the authority to deal with abortion in all of its dimensions, while the legislative branch would not have the slightest authority to address it in any dimension? A contention of that kind simply wars with the most fundamental things that should be understood about the American Constitution, especially by lawyers and members of Congress. Chief Justice Marshall once remarked on this axiom of the Constitution in *Cohens v. Virginia,* in 1821: "[T]he judicial power of every well constituted government," he said, "must be coextensive with the legislative, and must be capable of deciding every judicial question which grows out of the constitution and laws."[9] To put it another way, any issue that arose under the Constitution and laws of the United States had to come within the jurisdiction of the federal courts. And yet, even jurists are persistently taken by surprise by the corollary of that axiom: Any issue that comes within the competence the judicial branch must come, presumptively at least, within the reach of the legislative and executive branches. After all, if the Court can articulate new implications of the Fourteenth Amendment—if the Court can proclaim, say, a deeper right on the part of black people not to suffer discriminations based on race—did Congress not have the power to act on the same clause in the Constitution in vindicating those rights? Congress did exactly that in 1964, and it acted with the wider range of flexibility that a legislative body can summon, when it is not confined, in the style of courts, to the task of addressing cases in controversy between two parties.

We might put the matter finally in this way: If the Court can articulate new rights under the Constitution—including a right to abortion—the legislative branch must be able to act, on the same ground in the Constitution, in filling out those rights. But in filling them out, the legislature must have the power to mark their limits or their borders. It should be as plain as anything could be that what is not tenable under the Constitution is that the Supreme Court can articulate new rights—and then assign to itself a monopoly of the legislative power in shaping those rights.

The genius of the separation of powers is that no one branch can be in complete control over the laws or its own powers. The provision on bills of attainder, for example, means that Congress may not legislate guilt or direct prosecutions under the laws it passes. Congress must work by defining in impersonal terms the nature of the wrong it would forbid, and it must work with the awareness that the law it passes will be placed in other hands to be administered. That is to say, the power to prosecute under the laws may be placed in hands unfriendly to those men and

[9] 6 Wheaton 264, at 384.

women in Congress who frame the laws. But as John Locke pointed out, that state of affairs provides a wholesome caution to the legislators: "[T]hey are themselves subject to the law they have made; which is a new and near tie upon them to take care that they make them for the public good." [10] In other words, they have an inducement not to pass laws that they would not willingly see enforced even against themselves. In that respect the logic of the separation of powers draws on the logic of a moral principle: do not legislate for other people a rule that you would not see applied universally, to yourself as well as others.

That is a wholesome principle, which may aptly govern the government in general—which means that it is no less wholesome when applied to the judicial branch as well as the legislative. The Congress did not inject the federal government into the matter of abortion; it was the Supreme Court that did that with crashing cymbals, and reverberations continuing to our day. Since *Roe v. Wade*, the Congress has not exercised its legislative authority to restrict or cabin or scale down in any way the rights that were proclaimed in that landmark case. But now we are at a point at which the Court has struck down the effort of legislatures in 30 States to protect children at the point of birth from one of the most grisly abortions. The Court has brought us to the very threshold of infanticide, and we are asked now to take a deep breath, avert our eyes, and simply get used to the notion that the right to abortion will be spilling past the child in the womb, to order the deaths of children outside the womb. It has become more critical than ever, at this moment, that a line be drawn. Any right must have its limit, including the right to abortion, and if that limit is not found in outright infanticide, we must ask: where could it possibly be? Congress is acting here in the most modest way simply to establish that limit. As a practical matter, it will affect only a handful of cases, but as I say, it will convey lessons running deep.

As we have come to understand, important principles may be vindicated even in a single case. Ollie's Barbecue in Birmingham, Alabama, was one family restaurant, but the Civil Rights Act of 1964 was tested and vindicated in the case of that one, local establishment. There may be a score of cases facing us here, with the infants who survive the abortion; and yet the principle has an import that goes well beyond the number of cases. But even so, even if we have but a handful of cases, would there not be a vast good contained in the move to save this handful of lives? From the massive volume of abortions in this country—from that 1.3 million carried out each year—why should we not take even this small gesture and rescue, from that ocean of deaths, a handful of lives? Why should we disdain that project as an undertaking too small for this Congress? Let us not confuse the modest with the insignificant.

At the same time I would enter the plea that we do not turn away from this modest but significant measure by invoking a misplaced concern for the extensiveness of the federal code as bar to further legislation. When I appeared last before this Committee, on the earlier version of this bill, Congressman Watt pointed out that there were several thousand references to "persons" in the federal code. This bill works, of course, by providing that all references to "persons" in the federal code will encompass now children who survive abortions. Again, there is no mandate here for heroic surgery, or for protections that run beyond those given to other persons under the law. The law would simply enjoin us to treat these newborns, surviving an abortion, on the same plane as we would treat other newborns, and not turn away from their care. Congressman Watt raised with me the concern over whether this alteration, or enlargement, in the coverage of "persons" might have some unanticipated and awkward effects as it is grafted onto the meaning of persons in the several thousand uses of that term in the federal code. The Congressman asked whether I had begun to look into that array of references to "person." I responded that I'd sampled some of them, but that it really did not matter to the issue in principle. A certain static entered the air, and I'm not sure that my explanation made it across the ether, and so I would offer it again. I had drawn on the analogy of Edward Bates, Lincoln's first Attorney General, when he was issuing an opinion of the Attorney General in guiding the government in the treatment of free black persons and resisting the Dred Scott decision of 1857. Bates announced that, in the understanding of the Lincoln Administration, black people born free in the United States would indeed be considered as "citizens" of the United States (the decision of the Supreme Court to the contrary notwithstanding). [11] And that move seemed to incorporate Lincoln's understanding that the reference to "persons" in the Privileges and Immunities Clause covered, in its terms, all people, black as well as

[10] John Locke, *Second Treatise on Civil Government*, Sec. 143.

[11] See his Opinion published under the heading of "Citizenship" in *Opinions of the Attorneys General*, vol. X (November 29, 1862) pp. 382–413.

white. I suggested then that when the Lincoln Administration issued its ruling, on the understanding guiding the Administration, that understanding could not have been defeated by someone invoking the complexity of the federal code and saying, "There are several thousand references to 'persons' and 'citizens' in the federal code. Shouldn't you spend more time looking into the bulk of those references before you install a change that can affect so many parts of our law?"

There was no need to do such a thing if we understood that *if there is a real principle engaged, that principle will cover every instance or application.* As I remarked to Congressman Watt, once we are clear on the principle by which the ball rolls down the inclined plane, as the angle of inclination is altered, we no longer have to ask what the effect would be if we had a blue plane or a yellow one, or an aluminum ball or a wooden one. And if we understand, for example, that it is wrong to draw adverse inferences about people on the basis of race, we would no longer have to ask whether racial discrimination would be quite as wrong in regulating access to tennis courts or swimming pools, as well as to schools. Our contention in this bill is that there is no defensible ground in principle to remove a newborn from the protections of the law because she happened to survive an abortion. Nothing in that accident could possibly affect in any way the innocence of the child, her standing as a human being, or her claim to receive the same protections that extend to any other newborn. The people who do not share our position would be free, of course, to challenge our reasoning on all of these points. But if they cannot quarrel with that reasoning, then we would simply suggest that there is no conceivable set of circumstances in which the innocence of the child would be impaired. And therefore, we can see no conceivable set of circumstances that could justify removing that child from the protections of the law.

Lincoln once remarked, in a famous line, that "in giving freedom to the slave, we assure freedom to the *free*—honorable alike in what we give, and what we preserve."[12] In this case, we might say that, in setting in place these, most elementary protections for human life, we are securing the ground for all of our rights, for the born as well as the unborn. This is the gentlest step to take, and to paraphrase Lincoln from another occasion, let the vast future not lament our having failed to take it.

Mr. CHABOT. Thank you very much for your testimony this afternoon, Professor.

Mr. ARKES. Thank you.

Mr. CHABOT. Ms. Stanek, you're recognized for 5 minutes.

STATEMENT OF JILL L. STANEK, MOKENA, IL

Ms. STANEK. Thank you for having me.

I am a registered nurse who has worked in the labor and delivery department at Christ Hospital in Oak Lawn, Illinois for the past 6 years. In the year that has elapsed since I last testified before this Committee, I have continued to work in the same hospital at the same position.

Christ Hospital performs abortions on women in their second or even third trimester of pregnancy. Sometimes the babies being aborted alive are healthy and sometimes they are not. The abortion technique that Christ Hospital and other hospitals use is called induced-labor abortion, and sometimes results in babies being aborted alive because throughout this particular procedure, the baby is not killed in utero. The focus of this procedure is to forcibly dilate a woman's cervix so that she will prematurely deliver a baby who dies during the birth process or soon after.

The cervix is the opening that's at the bottom of the uterus that normally stays closed until a woman is about 40 weeks pregnant and goes into labor. There are a few ways to force the cervix to open early. At Christ Hospital, the most common way this is done

[12] Lincoln, Message to Congress (December 1, 1862), in *The Collected Works of Abraham Lincoln*, ed. Roy P. Basler (New Brunswick, N.J.: Rutgers University Press, 1953), Vol. V, p. 537.

is by the physician inserting a medication called Cytotec into the birth canal close to the cervix. Cytotec irritates the cervix and stimulates it to open early. After the cervix is prematurely dilated, the small pre-term baby drops out of the uterus, sometimes alive.

In the event that a baby is aborted alive, he or she is given what my hospital calls comfort care. Comfort care involves wrapping the baby in a blanket and offering her to her parents to hold until she dies. If parents do not want to hold their baby, as I have been told is most often the case, it is left to staff to care for the baby.

Up until recently, staff options were to hold the baby until death, or put the baby in our soiled utility if we got too busy or if the baby lingered too long. Indeed, it is not uncommon for one of these babies to live for an hour or two or even longer. Last year, of the 16 babies that Christ Hospital states were aborted, at least five were born alive. Four of those babies, two boys and two girls, lived between one and a half and 3 hours. At Christ Hospital, one aborted baby lived once for almost an entire 8-hour shift. At least two of the second-trimester babies who were aborted last year at Christ Hospital were healthy babies.

One night, a nursing co-worker was taking an aborted Down's Syndrome baby who was born alive to our soiled utility room because his parents did not want to hold him and she did not have the time to hold him. I could not bear the thought of this suffering child dying alone in the soiled utility room, so I cradled and rocked him for the 45 minutes that he lived. He was between 21 and 22 weeks old, weighed about a half a pound, and was about ten inches long. He was too weak to move very much, expending any energy he had trying to breathe.

Toward the end, he was so quiet, I couldn't tell if he was still alive unless I held him up against the light to see if I could see his heart beating through his chest wall.

After he was pronounced dead, we folded his little arms across his chest, wrapped him in a tiny shroud, and carried him to the hospital morgue where we take all of our other dead patients.

Other co-workers have told me about incidences of live aborted babies whom they have cared for. A support associate told me about an aborted baby who was left to die on the counter of the soiled utility room wrapped in a disposable blanket—I'm sorry—towel. This baby was accidentally thrown into the garbage, and when they later were going through the trash to try and find the baby, the baby fell out of the towel and onto the floor.

A nurse co-worker told me about an abortion she was involved in where the baby was supposed to have spina bifida but was born with an intact spine. Since I spoke before you last year, this nurse that was involved in this particular abortion told me that what actually happened was that there was an incompletely formed twin who appeared as a mass on his brother's back during ultrasound. The nurse told me that the father came into the soiled utility room to see his son, took one look and saw that he had been involved in aborting a completely healthy baby, turned and left the room without saying a word.

I was recently told about a situation by a nursing co-worker who said, "I can't stop thinking about it." She had a patient who was just over 23 weeks pregnant, and she was not going to be able to

complete her pregnancy to term. This baby was completely healthy and had up to a 39 percent chance of survival according to the national stats, but the patient chose to abort. The baby was born alive. If the mother had wanted everything done for this baby, there would have been a neonatologist, a pediatric resident, a pediatric nurse, and a respiratory therapist present for this delivery and the baby would have been taken to our NICU for specialized care. Instead, the only personnel present for this delivery were a resident and my co-worker.

After delivery, the baby, who showed early signs of thriving—she began to breathe on her own and her FR scores improved—was merely wrapped in a blanket and kept in the labor and delivery department until she died two and a half hours later.

Just 3 weeks after this baby was aborted, another mother came to the hospital under similar circumstances, identically aged gestation, and was offered the same options. But she wanted to keep her baby, and so present at her delivery were those four aforementioned NICU personnel, and for the 2 days that I tracked her, that little girl lived.

When I testified before you last July, another nurse who worked at the hospital named Allison Baker also testified. Allison described walking into our soiled utility room on two separate occasions to find live aborted babies left naked on a scale one time and on a metal counter another time. She told about the patient she herself had who didn't know that her baby was going to be aborted alive and who did not want to hold him. After he was taken to the soiled utility room, she kept asking, "Is he dead yet? Is he dead yet."

Lest you think that Christ Hospital's live abortion practice is uncommon, I am entering into the congressional record today literature from a March 30th, 2001 symposium sponsored by Waukesha Memorial Hospital in Wisconsin wherein Dr. Washington Hill wrote, that one of three potential complications of a mid-trimester abortion is a live birth.

After I testified last year, Christ Hospital stopped putting babies into the soiled utility room to die. Seven months ago, it unveiled its comfort care room. This is a small, nicely decorated room complete with a First Foto machine in case parents want pictures of their aborted babies, baptismal supplies if parents would like their aborted babies baptized, and a footprinter and bracelets if parents would like keepsakes of their aborted babies. There is also a wooden rocker in the corner to rock the babies to death. And I am entering pictures of the comfort care room into the hearing record with your permission.

Mr. CHABOT. Without objection.

Ms. STANEK. When Christ Hospital opened its comfort care room, I was honestly galled. It became clearer to me than ever that a law must be enacted that specifies that all babies born alive are indeed human and American citizens with civil rights to equal protection. This is a point that is obviously not clear to extremists in this country who believe the right to abort must be extended to include the right to infanticide.

If a hospital named "Christ" does not willingly stop committing infanticide but handles public and legal scrutiny by merely trying

to make those lives they're snuffing out more comfortable, I have such grave concerns about children whose lives are being ended in abortion clinics and hospitals where there's no spotlight of attention on them.

Once a fetus has been aborted, the pregnancy has been terminated. But when what emerges on the other side of the vaginal vault is alive, by medical definition, it is no longer a fetus, but is now a neonate, a baby, with rights as human beings and American citizens that must be zealously protected. If we cannot all agree that civil rights begin at birth, then we will have to begin debating when do civil rights begin for a human being? Five minutes? Ten minutes? Three hours? Three weeks? And a Pandora's Box will have been opened that none of us can possibly assess the depths of today.

In closing, the Department of Health and Human Services wrote to me that civil rights laws do not cover the rights of newborns. The Illinois Attorney General wrote to me that there was no basis for legal action by their office against Christ Hospital at this time in regard to Christ Hospital's labor-induction abortion practices. And I am entering both of those letters in the hearing record.

Alan Keyes recently observed, "If we reflect for a moment upon the example of the Declaration of Independence, we will remember that sometimes even self-evident truths need to be declared." And I think that this is completely obvious that this is one of those times that that is true.

Thank you very much.

[The prepared statement of Ms. Stanek follow:]

PREPARED STATEMENT OF JILL L. STANEK

I am a Registered Nurse who has worked in the Labor & Delivery Department at Christ Hospital in Oak Lawn, Illinois, for the past six years. In the year that has elapsed since I testified before your committee regarding the same bill under discussion today, I have continued to work at the same hospital in the same position.

Christ Hospital performs abortions on women in their second or even third trimesters of pregnancy. Sometimes the babies being aborted are healthy, and sometimes they are not. The abortion technique that Christ Hospital and other hospitals use, called "induced labor abortion," sometimes results in infants being aborted alive, because throughout this particular abortion procedure the fetus is not killed in the uterus. The focus of this method is to forcibly dilate a woman's cervix so that she will prematurely deliver a baby who dies during the birth process or soon afterward.

The cervix is the opening at the bottom of the uterus that normally stays closed until a woman is about 40 weeks pregnant and goes into labor. There are a few ways to cause the cervix to open early. At Christ Hospital the most common way this is done is by the physician inserting a medication called Cytotec into the birth canal close to the cervix. Cytotec irritates the cervix. The FDA does not approve Cytotec for this use. It is a drug that is supposed to be taken by mouth to help control ulcers. The manufacturer of Cytotec issued a public letter in August 2000 warning that this drug may be harmful to women if used to induce labor, up to and including causing the uterus to rupture and causing death. But Christ Hospital continues to use Cytotec for pregnancy terminations.

After the cervix is prematurely dilated, the small, preterm baby drops out of the uterus, sometimes alive. In the event that a baby is aborted alive, he or she is given what my hospital calls "comfort care." "Comfort care" involves wrapping the baby in a blanket and offering him or her to the parents to hold until the baby dies. If parents do not want to hold their baby, as I have observed is most often the case, it is left to staff to care for the baby. Up until recently, staff options were to hold the baby until death or put the baby in our Soiled Utility Room if we got busy or if the baby lingered too long. Indeed, it is not uncommon for one of these babies

to live for an hour or two or even longer. Last year alone, of the 16 babies that Christ Hospital states were aborted, I am aware of four who were born alive. Each of these babies—two boys and two girls—lived between 1½ and 3 hours. At Christ Hospital one of these babies once lived for almost an entire eight-hour shift. At least two of the second-trimester babies who were aborted last year at Christ Hospital were completely healthy.

One night, a nursing co-worker was taking an aborted Down's syndrome baby who was born alive to our Soiled Utility Room because his parents did not want to hold him, and she did not have time to hold him. I could not bear the thought of this suffering child dying alone in a Soiled Utility Room, so I cradled and rocked him for the 45 minutes that he lived. He was 21 to 22 weeks old, weighed about ° pound, and was about 10 inches long. He was too weak to move very much, expending any energy he had trying to breathe. Toward the end he was so quiet that I couldn't tell if he was still alive unless I held him up to the light to see if his heart was still beating through his chest wall. After he was pronounced dead, we folded his little arms across his chest, wrapped him in a tiny shroud, and carried him to the hospital morgue where all of our dead patients are taken.

Other co-workers have told me about incidences of live aborted babies whom they have cared for. A Support Associate told me about an aborted baby who was left to die on the counter of the Soiled Utility Room wrapped in a disposable towel. This baby was accidentally thrown into the garbage, and when they later were going through the trash to find the baby, the baby fell out of the towel and on to the floor. A nurse coworker told me about an abortion she was involved in where the baby was supposed to have spina bifida but was born with an intact spine. She said that what actually happened was that there was an incompletely formed twin who appeared as a mass on his brother's back during an ultrasound. The nurse told me that the father came into the Soiled Utility Room to see his son, took one look and saw that he had been involved in aborting his completely healthy baby, and turned and left the room without saying a word. I was recently told about a situation by a nursing coworker who said, "I can't stop thinking about it." She had a patient who was just over 23 weeks pregnant, and she was not going to be able to complete her pregnancy to term. The baby was healthy and had up to a 39% chance of survival, according to national statistics. But the patient chose to abort. The baby was born alive. If the mother had wanted everything done for her baby, there would have been a neonatologist, pediatric resident, neonatal nurse, and respiratory therapist present for the delivery, and the baby would have been taken to our Neonatal Intensive Care Unit for specialized care. Instead, the only personnel present for this delivery were an obstetrical resident and my coworker. After delivery the baby, who showed early signs of thriving, was merely wrapped in a blanket and kept in the Labor & Delivery Department until she died 2½ hours later. Just three weeks after this baby was aborted, another mother came to the hospital under similar circumstances, carrying an identically aged baby and was offered the same options. But she said that she wanted her baby. And so present at her delivery were the aforementioned NICU team, and for the two days that I tracked her, that little girl lived.

When I testified before you last July, another nurse who worked at Christ Hospital, Allison Baker, also testified. Allison was not asked back today due to the new limit on the number of witnesses allowed. But last year Allison described walking into the Soiled Utility Room on two separate occasions to find live aborted babies left naked on a scale and the metal counter. She told about the patient that she herself had who didn't know that her baby might be aborted alive and who did not then want to hold him. After he was taken to the Soiled Utility Room she kept asking, "Is he dead yet? Is he dead yet?" (This testimony is being entered today into the Congressional Record.)

Lest you think that Christ Hospital's live birth abortion practice is uncommon, I am entering into Congressional Record today literature from a March 30, 2001, symposium sponsored by Waukesha Memorial Hospital in Wisconsin that was "reviewed and is acceptable" by the American Academy of Family Physicians, wherein Dr. Washington Hill writes that a "complication" of a mid-trimester labor induction is a "live birth." The American College of Obstetricians and gynecologists also gave credit hours to physicians for taking this course.

After I testified last year, Christ Hospital stopped putting aborted babies to die in the Soiled Utility Room. This past December it unveiled its "Comfort Room." This is a small, nicely decorated room complete with a First Foto machine in case parents want pictures of their aborted babies, baptismal supplies if parents would like their aborted babies baptized, and a foot printer and baby bracelets if parents would like keepsakes of their aborted babies. There is also a wooden rocker to rock these babies to death. (Pictures entered into Congressional Record.)

When Christ Hospital opened its Comfort Room, I was honestly galled. It became clearer to me than ever that a law must be enacted that specifies that all babies born alive are indeed humans and American citizens with civil rights to equal protection. This is a point that is obviously not clear to extremists in our great country who believe that the right to obtain an abortion must be extended to include the right to commit infanticide. If a hospital named "Christ" does not willingly stop committing infanticide but handles public and legal scrutiny by merely trying to make those whose lives they're snuffing out more "comfortable," I have grave concerns about children whose lives are being ended at abortion clinics and hospitals where there is no spotlight of attention.

Once a fetus is aborted, the pregnancy has been terminated. But when what emerges on the other of the vaginal vault is alive, "it" by medical definition is no longer a fetus but is now a "neonate" or "baby," with rights as human beings and American citizens that must be zealously protected. If we all cannot at least agree that civil rights begin at birth, then we will have to initiate the debate as to when after delivery a living person *does* begin to have rights, and a Pandora's Box will have been opened, the depths of which none of can possibly ascertain today.

The Department of Health & Human Services wrote me that, "civil rights laws do not cover abortion procedures or the rights of newborns." The Illinois Attorney General determined that "there is no basis for legal action by this office against the Hospital" at this time . . . in regard to Christ Hospital's labor induction abortion practices. (Both letters entered into Congressional Record.) Alan Keyes recently observed, "If we reflect for a moment upon the example of the Declaration of Independence, we will remember that sometimes even self-evident truths need to be declared." I think it is obvious that this is one of those times.

Mr. CHABOT. Thank you very much. We appreciate it. I know that you've testified a number of times before and I just want to personally say that I really respect you and the fact that you've come forward——

Ms. STANEK. Thank you.

Mr. CHABOT [continuing]. To describe things which are not particularly pleasant to describe. So thank you.

Dr. Bowes, you're recognized for 5 minutes.

STATEMENT OF WATSON A. BOWES, JR., MD, PROFESSOR EMERITUS, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL SCHOOL OF MEDICINE

Dr. BOWES. Thank you, Mr. Chairman and Members of the Committee.

You've accurately summarized my professional background, so I won't repeat that in the interest of time. I would like to say that as an obstetrician caring for high-risk babies, especially premature infants, I worked daily in close conjunction with a neonatologist especially around issues that I think this bill relates to. This seems to be specific for babies who are born, not babies who are being cared for days later in the neonatal intensive care unit, and I think Mr. Nadler made that point and I would like to emphasize that.

Mr. NADLER. Could you comment on one question at this point?

Dr. BOWES. Yes.

Mr. NADLER. And I ask unanimous consent——

Mr. CHABOT. Without objection.

Mr. NADLER. Because it's—you deal with all these issues daily.

Ms. Stanek just gave us accounts of various practices in the hospital she works at. Essentially what she was saying is that babies who were intended to be born got extraordinary medical care. Neonates who weren't wanted just got comfort care without the extraordinary medical attention.

As I read the bill, it wouldn't change that at all. How would this bill affect what Ms. Stanek was talking about, what she obviously disapproves of?

Mr. CHABOT. If the witness would like to address that now, or it could also be addressed later on in the questioning stage. I thought he was particularly——

Dr. BOWES. Well, I think I will address it in my statement, Mr. Nadler, and if not, I'll expand on it.

Mr. NADLER. Okay.

Dr. BOWES. I have read this legislation carefully and as it relates to an infant born alive at any stage of development, and that the infant breathes or has a beating heart, pulsation of the umbilical cord or definite movement of the voluntary muscles, this definition applies regardless of the duration of pregnancy at which the infant is born or the means by which it is born. This definition of live birth is consistent with that of the World Health Organization and is in current use by health department guidelines throughout most of the United States. Furthermore, these criteria of live birth are unambiguous and easily discernible by any birth attendant.

It is my opinion that this definition of being born alive does not and will not have a detrimental effect on either maternal or infant health care. I am confident of this because this is a definition of live birth that is in effect in the State of North Carolina in which I have practiced for 18 years.

During this time, these criteria for defining live birth did not interfere with physicians making clinical judgments about providing appropriate care for newborn infants, nor with parents being involved in those decisions.

Importantly, this definition of live birth does not restrict a physician's prerogative to recommend that medical care regarded as futile be withdrawn or withheld.

It is important to keep in mind that this bill deals solely with the criteria that define whether an infant is alive at the time of birth. It does not legislate how physicians and parents may deal with the decisions about withholding or discontinuing medical or surgical treatment that is considered futile in the care of an infant. Providing life-sustaining treatment at the time of birth for infants in whom there is some doubt about whether they will survive allows physicians and parents the opportunity to discuss management options after more information is available about the infant's condition and prognosis.

A delivery room is not an optimum place for parents to make life and death decisions about their newborn infant. Of course, there are times when resuscitation of a depressed newly born infant is not successful. This bill does not require physicians to persist in treatment that is not successful or is considered futile.

Finally, in my role on the Infant Care Review Committee at the University of North Carolina, which I served on for a number of years, I was never aware of the egregious use or prolongation of futile medical interventions that could have been attributed to this definition of live birth. This is a matter that I think concerns the neonatologists. We simply did not have that issue arise in those 8 years that I was on that Committee.

I appreciate the opportunity to speak in regard to this bill.

[The prepared statement of Dr. Bowes follows:]

PREPARED STATEMENT OF WATSON A. BOWES, JR.

Mr. Chairman and members of the committee:

My name is Watson A. Bowes Jr. I am professor emeritus of Obstetrics and Gynecology in the School of Medicine at the University of North Carolina at Chapel Hill. My medical school education and residency training in Obstetrics and Gynecology were at the University of Colorado Medical Center in Denver. I am board certified in Obstetrics and Gynecology and Maternal-Fetal Medicine. My major professional interest was in the care of women with high-risk pregnancies, especially those at risk of delivery of a premature infant.

From 1982 until June 20, 1999, I was a member of the full-time faculty of the University North Carolina at Chapel Hill. From 1984 until 1998 I was chairman of the Infant Care Review Committee at the University of North Carolina Hospitals. This interdisciplinary committee had the responsibility of developing guidelines regarding withholding or withdrawing medical care from seriously ill infants and reviewing any instance in which there was concern that these guidelines were not followed. Also from 1994 until 1999 I served on the Committee on Ethics of the American College of Obstetricians and Gynecologists and was Chairman of that committee during the last two years of that time.

My comments and opinions about are not made in behalf of the University North Carolina or any other organization.

I have read the legislation proposed in the Born Alive Infant Protection Act of 2001 which states that the criteria that an infant is born alive at any stage of development are that the infant "breaths or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles." This definition applies regardless of the duration of pregnancy at which the infant is born or the means by which it is born. This definition of live birth is consistent with that of the World Health Organization and is in current use by health department guidelines throughout most of the United States. Furthermore, these criteria of live birth are unambiguous and easily discernible by any birth attendant.

It is my opinion that this definition of being born alive does not and will not have a detrimental effect on either maternal or infant health care. I am confident of this because this is definition of live birth that is in effect in the state of North Carolina in which I practiced for 18 years. During this time, these criteria for defining live birth did not interfere with physicians making clinical judgments about providing appropriate care for newborn infants nor with parents being involved in those decisions. Importantly, this definition of live birth does not restrict a physician's prerogative to recommend that medical care regarded as futile be withheld or withdrawn.

It is important to keep in mind that this bill deals solely with the criteria that define whether an infant is alive at the time of birth. It does not legislate how physicians and parents may deal with the decisions about withholding or discontinuing medical or surgical treatment that is considered futile in the care of an infant. Providing life-sustaining treatment at the time of birth for infants in whom there is some doubt about whether they will survive allows physicians and parents the opportunity to discuss management options after more information is available about the infant's condition and prognosis.1 A delivery room is not an optimum place for parents to make life and death decisions about their newborn infant. Of course, there are times when resuscitation of a depressed newly born infant is not successful. This bill does not require physicians to persist in treatment that is not successful or is considered futile.

Finally, in my role on the Infant Care Review Committee at University of North Carolina Hospitals, I was never aware of the egregious use or prolongation of futile medical interventions that could have been attributed to this definition of life birth.

Mr. CHABOT. Thank you very much, Dr. Bowes. We appreciate your testimony this morning.

At this point, Members will have 5 minutes to ask questions of the panel. I recognize myself for that purpose for 5 minutes.

Ms. Stanek, let me start with you, if I can. You have described things, some awful things which I hate to even think of and I think a lot of us hate to think of, and the fact that you were there and had to undergo that is quite—it's hard to comprehend, to tell you the truth.

Could you tell us how—if you've talked to other nursing personnel, either at your hospital or others? Since this has happened, I know you have become involved in trying to make this aware—make the public aware of what's actually happening to see if we can't do something to change this.

Could you tell us how widespread this practice is around the country or in your community or whatever is appropriate for you to comment on?

Ms. STANEK. Right. When I first started becoming involved in this, I found out immediately that there have been articles written from hospitals in Australia. A nurse there held an aborted baby who was alive for 80 minutes. It's a huge controversy in Canada.

All I can speak to today in regard to how widespread it is in the United States is that Christ Hospital didn't make it up. They told me they glean their policy from other policies of other hospitals. I can only say that I have, you know, been on talk shows since then, I have spoken with nurses, one in San Diego that said it was going on in her hospital. I was just on a show 2 weeks ago where a mother from Washington State called in crying but defending the fact that she had aborted her spina bifida baby alive, and so I can speak to that, and speak also to the symposium information that I'm entering in the congressional record today that was approved by—I forget the names of the organizations, but important organizations, OB organizations and pediatric organizations, before it was given that mentioned that one of three complications is a live birth to this sort of abortion procedure.

Mr. CHABOT. Thank you very much.

Professor Arkes, in your written statement, you had stated that the notion that a child born alive that was marked for abortion prior to death is not a person whose life State law may protect. State law may protect has merged in the most fearful way with the decision last year in *Stenberg* v. *Carhart*.

Would you comment about how that particular court case has affected this particular area and what your opinion is about that?

Mr. ARKES. Well, you've already cited from the concurring opinion by Justice Ginsburg and Stevens. But in his main opinion for the Court, Justice Breyer pointed out that this procedure of the partial-birth abortions could be safer for the woman because no instruments were introduced into the uterus. Well, by that construction, the kind of abortion described by Jill Stanek in Christ Hospital would be even safer—no instruments are being introduced. All the safer, then, simply to deliver the child alive and allow the child to die.

So I think what Justice Breyer did was sort of pave the way or pave the ground here to make the public a bit more suggestible to the notion of letting the child die and delivering the child alive. When I say we're at the threshold of infanticide, I think we're essentially there.

Mr. CHABOT. Thank you.

Let me——

Mr. ARKES. By the way, Mr. Chairman, just quickly in response to your other question,——

Mr. CHABOT. Sure.

Mr. ARKES [continuing]. Jill Stanek in her testimony last year gave the response I think to Congressman Nadler's question. She reported that were it not for the fact that these children had been marked for abortion, those children would have been given the benefit of every bit of equipment and artistry available to the hospital. The only difference was that they had been marked for abortion.

Mr. CHABOT. Thank you.

Ms. Stanek, if you could comment, were some of these babies that had been born, is it your opinion that, from what you knew, that some of these babies would have been capable of surviving if they had received proper care and life support which others would——

Ms. STANEK. Yes.

Mr. CHABOT [continuing]. Would oftentimes get if they were——

Ms. STANEK. Can I add one little thing to the last question——

Mr. CHABOT. Yes.

Ms. STANEK. When he was offering it, I remembered one little thing.

Mr. CHABOT. Sure.

Ms. STANEK. That as soon as Christ Hospital confessed to being involved in this sort of abortion 2 years ago, two other hospitals in Chicago immediately confessed also to being involved in this sort of abortion, Rush Presbyterian, St. Luke's, and Lutheran General. And so just in Chicago alone, there have been three hospitals that have come forward and said that they take part in this sort of abortion.

Now to answer your question specifically, the 23-weeker who was aborted last year, under the guidelines of the American Heart Association, was potentially viable. They say now, and the lines do keep changing, that a baby that's 23 weeks and 400 grams they consider potentially viable, and this baby was 23 and one-seventh weeks and 460 grams, and she was a girl, and girls typically are heartier than boys in this sort of situation, so she stood a great chance of surviving, yes.

Mr. CHABOT. I would ask unanimous consent for one additional minute to ask one more question, if I could. Without objection.

Dr. Bowes, could you comment on nowadays with the technology that we have how early—what are about the earliest stages that babies can be—could survive these types——

Dr. BOWES. All right. In sophisticated neonatal intensive care units such as Ms. Stanek was describing, 23 weeks is generally considered the margin at which survival is expected with good neonatal intensive care. Now, there are instances where babies younger than that have survived, but over all.

Now, that doesn't mean that there aren't exceptions to that rule, and that has changed. It's interesting, in 1975, that was 28 weeks gestation. So the technology is evolving all the time, so that is not a hard-and-fast gestational age at which you would make that cutoff.

Mr. CHABOT. Thank you very much.

My time has expired and I now recognize the gentleman from New York, the Ranking Member, Mr. Nadler, for five——

Mr. NADLER. Thank you. Just quickly, Dr. Bowes, before we get into the questions, what is the age of viability without the extraor-

dinary technology? In other words, the change from—the technology changed in the last 20 years; the human beings didn't change, obviously. So what is the general age of viability in a premature delivery without the use of modern technology?

Dr. BOWES. Well, babies who aren't resuscitated and given the supportive care of neonatal intensive care around 30 weeks, a substantial portion of them will die.

Mr. NADLER. Okay.

Dr. BOWES. And——

Mr. NADLER. Thank you. I only have 5 minutes.

Dr. BOWES. Okay. Excuse me.

Mr. NADLER. I was just curious about that.

Dr. Arkes, you object to the fact that a court may allow an abortion at any stage of pregnancy under certain circumstances. You stated that. And you also wrote in a 1988 article that most Americans believe that life begins at conception. Does that mean that you would consider an IUD that destroys a blastocyst by not permitting it to be implanted is a form of infanticide?

Mr. ARKES. Well, as I wrote on that, I addressed that in a book of mine, it possibly could. But I would say out of prudence, that though it would be destroying the life, the law does not require us to reach every hard case. So I would just—I would back away on that.

Mr. NADLER. You think in general the answer is yes, but you would back away from insisting on it.

Mr. ARKES. I think, first of all, if I understand that I'm dealing with a human being, that the way in which that human being is killed, by a bus or any other kind of device, is really beside the point principle.

Mr. NADLER. Or an IUD.

Mr. ARKES. Or IUD.

Mr. NADLER. Same thing.

Mr. ARKES. Now, the question is, even though that could be the case, it may not be practicable to reach every instance of a wrong.

Mr. NADLER. Okay. Thank you.

Dr. Bowes, now I would ask you to address the question. The law of every State as I understand says that an infant who is alive and is not with—and is separate from its mother is clearly a human being. We've always recognized that in law. The question—the situation that Ms. Stanek addressed in Christ Hospital was that the hospital didn't give an appropriate level of care to infants for whatever—to certain infants as opposed to other infants for whatever reason.

Now, one might think that's right or wrong. I don't see that this bill would change that situation at all. Would it, and if so, how?

Dr. BOWES. Well, I would suggest that if someone intervened on behalf of a child that was clearly viable after its birth with the aid of neonatal intensive care and it was not provided——

Mr. NADLER. That's a—clearly viable is a medical judgment, obviously.

Dr. BOWES. Yes.

Mr. NADLER. Okay. Go ahead.

Dr. BOWES. The—someone could intervene on behalf of that child.

Mr. NADLER. And that's true under current law.

Dr. BOWES. Yes.

Mr. NADLER. And how does this bill change that?

Dr. BOWES. I don't think it does change that.

Mr. NADLER. So this bill doesn't change anything that Ms. Stanek was talking about.

Dr. BOWES. Yes, I—that's what I said in my statement. I don't think this changes medical care for those babies.

Mr. NADLER. So all the testimony that we heard here, the heart-wrenching testimony, is very interesting, but irrelevant to consideration of this bill. This bill doesn't have any effect on that. In other words, the current—the current law—and maybe the people at Christ Hospital weren't obeying the current law, but the current law with respect to all of those situations is not changed by this bill, correct?

Dr. BOWES. I think—I think that's correct.

Mr. NADLER. What?

Dr. BOWES. I think that's correct. If—now, I don't know——

Mr. NADLER. Correct. Thank you.

Dr. BOWES [continuing]. Specifically what the State of Illinois——

Mr. NADLER. Well, I don't know specifically the State of Illinois, either. I assume it's the same as the other 49 States in the crucial respect.

Well, we come back to what I said to my evaluation of the bill before—it doesn't change the law in any way. The situation in Christ Hospital, maybe the law should be obeyed a little more or someone should enforce it, but this bill doesn't deal with that. Does anybody disagree with that?

Mr. ARKES. Well, sure. I think you have—you don't seem to count on the intervention of the understanding of someone like Judge Barry. Judge Barry comes in and simply says we simply shift the labels. That isn't a child who was——

Mr. NADLER. Excuse me a minute.

Mr. ARKES. Yes.

Mr. NADLER. This bill doesn't change that, either.

Let me suggest—okay. I think I've established what I need to, that maybe somebody has to do something at Christ Hospital, but that this bill doesn't deal with these problems.

And I'll yield back.

Mr. CHABOT. I thank the gentleman for yielding. We have a disagreement on what it establishes and doesn't.

But the gentleman from Alabama is recognized for 5 minutes.

Mr. BACHUS. I have no questions. I appreciate the panelists' testimony.

Mr. CHABOT. The gentleman from Virginia.

Mr. SCOTT. Thank you, Mr. Chairman.

Professor—how do you pronounce your—is it Arkes?

Mr. ARKES. Arkes.

Mr. SCOTT. Are you familiar with the Federal definition of death?

Mr. ARKES. The Federal definition of death? No.

Mr. SCOTT. No? You said yes or no?

Mr. ARKES. No, I haven't looked—checked the code recently.

Mr. SCOTT. Well, whatever it is, is it possible that a person could be clinically dead but still meet the—this definition of born alive?

Mr. ARKES. Why don't you fill it in for me?

Mr. SCOTT. I don't know. Does anybody know whether or not you could be technically born alive pursuant to this bill and also meet the clinical definition of death?

Mr. NADLER. Would the gentleman yield? I—the definition here is that, aside from that you're outside the mother, is that the subject breathes or has a beating heart, pulsation of the umbilical cord, and definite movement of voluntary muscles. If you—that could—if a person was brain dead, have no flat medical—flat EEGs and so forth, and was on a respirator, he might show these other symptoms and be considered clinical dead, though, if he were on a respirator which maintained his beating heart and so forth.

Mr. SCOTT. Well, we don't know whether or not someone, based on the witnesses we have before us, don't know whether someone could be clinical dead but by this legislation be designated as born alive.

Professor, could you tell me if you could be born alive by Federal law but not born alive by State law? Is that possible?

Mr. ARKES. Well, I think the State law would be the primary law in being, and I think all you're doing here is correcting for those places in which people think that the intervention of that right to abortion simply changes all the standing law.

Mr. SCOTT. Let me ask you again. This defines born alive by Federal law. Is it possible that you could be born alive pursuant to Federal law but not born alive pursuant to State law?

Mr. ARKES. I think it's essentially the same standard. I yield—I would yield to my colleague from North Carolina. I think it's the same standard in most places.

Mr. SCOTT. Well, if we don't know, we don't know. We just—there are a lot of things we don't know about the legislation.

Can somebody tell us what this does to inheritance law?

Mr. ARKES. Well, I assume the same thing would be in place. Right now, if you have a child in the womb, it could have standing to inherit property. So it's the same thing. If the child comes out alive and the child is preserved, then he's simply preserved in his status as one who's capable of inheriting property. Nothing novel there.

Mr. SCOTT. So this would—would this change inheritance law or not?

Mr. ARKES. No, I can't see how it could change inheritance law.

Mr. SCOTT. This would have no effect on inheritance law?

Mr. ARKES. Not that I can see.

Mr. CHABOT. Would the gentleman yield?

Mr. SCOTT. I yield.

Mr. CHABOT. Inheritance law is State law in any event, so this wouldn't have any effect.

Mr. SCOTT. Well, we didn't get an answer to the question as to whether you're alive under State law and not alive under Federal law or vice versa.

Mr. CHABOT. Well, if the gentleman will yield,——

Mr. SCOTT. I yield.

Mr. CHABOT [continuing]. The State laws already have definitions for being dead or being alive.

Mr. SCOTT. Well, let me ask the Chairman, then——

Mr. CHABOT. The definition—the definition in here talks about when one is considered to be alive and it talks about breathing or voluntary muscle activity or pulsation of the umbilical cord.

Mr. SCOTT. But is it the legislative intent that you could be born alive pursuant to Federal law but not born alive pursuant to State law?

Mr. CHABOT. This is—if the gentleman will yield?

Mr. SCOTT. I will yield.

Mr. CHABOT. The purpose of this legislation is to remedy a situation which is out there right now relative to decisions by the United States Supreme Court in *Stenberg* v. *Carhart*, the *Farmer* case, which essentially may well allow infanticide in this country to exist, and this legislation is to—is to clearly say that if a person is born, if they're outside the mother, then that person is alive.

Mr. SCOTT. I recognize what you are trying to do. My—it was just a simple question. There are definitions of death in Federal and State law, I assume. But the question is whether you can be not born alive pursuant to State law for inheritance purposes but born alive by Federal law.

Mr. WATT. Will the gentleman yield?

Mr. SCOTT. I will yield to the gentleman from North Carolina.

Mr. WATT. I can't answer that question, but I do think you picked up on an interesting line. Inheritance is all controlled by State law, but taxation, at least Federal inheritance taxation, is not controlled by Federal law. It would be interesting to know whether this has any impact on exemptions under Federal inheritance taxation law, would be an interesting question.

Mr. CHABOT. If the gentleman will yield although his time is expired,——

Mr. SCOTT. I yield.

Mr. CHABOT [continuing]. We just did away with Federal inheritance taxes in any event, but——

Mr. WATT. Not until 2011.

Mr. CHABOT. It comes back again, but if Republicans are around, it won't come back; if Democrats are around, it will come back.

Mr. WATT. Mr. Chairman, in the interim——

Mr. CHABOT. But I understand this was part of the Republican tax package.

Mr. WATT. In the interim between now and 2010, this would still be a relevant question.

Mr. CHABOT. The gentleman's time has expired. We thank the gentleman for those probing questions.

The gentleman from Indian, Mr. Hostettler, is recognized for 5 minutes.

Mr. HOSTETTLER. I thank the Chairman. If I can be of some assistance, while I'm not an attorney, I think article VI of the Constitution sheds a little light on this in that this Constitution and the laws of the United States which shall be made in pursuance thereof and all treaties made or which shall be made under the authority of the United States shall be the supreme law of the land and the judges in every State shall be bound thereby, anything in

the Constitution or laws of any State to the contrary notwithstanding.

So we are——

Mr. SCOTT. What part did you just read—what part did you just read from?

Mr. HOSTETTLER. Pardon? The supremacy clause.

That being aside, since we are discussing IUDs and inheritance law at this time of born-alive infants, I thought it would be relevant to talk just briefly about the issue of infanticide and partial-birth abortion in that while Justice Stevens and Ginsburg have said, quote, "The notion that a partial-birth abortion is more akin to infanticide than any other abortion procedure is simply irrational," end quote; however, someone who has a little bit more experience with the practice of abortion—namely, Dr. Bernard Nathanson—in fact refers to and did refer to in a seminar here in the Capitol that partial-birth abortion is, in fact, a misnomer, that the practice of partial-birth abortion is, according, medically, to Dr. Bernard Nathanson, who oversaw thousands of abortions himself, is infanticide, and I think that speaks directly to the importance of this issue today. And I am so glad that the Chairman has brought this bill up, because if we decide that allowing these young babies not to die isn't infanticide, then we can, in fact, say that it's not infanticide and it can continue unabated.

The point, Professor Arkes, that you've made is I think very relavant, and that is in your testimony, you talked about the opinion that Judge Barry made that spoke about the issue and says that the fact that a baby that is allowed to die allows an abortion to be completed even if it's outside the womb confirms what many pro-life lawyers had refused to believe. Judge Haynsworth's opinion in *Flood* v. *Anders* was not an anomaly or aberration; it expressed the understanding that had now become the operational doctrine among many Federal judges. And the point is this, that we are drawing a bright line here today when it comes to the idea that infants that are born alive are, in fact, persons that require the safety and security of the law, and—but in fact, Professor Arkes, if you could help me, not being an attorney, if, in fact, the Supreme Court says that what we do today is unconstitutional, will the country not be bound to continue to allow what Ms. Stanek has said has happened time and time again in a hospital named after Christ to continue to happen?

If the Court says that what we do today is unconstitutional, will it not, in fact,—if what you say is true, that it's not an anomaly and that it is becoming the prevalent opinion of Federal judges that this practice should be allowed to continue and it's nonsensical to think about the position of the baby at the time of birth or completed abortion, won't this have to continue?

Mr. ARKES. Well, you read the supremacy clause and presumably that supremacy attaches to the decisions of the Supreme Court unless, of course, you revive Lincoln's understanding about the relations among the branches and the way that Lincoln resisted the *Dred Scott* decision. He said the political branches could simply insist that we respect the disposition of the case in regard to those two litigants, but if we reject the principle, say, in the *Dred Scott* case, we're not obliged to apply that principle.

Mr. NADLER. You wouldn't impose that on *Bush* v. *Gore*, would you? [Laughter.]

Mr. ARKES. I invite you to legislate on that! I think you should really grasp your warrant and try to summon the powers of Congress to legislate. I think you should try your hand at that.

Remember, the Lincoln administration very early on, they had an application from a black student for a passport to study in France. The application was denied because the Supreme Court had decided that the Blacks couldn't be citizens of the United States and carry passports, and the Lincoln administration quashed that decision. It was a case of a branch of the Federal executive applying the principle of the *Dred Scott* case to circumstances quite remote from anything that arose in that case. And in a similar way, this Congress is the coordinate branch and if the Supreme Court did something like that, which I rather doubt it would do, I would hope members of Congress would do what they've done with the legislative veto in the *Chadha* case, simply try to restrict that holding to a decision bearing on immigration but continue to legislate in that vein in the hope of inducing the Supreme Court to take a sober second look at what it's done and perhaps change its mind.

Mr. CHABOT. The gentleman's time has expired.

Mr. HOSTETTLER. If I could just follow up with one question.

Mr. CHABOT. Without objection.

Mr. HOSTETTLER. You're saying that all legislative power should be vested in a Congress and not necessarily in the——

Mr. ARKES. Yes, that's a dramatic notion, I know, but——

Mr. HOSTETTLER. Thank you.

Mr. CHABOT. Thank you. The gentleman's time has expired.

The gentleman from North Carolina, Mr. Watt, is recognized for 5 minutes.

Mr. WATT. Thank you, Mr. Chairman. I am not sure I have any questions, but as I was walking in the door, Professor Arkes obviously came prepared to give me a response to some question that was lingering over from the last time, and I certainly—and I got the impression that he would prefer to have had me here to deliver the lecture. [Laughter.]

Mr. WATT. I didn't want to deprive him of that opportunity. I wanted to be sitting here looking at him.

Mr. ARKES. I didn't think you could bear to go for a whole year without seeing me at one of these hearings.

Mr. WATT. And I missed the point that you were making anyway, so I am going to give you the opportunity to—and the satisfaction of making that point again since I don't have any questions. Maybe that will stimulate one. But go right ahead.

Mr. ARKES. You raised the question last year: There were something like 57,000 references to persons.

Mr. WATT. If so, I've won it several times during the course of this hearing.

Mr. ARKES. The point I was making here was that it's an old dictum that once we're clear on the principle, the principle covers all the instances. I remember I drew upon the analogy of the ball rolling down the inclined plane. Once we understand what that prin-

ciple is, then we no longer have to ask: Is it a blue plane or a yellow plane, is it a glass ball?

We see this confusion at times say in civil rights. There were lawyers who said, how do we get from the question of racial segregation in schools to swimming pools? Nobody's capacity to learn was being affected. What these professors didn't understand is that once we're clear on the principle involved in racial discrimination, it covers all of the instances, whether we're talking about drugstores or anything else.

So that was my point: If we think that it's simply a question of whether we can conceive of any arrangements under which an innocent child could forfeit the same protections that are given to any other child, then the circumstances may become relevant. But if we have a hard time conceiving any of those circumstances, it's hard to see how any one of those instances could possibly throw off that principle.

Mr. WATT. I appreciate that. It's in some ways, many ways, very consistent with some of the things I believe in. I do think that you probably need to know what it is you're doing before you do it,——

Mr. ARKES. That's always useful.

Mr. WATT [continuing]. But once you know what you're doing, if it's good for the goose, it's good for the gander, which is one reason I've been trying to convince a number of my Jewish friends that reparations for Jewish atrocities—the principle is the same, reparations for atrocities in the United States. So I don't—I don't argue with that principle. I think the point I'm concerned about is have we a full understanding of what this bill does, and I still don't have that full understanding.

Some people keep saying it does nothing and I have never seen a need to legislate in a way that does nothing. Some people say it does something, and I would simply like to know what that something is before I vote in favor of it. That's all I said the last time and signed off on the dissenting opinion, which said the same thing.

It may be that what this bill does, I stand for, but I need to know what it does before I can make that determination. So—and that's pretty much where I am again this year.

Mr. ARKES. I appreciate that. Could I just say something quickly in response?

Mr. WATT. Sure. I've got a little bit more time.

Mr. ARKES. I think Mr. Nadler has it mostly right. There should be very little change. Congressman Scott made me think that the problem he mentioned really came into being with that legislation in the mid '80's when we were trying to deal with the withdrawal of medical care from children because they were afflicted with spina bifida or Down's Syndrome. Now, you could say that until the Federal law intervened to ensure against the withdrawal of thir care, those children would have died and they wouldn't have been inheriting any property. So I suppose you could say that the intervention of the Federal law in making clear that those children had a claim to medical care and protection affected the kinds of people who were going to be around to inherit property.

It's in the same way now. The problem involves the willingness of people to shift the protections of the law, to remove them from

whole classes of beings. Its an ancient device of simply shifting the labels. It's not a snark, it's a bojum. It's not a child, it's a fetus marked for termination.

Mr. WATT. But if you've got some name for them already, what good is it to add another name, another word?

Mr. ARKES. It's not whether we have——

Mr. WATT. If it doesn't change anything, what good is it? If it does change something, then shouldn't we at least know what it changes? That's——

Mr. ARKES. Well——

Mr. WATT. That's the only point I'm trying to make, and——

Mr. CHABOT. The gentleman's time——

Mr. WATT. I'll be happy to yield back my time.

Mr. CHABOT. Thank you. The gentleman's time has expired.

The gentlelady from Pennsylvania, Ms. Hart, is recognized for 5 minutes.

Ms. HART. Thank you, Mr. Chairman. I want to commend you and the others who have worked to bring this bill before us.

As obviously one of the sponsors of the legislation, I recognize the need for it and I am pleased to see Ms. Stanek sticking it out with us to make sure that that happens.

I have a question, actually. I'm not sure if it was asked since I was out of the room. But, Dr. Bowes, I happen to be a liberal arts college graduate, so my friends are either physicians or attorneys. I am the latter. Not being a physician, I would like you to describe for me how a decision is made upon the birth of a premature infant who's on that cusp, of how and when you provide care.

Dr. BOWES. Well, in most cases, there are a number of things you can assess about an infant when it is born, and there has been quite a debate in neonatal circles and obstetrical circles about how to do the immediate assessment and how to behave in that setting when the baby—immediately after the baby is born, and it has—although there is not complete agreement on it, there is general agreement that you ought to provide resuscitation for the infant if there is any doubt, and then make a decision at a later time if that resuscitation is being successful and the infant will survive.

Now, at 20 weeks gestation, survival just does not occur, so it's—if we know for sure that the baby is 20 weeks gestation and, say, weighs 250 grams, the likelihood of survival is essentially zero, so you would not resuscitate that infant, you would not put it through—even though it might show the signs of life.

At 23 weeks or 24 weeks gestation, then applying those methods of resuscitation would allow those babies who are going to survive to show their colors in the next two or 3 days. Those who will not survive, the resuscitative efforts will eventually show themselves, and that eventually is usually in a few hours, to not be successful.

So you don't make the decision instantaneously, and I think that's the point I was trying to make. The infant is alive, it deserves that resuscitation, and then the decision is made later.

Ms. HART. Okay. The 20-week-old infant who is alive,——

Dr. BOWES. Yes.

Ms. HART [continuing]. On occasion is obviously going to get the resuscitation; am I not correct?

Dr. BOWES. I would say in the United States at this time with the level of our technology what it is, those babies would not be resuscitated——

Ms. HART. They would not.

Dr. BOWES [continuing]. Because they would not respond to resuscitation and live. In other words, that care is futile, that is futile care.

Ms. HART. Does this bill change anything regarding the 20 weeks, then?

Dr. BOWES. No.

Ms. HART. Okay. So——

Dr. BOWES. What I was trying to make the point in my testimony is that that is a medical decision based on our experience with 20-week babies and the resuscitative technology that we have.

Ms. HART. So it's a medical decision based on scientific experience?

Dr. BOWES. Scientific data and the scientific experience, and I don't think this bill would change that. It would allow physicians, nurses, families, to say, look, at 20 weeks, that's futile care——

Ms. HART. It just doesn't happen.

Dr. BOWES [continuing]. And we're not obliged to provide futile care.

Ms. HART. Okay. But for the child who would be a couple weeks older, then it is, and then the medical judgment is used basically, when in doubt, resuscitate and then wait and see——

Dr. BOWES. When in doubt, resuscitate.

Ms. HART [continuing]. What happens. Okay.

Dr. BOWES. And that is—that does not—that does not require that that care be carried on indefinitely.

Ms. HART. Right.

Dr. BOWES. If it's clearly not being helpful, if the infant isn't responding, then you can stop that care.

Ms. HART. Right. And everyone accepts that,——

Dr. BOWES. Yes.

Ms. HART [continuing]. I believe.

Would the reason by which that child is born make any difference, then, to you if you were the person in the room at the time?

Dr. BOWES. In other words, if it was——

Ms. HART. Like if it was induced labor——

Dr. BOWES [continuing]. Born as a result of an abortion.

Ms. HART [continuing]. Because the mother was—if it was induced labor because the mother was in distress for other reasons or induced labor because the mother was seeking an abortion, it wouldn't make any difference.

Dr. BOWES. It shouldn't make any difference, no. But I think this is the point that Professor Arkes was making. The new Supreme Court—or the court decisions suggest that the mother's intention does affect how you treat the child. I don't think that—I think that's the danger,——

Ms. HART. Okay.

Dr. BOWES [continuing]. Is that the intent of the mother of the baby living or dying is the crucial factor. I think it's whether the child can survive.

Ms. HART. Then we're fortunate now to have it be clarified in law.

Dr. BOWES. Yes. And I think that's what this law does.

Ms. HART. Good. Okay. Thank you very much.

Thank you, Mr. Chairman.

Mr. CHABOT. I thank the gentlelady for making that point. I think that really clarified a lot and I thank her for doing that.

I would like to acknowledge the presence of the gentleman from Texas, Mr. Smith, also for being here this afternoon. It's my understanding he has no questions.

It's the Chairman's intention to go immediately to a markup. The Ranking Member had one additional question, so without objection, we are going to acknowledge him to ask that question.

Mr. NADLER. I thank the Chairman.

I want to ask Dr. Bowes, you're an obstetrician or a neonatologist?

Dr. BOWES. I'm an obstetrician.

Mr. NADLER. Okay. Good. Then the following question: The definition of a child that's born alive in this bill says someone who has experienced the complete expulsion or extraction from his or her mother—in other words, he's separate from the mother now, he or she—who, after such expulsion or extraction, breathes or has a beating heart, pulsation of the umbilical cord, definite movement of the voluntary muscles regardless, et cetera.

The question I have is this, to the accuracy of one part of that, the pulsation of the umbilical cord, can you have a baby who is not alive but the umbilical cord will pulsate because of the placenta? Is that a real situation?

Dr. BOWES. No.

Mr. NADLER. Why not?

Dr. BOWES. No. The reason the umbilical cord pulsates is as a reflection of the baby's heart beating. The blood vessels are coming from the baby——

Mr. NADLER. The umbilical cord can't pulsate because of the mother's heart beating?

Dr. BOWES. No. No. The umbilical cord is not attached to the mother's circulation in any way. It's separate from the mother's circulation. And so the pulsation of the umbilical cord——

Mr. NADLER. Is because the baby's heart is beating.

Dr. BOWES. Yes. That's right.

Mr. NADLER. So if that's the case, why would you want—the umbilical cord will only pulsate if the baby's heart breathes—beats.

Dr. BOWES. That's correct.

Mr. NADLER. So why do you have it as a separate thing in here? Why would you list it as a separate criteria than the baby's heart beating? Certainly if the baby's heart beating is——

Dr. BOWES. Because when a baby is born, it's easy to see if the——

Mr. NADLER. I see.

Dr. BOWES [continuing]. If the umbilical cord is pulsing. You may not have a stethoscope with you that moment, but pulsation of the umbilical cord is unequivocal evidence that the baby's heart is beating.

Mr. NADLER. Baby's heart is beating. Thank you very much.

Mr. CHABOT. I thank the gentleman.

And I would just note that this definition came from the World Health Organization that they accepted 15 years ago, and many States use the same definition and that's why we used it.

At this point, I want to thank all the witnesses for their testimony and you're excused, and we're going to move immediately to the markup. We really do appreciate your testimony and your being here.

[Whereupon, at 2:56 p.m., the Subcommittee proceeded to other business.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Christ Hospital Comfort Room

First Foto machine that takes professional pictures of aborted babies if parents want this keepsake.

Baptismal certificates, gowns, and shells if parents want their aborted baby baptized.

Scale to weigh babies.

....To rock live aborted babies until they pass away.

PREPARED STATEMENT OF ALLISON BAKER, RN, BSN

In August of 1998 I began working in a high risk labor and delivery unit at Christ Hospital and Medical Center in Oak Lawn, Illinois. When I was hired, I was informed of a procedure called "therapeutic abortion" which was performed in the unit. This procedure was reserved for babies with particular conditions such as Down's Syndrome, Spina Bifida, Potter's Syndrome and many others. It was explained to me that in these cases, the mother would have an induced labor to expel the fetus in order to discontinue growth and life. This was an elective procedure and the patient was to be informed of all the details it involved.

Between August of 1998 and August of 1999, I witnessed three particular cases of therapeutic abortions at Christ Hospital first hand. The first occurred on a day shift. I happened to walk into a "soiled utility room" and saw, lying on the metal counter, a fetus, naked, exposed and breathing, moving its arms and legs. The fetus was visibly alive, and was gasping for breath. I left to find the nurse who was caring for the patient and this fetus. When I asked her about the fetus, she said that she was so busy with the mother that she didn't have time to wrap and place the fetus in the warmer, and she asked if I would do that for her. Later I found out that the fetus was 22 weeks old, and had undergone a therapeutic abortion because it had been diagnosed with Down's Syndrome. I did wrap the fetus and place him in a warmer and for 2 ° hours he maintained a heartbeat, and then finally expired.

The second case involved a couple who had requested a therapeutic abortion for their 20 week fetus with Spina Bifida. My shift started at 11:00 PM, and the patient delivered her fetus about 10 minutes before I took her as a patient. During the time the fetus was alive, the patient kept asking me when the fetus would die. For an hour and 45 minutes the fetus maintained a heartbeat. The parents were frustrated, and obviously not prepared for this long period of time. Since I was the nurse of both the mother and fetus, I held the fetus in my arms until it finally expired.

The third case occurred when a nurse with whom I was working was taking care of a mother waiting to deliver her 16 week Down's Syndrome fetus. Again, I walked into the soiled utility room and the fetus was fully exposed, lying on the baby scale. I went to find the nurse who was caring for this mother and fetus, and she asked if I could help her by measuring and weighing the fetus for the charting and death certificate. When I went back into the soiled utility room, the fetus was moving its arms and legs. I then listened for a heartbeat, and found that the fetus still was alive. I wrapped the fetus and in 45 minutes the fetus finally expired.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights

Region V
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601

September 1, 2000

Jill L. Stanek
11664 Sundance Trail
Mokena, IL 60448

Docket Number: 05003295

Dear Ms. Stanek:

We received your complaint concerning Christ Hospital on August15, 2000. However, we have determined that we will not be able to accept your complaint for investigation.

The Office for Civil Rights (OCR) enforces civil rights laws which prohibit discrimination in the delivery of health and welfare services because of race, color, national origin, disability and age. OCR also enforces a law which prohibits discrimination in employment on the basis of disability. We can only investigate complaints involving programs that receive money from the Department of Health and Human Services.

We cannot investigate your allegation because these civil rights laws do not cover abortion procedures or the rights of newborns. We note that you have contacted a variety of agencies and trust that one or more of them will be able to investigate your allegations. We also note that you mentioned a patient among your examples who did not speak English and who was not provided with an interpreter regarding the abortion procedure. Communication with Limited-English speaking persons is a civil rights issue which falls within our jurisdiction. If that patient wishes to file a complaint with our office, please encourage her to do so.

If we can be of assistance to you in the future, please feel free to contact me at (312) 886-5893 (voice) or (312) 353-5693 (TDD) or at the above address.

Sincerely yours,

Michael F. Kruley
Special Assistant to the Regional Manager
Office for Civil Rights
Region V

OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Jim Ryan
ATTORNEY GENERAL

July 17, 2000

Ms. Karen Hayes
Director
Concerned Women for America
P.O Box 188
Palos Heights, IL. 60463

Dear Ms. Hayes:

I am writing to advise you of the status of your September, 1999, request that this office open an investigation into Christ Hospital's practice and method of conducting certain abortions.

Insofar as the information you provided involved medical practice issues, the matter was referred for investigation to the Illinois Department of Public Health (IDPH). Further information provided by the interested parties was also forwarded to IDPH as we received it.

Pursuant to its statutory authority and authority under its contract with the Health Care Financing Administration (HCFA), IDPH dispatched investigators to Christ Hospital in late September, 1999. The results of their on-site survey were forwarded to the Regional office of HCFA.

On December 6, 1999, IDPH provided this office with its investigative report and advised us that IDPH's internal review did not indicate a violation of the Hospital Licensing Act or the Vital Records Act.

No other allegations or medical evidence to support any statutory violation (including the Abused and Neglected Child Reporting Act about which you inquired) were referred to our office by the Department for prosecution.

Finally, the April 20, 2000, correspondence from nurse Jill Stanek regarding Christ Hospital's practices was forwarded to IDPH. The Department advised this office in June that this additional information provided no grounds to further investigate at this time.

Counsel for the Department of Public Health advises us that at the time the Department conducted its investigation at Christ Hospital, the Hospital Licensing Act prohibited release of any investigative files, so we are unable to share these reports with you. However, I can assure you, this office reviewed the reports of the Department, participated in a post-report interview of one of the complainants and independently reviewed the statutes at issue.

While we are deeply respectful of your serious concerns about the practices and methods of abortions at this hospital, we have concluded that there is no basis for legal action by this office against the Hospital or its employees, agents or staff at this time.

Very truly yours,

Carole R. Doris
Chief Deputy Attorney General

CRD/md

Waukesha Memorial Hospital's Women's Health Services, Department of Obstetrics & Gynecology and The Medical College of Wisconsin, Department of Obstetrics & Gynecology present

Fifth Annual

Perinatal Symposium
Physicians and Nurses in Partnership

Friday, March 30, 2001

The Country Inn Hotel & Conference Center
Waukesha, Wisconsin

Women's Health Services

Waukesha Memorial Hospital · Oconomowoc Memorial Hospital

Extraordinary Care

ProHealth Care, Inc.

Medical College of Wisconsin

This presentation made possible in part by unrestricted educational grants from the following organizations:

ATL Ultrasound

Aventis Pharmaceuticals

Hill-Rom Airshields

Matria Healthcare

Mead Johnson

Medimmune

Nellcor Perinatal

Ross Pediatrics

Accreditation

Physicians

Continuing Medical Education: 6.0 hours Category 1

Waukesha Memorial Hospital designates this educational activity for a maximum of 6.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

The American College of Obstetricians and Gynecologists has assigned 7.0 cognate hours to this program

Present your ACOG CME (green) card for credit. Your attendance record will be sent to ACOG for recording. If you do not have your card, submit the validation form directly to ACOG after filling in your name and ACOG identification number.

American Academy of Family Physicians

This program has been reviewed and is acceptable for six (6.0-prescribed) hours by The American Academy of Family Physicians.

A certificate of attendance will be available at the end of the program.

Registered Nurses

Application has been made to the WNA continuing education approval program for approval of contact hours.

A certificate of attendance will be available at the end of the program.

Please follow instructions above for continuing medical education credit.

All Others

A certificate of attendance will be available at the end of the program.

Schedule for Friday, March 30, 2001

7:00-7:45 a.m.	Registration/Continental Breakfast/Exhibits
7:45-8:00 a.m.	Opening Remarks
8:00-8:45 a.m.	Fetal Oxygen Saturation Monitoring *J.M.R. Arafeh MSN*
8:45-9:30 a.m.	Thrombophilias in Pregnancy *R. Guilman MD, PhD*
9:30-10:00 a.m.	Break & Exhibits
10:00-10:45 a.m.	Cervical Ripening *Washington C. Hill MD*
10:45-11:30 a.m.	Twin-to-Twin Transfusion Syndrome *A.L. Delia MD*
11:30-11:45 a.m.	Panel Discussion
11:45 p.m.-12:45 p.m.	Lunch & Exhibits
12:45-1:30 p.m.	Monitoring of the Preterm Fetus *J.M.R. Arafeh MSN*
1:30-2:15 p.m.	Managing the Postpartum Patient Who Bleeds and Bleeds and Bleeds *Washington C. Hill MD*
2:15-2:45 p.m.	Break & Exhibits
2:45-3:30 p.m.	HIV Infection in Pregnant Women *B. Cuene RN, MSN*
3:30-4:15 p.m.	New WAPC Guidelines for Lab Testing in Pregnancy *D.P. Cruishank MD*
4:15-4:30 p.m.	Panel Discussion & Closing Remarks

Numbers indicate corresponding tab.

Controversial Issues in the Indications and Management of Labor Induction

Washington C. Hill, MD, FACOG
Director, Maternal-Fetal Medicine and The Perinatal Center of
Sarasota Memorial Hospital
1700 S. Tamiami Trail
Sarasota, Florida 34239-3555
Washington-hill@smh.com
(941) 917-6262
(800) 892-7088

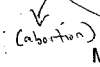
Learning Objectives:

1. Understand which oxytocin protocol for labor induction is best.
2. Discuss the appropriate use of misoprostol in ripening the cervix and induction of labor.
3. Discuss the methods of mid-trimester labor induction.
4. Have a better understanding of labor induction after previous cesarean section.
5. List and understand the indications, contraindications and controversial indications for induction of labor.
6. Review and update their own clinical guidelines for induction of labor.

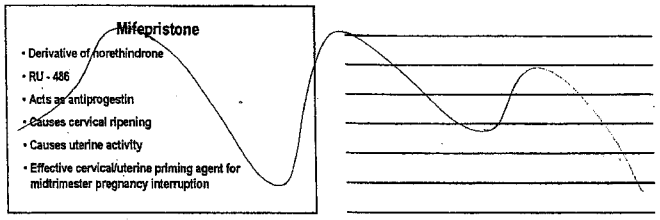
CONTROVERSIAL ISSUES IN THE INDICATIONS AND MANAGEMENT OF LABOR INDUCTION

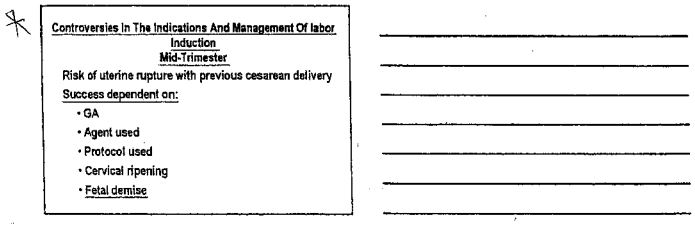
CASE PRESENTATIONS

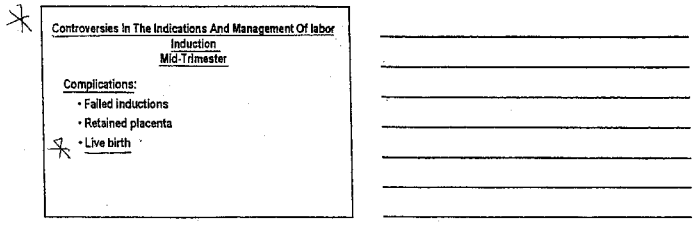
AB is a 30-year-old G2P1001 who had an amniocentesis at 17 weeks gestation with the results showing trisomy 18. Ultrasound shows findings of trisomy 18. The patient is now at 19-1/2 weeks gestation and has opted for induction of labor. How would you initiate her midtrimester labor induction? What method would you use?



MA is a 30-year old G1P0 at 42 weeks gestational age. Ultrasound shows an amniotic fluid index of 2.0. The rest of the biophysical profile is normal. Induction of labor is planned. The cervix is long, closed and uneffaced. What are the methods available for induction of labor?


Mifepristone
• Derivative of norethindrone
• RU - 486
• Acts as antiprogestin
• Causes cervical ripening
• Causes uterine activity
• Effective cervical/uterine priming agent for midtrimester pregnancy interruption


Controversies In The Indications And Management Of labor Induction
Mid-Trimester
Risk of uterine rupture with previous cesarean delivery
Success dependent on:
• GA
• Agent used
• Protocol used
• Cervical ripening
• Fetal demise


Controversies In The Indications And Management Of labor Induction
Mid-Trimester
Complications:
• Failed inductions
• Retained placenta
• Live birth

Alive: Wanted or not

Responding to judicial decisions that approved infanticide, the House moves to protect abortion survivors » *by* LYNN VINCENT

Jerrold Nadler's momma didn't raise a fool.

The New York congressman, who has built a reputation as the National Abortion Rights Action League's go-to guy, wasn't about to "step into this trap"—legislation in Congress granting full personhood and legal protection to babies who survive abortions.

"The purpose of this bill is only to get the pro-choice members to vote against it so they can slander us and say we are for infanticide," said Mr. Nadler last week as the House passed the measure virtually without opposition. "That's why I voted for it in committee, and that's why we will vote for it on the floor."

AVOIDS "SLANDER" BY OPPOSING INFANTICIDE: Nadler, an abortion supporter, voted pro-life.

Still, 15 members of Congress—including two of the most fanatical pro-abortion Republicans, Nancy Johnson of Connecticut and Benjamin Gilman of New York—stood up for infanticide. So did NARAL, though even that organization grew uncharacteristically sheepish in its opposition: The abortion industry's voice in Washington, which typically cranks out press releases nanoseconds after Congress acts, placed no statements on the PR Newswire. The one media statement NARAL produced on the subject is no longer even archived on its website. (In July, NARAL condemned the anti-infanticide measure as "yet another anti-choice assault," which could "interfere with the sound practice of medicine.")

Pro-life congressmen used riveting testimony to shed embarrassing light on that "sound practice." They called before a subcommittee hearing two nurses from Christ Hospital in Oak Lawn, Ill., where abortionists employed the "induced labor abortion" method, in which babies are delivered prematurely and left to die. Registered Nurse Jill L. Stanek, who worked in Christ Hospital's delivery ward, testified of a Down syndrome child abandoned to the "soiled utility room because his parents did not want to hold him" (see sidebar, next page).

Nurse Stanek told Congress she cradled the child and rocked him for the last 45 minutes of his life: "He was about 22 weeks old, weighed about a half a pound, and was about 10 inches long, about the size of my hand. He was too weak to move very much, expending any energy that he had trying to breathe. Toward the end of his life, he was so quiet that I couldn't tell if he was still alive unless I held him up to the light to see if his little heart was still beating through his chest wall. After he was pronounced dead, we folded his little arms across his chest, tied his hands together with a string, wrapped him in a tiny shroud, and carried him to the hospital morgue where all of our dead patients go."

THE FANATICAL 15

Although Florida congressman Charles Canady's Born-Alive Infants Protection Act passed the House last week with only 15 dissenting votes, it remains significant that even a small number of abortion officials would cast a vote against legislation banning infanticide. Combined with the shame House supporters of abortion had plenty of political cover to say pro-choicers like Rep. Jerrold Nadler of New York AP reported the roll call: Julia Carson, D-Ind.; Alcee Hastings, D-Fla.; Carolyn Maloney, D-N.Y.; John Dingell, D-Mich.; Jesse Jackson Jr., D-Ill.; Cynthia McKinney, D-Ga.; Chaka Fattah, D-Pa.; Nydia Velazquez, D-N.Y.; Nancy Johnson, R-Conn.; Benjamin Gilman, R-N.Y.; Barbara Lee, D-Calif.; Maxine Waters, D-Calif.; Charles Gonzalez, D-Texas; Nita Lowey, D-N.Y.; Mel Watt, D-N.C.

TOP: RICHARD B. LEVINE / NEWSMAKERS • BOTTOM: JOE MARQUETTE / AP

Another nurse told of similar horrors at the Illinois hospital, which prompted lawmakers to seize the opportunity to grant personhood rights to abortion survivors. The legislation, the Born-Alive Infants Protection Act, establishes that an infant who is completely expelled or extracted from his mother, and who is alive, is a "person" under federal law. The legislation would apply regardless of such considerations as lung development, chances of long-term survival, whether the baby survived an abortion—and whether or not the child's parents want him.

Lawmakers cited legal developments that obligated them to act: A congressional aide involved in drafting the bill explained that the measure remedies the consequences of a pair of recent judicial rulings that threaten to undo the legal principle that born-alive infants are persons entitled to legal protections. In June, the U.S. Supreme Court struck down a Nebraska law banning partial-birth abortion in *Stenberg vs. Carhart*. In its ruling, the court majority considered the location of an infant's body at the moment of death—in partial-birth abortion the baby is fully delivered except for the head—to be of no legal significance in ruling on the constitutionality of the Nebraska law. Instead, the aide said, *Carhart* left open the implicit notion that "a partially born infant's entitlement to the protections of the law is dependent upon whether or not the partially born child's mother wants him or her."

The notion didn't stay implicit for long. In July, the 3rd Circuit Court of Appeals made it explicit in *Planned Parenthood of Central New Jersey vs. Farmer*. In striking down New Jersey's partial-birth abortion ban, the court cited *Carhart* and *Roe vs. Wade*, and ruled it "nonsensical" and "based on semantic machinations" and "irrational line-drawing" for a legislature to conclude that a baby's location in relation to its mother's body should bear on whether or not that infant may be killed. The *Farmer* court further held that a partially born baby is not entitled to legal protection because a "woman seeking an abortion is plainly not seeking to give birth."

The measure, despite its overwhelming approval in the House, is likely to die in the Senate because Congress is hustling to adjournment so its members can get home to campaign for reelection. Supporters hope for passage next year and the signature of a new president. George W. Bush backs the legislation; Al Gore's spokesman declined comment on the bill's passage, telling the *Washington Times* his boss has not reviewed it. ◆

Haunting memories

My name is Jill Stanek, and I'm a registered nurse who has worked in the labor and delivery department at Christ Hospital in Oak Lawn, Ill., for the past five years. Christ Hospital performs abortions on women in their second or even third trimesters of pregnancy. Sometimes the babies aborted are healthy, and sometimes they are not.

The method of abortion that Christ Hospital uses is called "induced labor abortion," also now known as "live-birth abortion." This type of abortion can be performed different ways, but the goal always is to cause a pregnant woman's cervix to open so that she will prematurely deliver a baby who dies during the birth process or soon afterward. . . .

When this occurs, the small, pre-term baby drops out of the uterus, often alive. It is not uncommon for a live aborted baby to linger for an hour or two or even longer. One of these babies was known to live for almost an entire eight-hour shift.

In the event that a baby is aborted alive, he or she receives no medical assessments or care but is only given what Christ Hospital calls "comfort care." "Comfort care" is defined as keeping the baby warm in a blanket until he or she dies, although even this so-called compassion is not always provided. It is not required that these babies be held during their short lives.

One night, a nursing co-worker was taking an aborted Down syndrome baby who was born alive to our soiled utility room because his parents did not want to hold him, and she did not have time to hold him. I could not bear the thought of this suffering child dying alone in a soiled utility room, so I cradled and rocked him for the 45 minutes that he lived. . . .

The mark that this little person's untimely death left on my heart will never go away. In large part, I ended up here today because of that baby.

Other co-workers have told me upsetting stories about live aborted babies whom they have cared for. I was told about an aborted baby who was supposed to have spina bifida but was delivered with an intact spine. Another nurse is haunted by the memory of an aborted baby who came out weighing much more than expected—almost two pounds. She is haunted because she doesn't know if she made a mistake by not getting that baby any medical help.

A support associate told me about a live aborted baby who was left to die on the counter in our soiled utility room wrapped in a disposable towel. This baby was accidentally thrown in the garbage. Later, when they later were going through the trash trying to find the baby, the baby fell out of the towel and onto the floor.

I was recently told about a situation by a nurse who said, "I can't stop thinking about it." She had a patient who was 23 plus weeks pregnant, and it did not look as if her baby would continue to be able to live inside of her. The baby was healthy and had up to a 29 percent chance of survival, according to our national statistics.

But the patient chose to abort. . . . The only personnel present for this delivery were an obstetrical resident and my co-working friend. After delivery the baby, who showed early signs of thriving, was merely wrapped in a blanket and kept in the labor and delivery department until she died two and a half hours later.

To me, something is very wrong with a legal system that requires doctors to pronounce babies dead but does not require them to assess babies for life. I am also very uncomfortable with the fact that the very doctors who may be miscalculating birth weights, due dates, or misdiagnosing fetal handicaps, are the same ones deciding that these babies should not be assessed after delivery. . . .

No other children in America are medically abandoned like this. ◆

—This article is taken from Nurse Stanek's congressional testimony.

CHICAGO SUN-TIMES

SEPTEMBER 29, 1999, WEDNESDAY, LATE SPORTS FINAL EDITION

SECTION: EDITORIAL; Pg. 49

LENGTH: 681 words

HEADLINE: A new low in heartlessness

BYLINE: Dennis Byrne

BODY:

The argument that abortion doesn't kill a "person" centers on the assertion that a fetus isn't a person until it is born.

So what do you call an abortion procedure in which the fetus is born alive, then is left to die without medical care? Infanticide? Murder?

Most people would recoil at just the thought of such a gruesome, uncaring procedure, but it is practiced at at least one Chicago suburban hospital. When I called Christ Hospital and Medical Center in Oak Lawn, I frankly expected a denial that it uses the procedure, but instead a spokeswoman explained it is used for "a variety of second-trimester" abortions when the fetus has not yet reached viability. That's up to 23 weeks of life, when a fetus is considered not yet developed enough to survive on its own.

Instead of medical care, the child is provided "comfort care," wrapped in a blanket and held when possible. The procedure is chosen by parents and doctors instead of another method in which the fetus is "terminated" within the womb by, for example, injection with a chemical that stops the heart. Under Christ Hospital's procedure, which the spokeswoman said is used at some other area hospitals, the abortion is induced with prostaglandin, a drug that relaxes the cervix and allows for the fetus to be born.

Pro-life advocates have reacted with incredulity, calling the procedure "live birth abortions." They wonder why, if a death certificate is required, a birth certificate isn't. They wonder how such a brutal procedure can be used at a faith-based hospital named after Christ. One hospital nurse has complained that babies are sometimes are left to struggle on their own for up six or seven hours until death frees them from their torment.

She said a newborn, with no one around to hold it, once was left to die in a soiled linen closet—a charge the hospital denies. The hospital says none of the abortions are "elective," but are done only to protect the life or health of the mother or when the fetus is nonviable due to extreme prematurity or lethal abnormalities. The nurse, Jill Stanek, says she has seen some elective abortions done on newborns whose physical or mental defects are deemed incompatible only with "quality of life."

Pro-life advocates have picketed the hospital. Karen Hayes, Illinois state director of Concerned Women for America, has asked Attorney General Jim Ryan to determine whether the practice violates the Illinois Hospital Licensing Act and the Abused and Neglected Child Reporting Act. Ryan in turn asked the Department of Public Health to conduct an inquiry into the practice. A Health Department spokesman said the law prohibits them from discussing the matter until a new law takes effect Jan.1.

Frankly, I wonder whether the procedure is any more brutal than other abortion procedures, involving the cutting or poisoning of the fetus before it is born. The fetus, according to studies, can feel pain. Those who consider themselves compassionate ought to be appalled at the idea that any death—inside or outside the womb—is a suitable, civilized solution.

But the procedure itself raises deeper questions. First, there's the legality. It should be up to the attorney general and state's attorney to determine whether the procedure is infanticide. Read Roe v. Wade upside down and sideways, and I find nothing in it that legitimizes the killing of a born child. If the law is unclear, the Legislature should make it clear.

Looming larger is the moral question. Partial-birth abortions supposedly are acceptable because a small part of the child still remains in the birth canal, and thus is considered unborn when it is killed. The Christ Hospital case now makes it clear that legal rights and protections don't even begin with birth, as many pro-choice advocates have staunchly argued. That even a live, born human being has no right to life because someone else has decided its chances at life are slim. Or that its life won't be worth living.

My only question to them is: To what hell is this leading us?

CHICAGO TRIBUNE

OCTOBER 2, 2000 MONDAY, CHICAGO SPORTS FINAL EDITION

SECTION: Metro Chicago; Pg. 1; ZONE: N

LENGTH: 814 words

HEADLINE: CATHOLICS CONDEMN CLINIC VIOLENCE; PARISH SHOCKED BY CHARGES AGAINST PRIEST

BYLINE: By Mickey Ciokajlo, Tribune staff writer. Tribune staff writer Vanessa Gezari contributed to this report.

DATELINE: ROCHELLE, Ill.

BODY:

Parishioners at St. Patrick Catholic Church and community residents say they know Rev. John P. Earl as a friendly and outgoing pastor with a genuine interest in children and a fine sense of humor that frequently finds its way into his sermons.

It's a much different image than that of a priest charged with wielding a pickax and smashing his way into a building that houses a Rockford abortion clinic.

"Quite honestly, when I heard about it, I didn't believe it," said Susan Metzger, 43, a longtime member of the Rochelle parish. "It didn't sound like him at all."

Metzger, who teaches religious education to 6th graders at St. Patrick, said she had never heard Earl, 32, mention abortion in his sermons.

And though she says she opposes abortion, she doesn't condone violence.

"I don't believe that breaking into a clinic is the answer for this," she said.

Earl, pastor of St. Patrick since June 1999, was charged Saturday with burglary and felony damage to property.

Police in Rockford, about 30 miles north of Rochelle, said Earl broke into a building at 1400 Broadway that houses the Northern Illinois Women's Center, an abortion clinic.

He drove his car into a garage door behind the building about 8 a.m. and then chopped through wood doors, police said. He was arrested after the building's shotgun-toting owner called police and confronted Earl.

The clinic was closed at the time. No one was injured.

Earl was released Saturday from the Winnebago County Jail after posting $10,000 bail.

Earl was not believed to have been particularly active in the anti-abortion movement in the Rockford area, and police in Rockford declined to discuss a motive.

But Catholics in the Rockford diocese had been asked to observe "a respect life" week, and abortion protests had been scheduled for Sunday in Rockford and elsewhere. The so-called life chains, held every year on the first Sunday in October, are occasions for prayer and recognition of the sanctity of human life, organizers say.

Emotions among those who oppose abortion had been running high after the decision last week by the federal Food and Drug Administration to approve the French abortion pill RU-486.

About 800 abortion opponents formed a human chain for about an hour Sunday afternoon along a 2-mile stretch of Alpine Road in Rockford, between Holy Family Catholic Church and a commercial strip on East State Street.

Protest organizers said Earl had not participated in demonstrations and prayer vigils held weekly in front of the clinic. And though some said they shared his passion, they condemned his methods.

"I don't believe terrorism ever gets a point across," said Mary Ann Allen, 52, a Rockford resident who was participating in the anti-abortion chain.

Kevin Rilott, 36, a Rockford resident who has been involved in organizing the chain for the past decade, said many in his group were unhappy about the incident.

"All the pro-life people can't believe it," he said. "They're so upset about it. It makes us look like radicals."

At a similar event in Oak Lawn, several hundred anti-abortion demonstrators lined the sidewalks around Christ Hospital, singing and reciting rosaries.

"We're against anything that would kill life at any stage, whether it's at the first moment of conception or a 95-year-old on oxygen," said Rose Marie Gurski, 71, of

Crestwood. "We believe God is in charge of life and death, and I feel that this is what I can do."

Many said they don't support using violence to advance the anti-abortion movement.

"I think, biblically speaking, it's a sin to go the route [Earl] went," said Jill Stanek, the Christ Hospital labor and delivery nurse who complained about the hospital's abortion policy last year, prompting an inquiry by the Illinois Department of Public Health.

Since last fall, Christ Hospital has been a target of protests over a labor-induction abortion procedure performed there in which fetuses can survive outside the womb for an hour or more.

Last October the hospital's parent company, Advocate Health Care, changed its policy and now abortions are done only in cases of rape or incest, lethal fetal anomalies or when the life or health of the mother is threatened.

But the hospital still uses the labor-induction procedure and has been the scene of several protests this year, Sue Reimbold, a hospital spokeswoman, said.

Earl appears to have been well-liked in Rochelle, and his arrest has left a ripple in the community that touched non-Catholics too.

Brenna Muncaster, 31, said Earl often played with neighborhood children at the parish school playground near her home.

But her 6-year-old daughter is now frightened after seeing a television report on Earl's arrest.

"She saw this on the news and she was really freaked out about it," Muncaster said. "It's a horrible thing. He's a terrible example for children in the community."

LOAD-DATE: October 2, 2000

JILL L. STANEK
11664 SUNDANCE TRAIL
MOKENA, ILLINOIS 60448
HOME PHONE 815–464–0984
EMAIL JILLLYNN22@AOL.COM

April 23, 1999

Dr. Steven Ambrose, Chair, OB-GYN Department
Reverend Dr. William Baugh, Vice President, Religion & Health
Christina Ryan, RN, Director, Women & Infant's Health Services
Dr. Melvin Wichter, Chair, Ethics Committee
Christ Hospital & Medical Center
4440 West 95th Street
Oak Lawn, Illinois 60453

Dear Christ Hospital Executives:

When I graduated from nursing school in 1993, Christ Hospital was the only hospital that I applied at to work. I focused my attention professionally on Christ because I felt it had the best reputation medically in the south suburbs and because I was confident that no elective abortions were performed here since it is a faith based hospital. I was so sure of the latter that when I transferred to Labor & Delivery in September 1995, it never even occurred to me to ask about hospital policy on abortion. I was just certain that this wasn't an issue.

You can thus imagine my dismay when I came to work one evening to learn in report an abortion was being performed in the department. This abortion was being done because the baby had Down's Syndrome It was being termed a "therapeutic" abortion. I learned that abortions of this type are performed at Christ every so often, and I have since witnessed several other abortions here. However, I have never observed a "therapeutic" abortion in the true sense of the term, that being to save the life of the mother. The abortions I have observed have been elective abortions, performed due to defects in the baby such as Down's or any one of a number of chromosomal abnormalities, or physical defects which have been decided to either be incompatible with life or incompatible with a "quality" life.

It is L&D policy that a nurse does not have to receive assignment of a patient in the process of having an abortion performed if the nurse's moral or religious belief disallows it. However, nurses such as myself who do indeed refuse to take these patients are still implicated. I have personally witnessed two babies who have been aborted alive (and this is actually not an unusual occurrence). Neither time did the mother nor father want to hold and care for the baby until s/he passed from this life. Department policy in this case is to provide comfort care to the child until s/he dies. Once, I held the aborted baby in a warm blanket for the 45 minutes it took for him to die. The other time a co-working Support Associate did the same. Can you imagine the revulsion of this? The only situation that could be worse was as an RN colleague related to me, a night when she did not have the time to personally care for one of these infants. Since we have no place designated to keep these babies, this one had to be left to die alone in the Soiled Utility Room.

The abortion issue is huge and complicated. There are several angles I could discuss at this point in my letter, but I would like to limit my scope to comparing the Christ Hospital Mission Statement to our current abortion policy. The Mission Statement is as follows:

"The mission of Advocate Health Care is to serve the health needs of individuals, families and communities through a wholistic philosophy rooted in our fundamental understanding of human beings as created in the image of God."

This Mission Statement is in harmony with Biblical Scripture. Probably the most poignant passage on the subject of humans being special and unique from inception is Psalm 139:13–18:

"You alone created my inner being. You knitted me together inside my mother. I will give thanks to you because I have been so amazingly and miraculously made... My bones were not hidden from you when I was being made in secret, when I was being skillfully woven in an underground workshop. Your eyes saw me when I was only a fetus. Every day of my life was recorded in your book before one of them had taken place."

Christ Hospital bears the name of Jesus and is spiritually overseen by no less than two Christian denominations, the Lutheran and United Church of Christ faiths. I appeal to the leaders of these faiths as well as hospital management who oversee the ethical operations of Christ Hospital to change our current abortion policy.

The aforementioned aborted children may indeed have been destined to die, but I believe it is incongruent with our Mission Statement to intervene directly to take their lives. Rather, we should teach parents alternative approaches and frames of mind to bringing defective children into the world which would be consistent with our medical ethics, our Mission Statement, and our hospital's strong Judeo-Christian base. This approach would be to encourage treatment of these children as imperfect but still as special as you or I, as we are all created in the image of God. I am aware of a couple to whom abortion was recommended because of a congenital defect in their child. They chose, however, to carry their baby to term and were able to hold and love her for the 20 minutes that she lived. This is an example of the guidance a Christian hospital should give.

I cannot speak to the anguish and lifestyle upheaval parents must endure who deliver defective babies. I cannot speak to the anguish and physical pain an imperfect human being may have to endure. I cannot speak as to why some babies are born only to die. Only God can speak as to how and why He does things in His infinite wisdom. "Who gave humans their mouths? Who makes humans unable to talk or hear? Who gives them sight or makes them blind? It is I, the Lord!" (Exodus 4:11) We cannot take his place.

Our Mission Statement is prominently displayed in various places throughout the hospital, one location being above our front entrance doors. I must walk through those doors each evening that I come to work. It is very difficult for me to do so at this time.

Thank you in advance for your consideration.

Yours very truly,

Jill L. Stanek
Registered Nurse, Labor & Delivery

CC:
Dr. William Adair, President of Medical Staff, Christ Hospital
Mary Francis, Perinatal Support Coordinator
Andrea Miller, RN, Manager of Clinical Operations, Women's Health
Coletta Neuens, Chief Executive, Christ Hospital
Reverend Gerald Oosterveen, Director of Pastoral Care
Sue Riegel, RN, Assistant Manager of Clinical Operations, Labor & Delivery
Carol Schneider, Chief Executive, Christ Hospital
Dr. Scott Strote, Residency Program Director, OB-GYN

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July 11, 2001

The Honorable Steve Chabot
U.S. House of Representatives
Judicial Subcommittee on the Constitution
129 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Chabot:

I am writing in response to Reverend Larry Easterling's letter to you dated June 18, 2001. The topic under discussion is a type of abortion procedure performed at Christ Hospital in Oak Lawn, Illinois, that often results in babies being aborted alive. I am a Registered Nurse who has worked in the Labor & Delivery Department (L&D) at Christ Hospital for the past 5-1/2 years.

Reverend Easterling infers in his letter that Christ Hospital only aborts babies who are fatally ill when he states, ". . . in calendar year 2000 . . . terminations were necessitated by unfortunate circumstances that occurred in the development of the fetus in the womb. No terminations were due to rape or incest. . . . None of these infants could have lived outside the womb." I find these inferences not only inaccurate but also misleading. Just because no baby was aborted at Christ Hospital last year because of rape or incest was mere happenstance, because Advocate's (Christ Hospital's parent company) written policy allows abortion for rape, incest, "selective reduction" in cases of multiple gestation, and for life or health of the mother as well as for fatal fetal anomalies. It is clear that no exception is made to protect healthy babies from being aborted at Christ Hospital. There were at least two healthy babies aborted at Christ Hospital last year for "health of the mother" issues. I, myself, admitted one of these two mothers to the floor. The other healthy baby I am aware of was aborted alive and lingered for 2-1/2 hours without ever being seen by neonatal personnel. She was kept in L &D and rocked until she died.

That Reverend Easterling clearly understands these pregnancies and abortions to be "complex," "complicated," "tragic," "devastating," and "most difficult and painful," underscores the irresponsibility of another Christ Hospital policy that he fails to mention in his letter to you that allows minor girls to abort without their parents" input or consent (Advocate Systemwide Policy on Pregnancy Termination dated 10/14/99). I wish that Reverend Easterling would tell you how many girls under the age of 18 have aborted at Christ Hospital during the last few years.

Reverend Easterling's statements, "Sometimes, a fetus that shows signs of life is delivered. Families know to expect this and often welcome it as an opportunity briefly to hold their baby . . . , are, again, incorrect. During last year's U. S. House Born Alive Infant Protection Act hearing, Allison Baker, an RN who worked in L&D at Christ Hospital for one year, testified that, "During the time the fetus was alive, the patient kept asking me when the fetus would die. For an hour and 45 minutes the fetus maintained a heartbeat. The parents were frustrated, and obviously not prepared for this long period of time. Since I was nurse to both the mother and fetus, I held the fetus in my arms until it finally expired." Two other nurses have told me of instances when their patients did not know that their baby was going

to be aborted alive. One of these patients had to be tranquilized after delivery when her baby was surprisingly born alive and also did not display the external physical defects that she had been told he would have. Finally, again based on my knowledge as an employee who actually works in Christ Hospital's L&D, Reverend Easterling is also inaccurate when he states, "whenever a 'live' birth occurs as a result of a pregnancy-termination procedure, a physician from our pediatric team assesses the neonate and issues appropriate medical orders." Pediatric personnel are not called to assess all babies who are born or aborted alive at Christ Hospital. I verified my observations with a nursing team leader on the floor who told me that NICU is only notified when staff "thinks the baby may be viable." Furthermore, even if Reverend Easterling's statement were true, requesting "a" physician from the pediatric team is not the same as requesting the entire team. The four-member team is comprised of the neonatologist, pediatric resident, pediatric nurse, and respiratory therapist. This entire team would be called for the birth of a wanted or assuredly viable compromised neonate. So, calling one member of the team does not provide equal medical attention to live aborted babies. Also, it is my understanding that if "a physician" is indeed called over to assess a live aborted baby, it is a pediatric resident who is sent, and not an attending physician, which is also no minor point.

Congressman Chabot, thank you for the opportunity to respond to Reverend Easterlng's letter. I respectfully request that my letter also be entered into the Congressional Record.

Yours very truly,

Jill L. Stanek, RN

CC:
Reverend Larry Easterling
The Honorable William Lipinski
The Honorable Peter Fitzgerald
The Honorable Richard Durbin

Advocate Health Care

OPERATING POLICY AND PROCEDURE

HEALTHCARE FACILITY Christ Hospital and Medical Center			DEPARTMENT Nursing-Labor & Delivery
INITIATING AUTHORITY Labor & Delivery Policy & Procedure Committee	APPROVING AUTHORITY Department of OB/GYNE		TITLE Cytotec Administration for Termination of pregnancy
EFFECTIVE DATE 6/98	DATE OF REVISION	PAGE 1 of 1	PROCEDURE NUMBER WHS434

PURPOSE:

To outline nursing care for a patient receiving cytotec to induce labor and delivery of an Intrauterine Fetal Demise (IUFD) or therapeutic abortion

Policy:

1. Cytotec administration is limited to those patients with a medical indication for delivery who are not in labor and have consented to this therapy

2. Plan of care must be discussed with patient and family by the attending/resident and nursing prior to the insertion of cytotec. Documentation should be recorded in the progress notes by attending/resident and in the Labor and Delivery flowsheet by the nurse.

3. The patient must be screened for contraindications to therapy.

ABSOLUTE CONTRAINDICATION

- Classical uterine scar
- Viable pregnancy
- History of allergic reaction to prostaglandins

EQUIPMENT

1. 2 - 100mcg tablets of cytotec
2. Sterile gloves

Procedure:

1. Initiate IV line per physicians order
2. Obtain pre-op labs per order
3. Obtain consent for possible D&C
4. The RN will assist with a SVE and insertion of cytotec
5. The RN will document the SVE, cytotec administration, dose and time on the Labor and Delivery flow sheet
6. I&O documented on flowsheet
7. Observe for signs of nausea, vomiting, diarrhea, abdominal cramping, increased temperature (all expected side effects)
8. After approximately 12 hours have passed with no sign of delivery, the SVE can be repeated with another dose of cytotec administered. This may be continued for a total of 48 hours.
9. Observe for signs and symptoms of imminent delivery. Notify attending/resident when appropriate[1]
10. Offer bereavement support including notifying the chaplain and following procedures as outlined in the bereavement packet

[1] Cross Refernce policy: Whs 532 Surgical Specimens:Care and labeling and Whs 495: Nonviable Newborns, Care of

SEARLE

Searle
5200 Old Orchard Road
Skokie, Illinois 60077
Phone (847) 982-7000
Fax (847) 470-1480

IMPORTANT DRUG WARNING
CONCERNING UNAPPROVED USE OF INTRAVAGINAL OR ORAL MISOPROSTOL IN PREGNANT WOMEN FOR INDUCTION OF LABOR OR ABORTION

August 23, 2000

Re: Cytotec® (misoprostol)

Dear Health Care Practitioner:

The purpose of this letter is to remind you that Cytotec administration by any route is contraindicated in women who are pregnant because it can cause abortion. Cytotec is not approved for the induction of labor or abortion.

Cytotec is indicated for the prevention of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)-induced gastric ulcers in patients at high risk of complications from gastric ulcer, e.g., the elderly and patients with concomitant debilitating disease, as well as patients at high risk of developing gastric ulceration, such as patients with a history of ulcer.

The uterotonic effect of Cytotec is an inherent property of prostaglandin E_1 (PGE_1), of which Cytotec is a stable, orally active, synthetic analog. Searle has become aware of some instances where Cytotec, outside of its approved indication, was used as a cervical ripening agent prior to termination of pregnancy, or for induction of labor, in spite of the specific contraindications to its use during pregnancy.

Serious adverse events reported following off-label use of Cytotec in pregnant women include maternal or fetal death; uterine hyperstimulation, rupture or perforation requiring uterine surgical repair, hysterectomy or salpingo-oophorectomy; amniotic fluid embolism; severe vaginal bleeding, retained placenta, shock, fetal bradycardia and pelvic pain.

Searle has not conducted research concerning the use of Cytotec for cervical ripening prior to termination of pregnancy or for induction of labor, nor does Searle intend to study or support these uses. Therefore, Searle is unable to provide complete risk information for Cytotec when it is used for such purposes. In addition to the known and unknown acute risks to the mother and fetus, the effect of Cytotec on the later growth, development and functional maturation of the child when Cytotec is used for induction of labor or cervical ripening has not been established.

Searle promotes the use of Cytotec only for its approved indication. Please read the enclosed updated complete Prescribing Information for Cytotec.

Further information may be obtained by calling 1-800-323-4204.

Michael Cullen, MD
Medical Director, U.S.
Searle

CY20141A

4440 West 95th Street
Oak Lawn, Illinois 60453-2699
Telephone 708.425.8000

Advocate Christ Medical Center

June 18, 2001

The Honorable Steve Chabot
Chair, Subcommittee on the Constitution
U.S. House of Representatives
362 Ford House Office Building
Washington, D.C. 20515
c/o Mr. Brad Clanton, Senior Staff
Subcommittee on the Constitution

Dear Chairman Chabot:

I am writing to you requesting that this letter be entered into the record of the Subcommittee on the Constitution on June 21, 2001, as the subcommittee takes up the issue of the Born Alive Infants Protection Act. Advocate Christ Medical Center and Advocate Health Care do not wish to take a position on this legislation. However, because Ms. Jill Stanek, an employee of Advocate Christ Medical Center, will be testifying on the type of care that is provided at our medical center, we feel compelled to request that our statement be entered into the record.

First, let me indicate that I am vice president of mission and spiritual care at Advocate Christ Medical Center and Advocate Hope Children's Hospital in Oak Lawn, Illinois. Christ Medical Center is a 662-bed teaching hospital, sponsored by Evangelical Lutheran Church in America and recognized as one of the top 100 hospitals in the United States.

Much of the oral and written testimony that you hear and see will attempt to paint a very simple, black-and-white picture of much larger and more complicated experiences that some families must face. I would like to explain the complexities involved when families experience tragic pregnancies and to attest to the comprehensive, compassionate care that Christ Medical Center and many other health-care institutions throughout the country offer to all patients and families, including those who face complex pregnancies.

At Christ Medical Center, we do not provide abortion on demand. To put this issue in context, our health-care staff participated in 4,024 happy, successful births in calendar year 2000. During that same year, only 16 patient cases involved tragic situations resulting in pregnancy terminations. These terminations were necessitated by unfortunate circumstances that occurred in the development of the fetus in the womb. No terminations were due to rape or incest. Of the 16 terminations, only five involved infants who were born with a pulse. These five babies would have been the only ones considered "born alive" under legislation that you are preparing to discuss. Among the five infants, three of them had developed major internal organ anomalies, one was anencephalic (had no brain) and one had been diagnosed in the womb as having acrania, a condition in which the fetus is developing without a

skull and the brain is literally dissolving in the amniotic fluid. None of these infants could have lived outside the womb.

Without our support of the 16 terminations, many of these mothers may have given birth at home or in a public place. Instead, we provided them a safe and compassionate place where they could be with family members, friends, nurses and chaplains. We did not abandon these young mothers during the most tragic time in their lives.

The families to whom we provide obstetrical care begin their pregnancies hoping for a happy ending. However, on rare occasions, something goes terribly wrong with a pregnancy or fetal development. At that point, the family is confronted with the most difficult and painful decision of their lives, knowing either choice – pregnancy termination or birth -- will lead to the same tragic and unwanted end. These pregnancies do not lead to delivery of a baby who can survive outside the womb, whether or not the mother carries the baby to full term.

As an ordained United Methodist minister, I have a doctorate in theology and am specially trained in bereavement counseling. This experience is especially relevant when a couple, looking to expand their family, experiences the tragedy of a non-viable pregnancy. I feel privileged to have the opportunity to walk with these families and minister to their needs under such devastating circumstances. I also feel privileged to be working at a medical center that provides such outstanding care to families who experience tragic pregnancies. We support patients and families with compassion, especially during the time they are weighing complex pregnancy decisions.

Informed by our church sponsors' position on this issue, the entire Advocate Health Care system, of which Christ Medical Center is a member, supports each individual's right and responsibility to weigh complex pregnancy decisions carefully in light of their own personal faith, values and moral commitments. We understand, however, that not everyone agrees with this position. That is why we have a "right-of-conscience" policy that gives our employees the option of not participating in health-care activities involving pregnancy termination.

As chairman of a 10-member perinatal ethics committee, which reviews each and every patient case that comes forward at Christ Medical Center, I can tell you very clearly what occurs when pregnancy termination is considered. Under very unfortunate circumstances, families may choose to terminate a pregnancy as a tragic necessity. The heart-breaking decision to end a complicated pregnancy is a private medical decision made by the patient and her family after much thought, prayer and counseling. This is not an institutional decision. The ethics committee, which includes counselors, physicians, hospital chaplains and community clergy, undertakes a lengthy review process for each pregnancy-termination request in order to determine whether or not pregnancy termination is ethically and morally warranted.

Our role as caregivers is to provide comprehensive information and compassionate support as families reach their own informed decisions and to assure continuity of competent medical care. Only when a family chooses to end their complicated pregnancy and that decision is supported by

the perinatal ethics committee do our physicians and staff move forward to initiate termination, using procedures and protocols approved by the American College of Obstetricians and Gynecologists.

Sometimes, a fetus that shows signs of life is delivered. Families know to expect this and often welcome it as an opportunity briefly to hold their baby and even have it christened. Our philosophy and policies affirm that human life is always sacred and thereby deserves and requires care, love and respect.

Whenever a "live" birth occurs as a result of a pregnancy-termination procedure, a physician from our pediatric team assesses the neonate and issues appropriate medical orders. Medical care is always provided to neonates who can sustain life outside the womb. When medical care cannot help and would only prolong the dying process, comfort care, namely competent and compassionate bereavement care, is the appropriate next step. In such cases, provision of treatment would only prolong the neonate's dying process and be futile in effecting survival.

The mission of Advocate Health Care is to serve the health needs of individuals, families and communities through a wholistic philosophy rooted in the fundamental understanding that human beings are created in the image of God. Our physicians and nursing staff provide compassionate and appropriate care that always shows respect for life, no matter how brief. Anything less would not be tolerated.

Chairman Chabot, thank you for your consideration of this statement, and, again, we respectfully request that it be entered into the record of the Subcommittee on the Constitution in its deliberations on the Born Alive Infants Protection Act.

Sincerely,

Rev. Larry Easterling
Vice President
Mission and Spiritual Care
Advocate Christ Medical Center

cc: The Hon. William Lipinski
U.S. House of Representatives

The Hon. Peter Fitzgerald
U.S. Senate

The Hon. Richard Durbin
U.S. Senate

PREPARED STATEMENT OF MATTHEW G. HILE

Mr. Chairman, Honorable Representatives, Staff and visitors:

My name is Matthew Hile. I hold a Ph.D. in Clinical Psychology and am a Research Associate Professor at the University of Missouri-Columbia Medical School. I sit on the Executive Committee of the American Psychological Association's Division of Mental Retardation and Developmental Disabilities and am a member of the Medical Ethics Committee of the St. Louis Children's Hospital.

However, today I come to offer testimony concerning the Born Alive Infants Protection Act (H.R. 2175) as the father of Amelia Meliss Hile.

> Fourteen years ago, I kept a very personal journal. A journal of the brief days of our daughter's life. A time of suffering for our daughter, Amelia, as well as suffering for her parents, grandparents and all that knew them.

My wife and I very much wanted a baby. We were, and still are, very much in love, were out of school, had been married 10 years and had bought our first home. This baby received ideal prenatal care. My wife lost 10 pounds before she conceived, ate two vegetables every night for dinner, drank absolutely no alcohol, very little caffeine, and we went to the obstetrician regularly. We had readied the nursery with curtains and crib, read books on parenting, received gifts from friends and family, and dreamed about our child's future. The grandparents to be called regularly and made plans to come visit the new arrival, who would be the first grandchild on either side of the family.

The following has been excerpted from my journal:

June 17th: Last Thursday we had an ultra sound, it always makes me nervous to have all those people bustling about, first one tech, then another, then a doctor—2 hours under the scan. We thought that there was just some difficulty in getting the precise measurements . . .

June 18th: Friday morning a call from the OB, get in for a feta scope now. That afternoon we have another sonogram with the head of the genetics department. He came into the room with a tech and our pediatrician. He begins talking and showing us things on the monitor. He is concerned about the baby's presentation, why was it in this position—he goes on to show the curved spine, the splayed hips, the twisted legs and feet, the oddly bent hands and the huge amounts of amniotic fluid. He says we are in for a lot of difficulties and suggests that our baby may not survive. He suspects central nervous system involvement. Through our tears, we call the grandparents. Through their tears they try to comfort us.

Meetings with physicians from Children's Hospital. With the Regan administration and the Baby Doe decision on our minds, we need to understand what that hospital can and cannot do. We need to be clear about our desire to avoid heroic measures. We fear having our role as parents and protectors of our child's welfare snatched from our hands.

June 25th: My wife labors for 13 hours before a c-section is performed. The operating room filled with Drs, nurses and technicians. At 11:14 the baby is born. Simon or Amelia? There is no noise, no crying. They are working on him or her. Silence in the room. The silence is deafening. I let go of my wife's hand to see the child's twisted little body. It is a girl. I watch them try to start an IV in her little twisted hand, but I cannot watch and turn back to cry with my wife. I go back and forth to touch my daughter as my wife's incision is closed. They wheel Amelia out, taking her to Children's Hospital.

At 3 am I take a long walk through corridors that will soon be familiar. Up to the 5th floor. I am shown how to wash and gown and then enter the unit. The nurse introduces herself and shows me how they have hooked up Amelia. Heart rate, respiration, a temperature probe to turn the lights on and off, and an oxygen helmet. Wires, tubes, lights, and alarms are everywhere. I touch Amelia and look, wish her goodnight and gently kiss her. I feel strangely better for having wished her good night.

June 26th: I visit Amelia a couple of times today. More importantly I get to hold her in my arms. This poor twisted body. I sit and rock her and cry and cry. I am so sorry for her, for us, but mostly for Amelia. As I hold her I feel a great warmth; a feeling washes over me that was unexpected. Until now, she was a potential but not a person to me. Now she is still a potential, but also a person in need of care and nurturing. Someone who needs our intelligence and energy if she is going to survive and someone who needs these same qualities if she is going to have but a little time in this world. She is a person now and it is, in part, her responsibility to survive and thrive. We will do what we can, but it is up to her.

June 27th: Mother and daughter have the opportunity to bond. I take pictures and cry; sad about the event I had hoped to be celebrating.

1. The testing begins. Cat scan—abnormal right side brain development. This rings in my head again and again—resounding in its implications. Right side, pattern recognition. Doctor says it may be that she could not recognize high notes or not appreciate the world around her. Not be able to read, listen and understand music or recognize her mother. More tests. We do have brain involvement. The geneticist was right.

June 28th: My wife is home and my daughter is not. That is not the way it is supposed to be.

1. Amelia has periods where she stops breathing and her heart rate drops. Her lips become blue and her skin gray. What if she dies? What if she doesn't die? Do we have the right to subject this child to tubes, wires, lights, and tests? Tests that help diagnose but do nothing to help her. My wife pumps breast milk that our daughter is fed with a tube. Our daughter cannot swallow. She cannot close her eyes. Her arms and legs are put in splints that do nothing.

July 9th: The nurse calls cheerily, "Oh she is doing very well, we did have to bag her once and her feed tube is blocked and she had two periods of hear rate stopping, but she is doing great!" This is getting more and more ludicrous. We feel something must be done but we are trapped. She cannot be released to another unit because she is not stable, she cannot die because they keep saving her life, we cannot stop treatment because they won't let us, we have to pay because we are responsible, and we cannot do anything because we are not responsible. We are told it is a medical decision. I wonder about the increased brain damage through these increasing periods of anoxia.

1. More tests—brain stem abnormalities with higher cortical function areas also having irregularities. No gag response. Nothing is getting better. Doctor says give her more time. We trust him.

July 14th: We held, cuddled, dressed, and photographed Amelia. She looks a little better—better color. The next day she has two bad heart rate drops, lots of aspirations and needed a transfusion in the night. The following day she is better and worse. She moved a little but was much slower to recover from her heart rate drops. At those times she dies and technology brings her back.

July 18th: We have another meeting with the staff. One young doctor wants to put her on a ventilator. One with more experience says he would not ventilate—medically, he says, that would not be in her best interest. We are given good advice, not to wish away our time with her as it may be very brief in the grand scheme of things.

1. Another week goes by. Another meeting. The decision is made by them to begin to push Amelia to see how much she can do. Since she cannot swallow they decide to suction her only every four hours and not every hour. When I return at 9pm she is laying on her side. She had spittle on her towel and it was apparent that she had not been suctioned. With the assistance of the nurse I got her up and rested her upright on my chest. I started reading Winnie the Pooh and the alarms went off. Her respiration dropped and her heart rate plummeted. She was gray, grayer than I had ever seen her before. A nurse came by to check her. Other nurses walked by, obviously concerned—some wore anti-abortion red roses on their nametags. Amelia was suctioned, and oxygen passed by her face. The nurses say they were never taught how to NOT treat someone.

July 25th: We become angry in a meeting with the medical staff. What are you doing making her suffer like this?? You have nothing to do to help her, why do you make her go through this over and over again? Why can't you let her go? If the nursing staff cannot do this we can!

July 26th: After being taught how to gavage feed Amelia, we are allowed to take our daughter into a room by ourselves. We suction, feed, and dress her. We have never been able to take her for a walk in the park, she has never been in the fresh air, and has never seen a tree. We play music, read Winnie the Pooh and hold her up to the window to see trees through her unblinking eyes. We cry. We choose not to suction her again, to let her go. My wife holds her baby to her breast but she is unable to suckle. We continue to feed her pumped breast milk. Medical staff checks on us throughout the day. After the 10 pm feeding Amelia is looking blue. Amelia lay silently in my wife's arms. After 5 minutes I tried but could find no heart beat. After 10 minutes I listened with a stethoscope and could hear nothing.

We were still, afraid to move her—but Amelia's suffering was over. Her spirit had flown to a better place.

Today I am here to suggest that you have the power to make the journals of others in our position have a very different and even more painful ending. It could read that Amelia suffered another month, or another year, before her death. As it was, Amelia lived, in her 31 days, to the fullness of her life. I urge you to leave these agonizing decisions to those most involved, the physicians and families who care deeply about their children.

PREPARED STATEMENT OF F. SESSIONS COLE

Mr. Chairman, Honorable Representatives, Staff, and spectators. My name is Francis Sessions Cole, and my family, including our two daughters, ages 17 and 15, and my wife of 29 years resides in St. Louis, Missouri. I offer testimony concerning Representative Chabot's "Born Alive Infants Protection Act of 2001" (H.R. 2175) as a physician whose specialty is care of newborn infants. My testimony is not sponsored by any organization. I completed my pediatric residency training at Boston Children's Hospital and my specialty training in caring for newborn infants in the Joint Program in neonatology at Harvard Medical School. Since my Board certification in Pediatrics in 1981, I have cared for more than 10,000 newborn infants directly, and I currently have administrative responsibility for approximately one half of all the babies born in St. Louis annually (approximately 13,000 babies). I also have an active clinical practice that focuses on caring for babies whose transition from womb to world is complicated by one or more problems like prematurely, birth defects, infections, or problems with the afterbirth or placenta. I routinely encounter babies whose problems place them on the edge of viability.

The language of H.R. 2175 would impose on doctors and parents a universal definition of "life" or "alive" which is, in my experience as a neonatologist, inconsistent with the harsh reality presented by a number of circumstances. The fact is that the indicia identified in the bill—breathing, or a beating heart, or pulsation of the umbilical cord, or definite movement of voluntary muscles—are not themselves necessarily indicative of life or continued viability. Frequently, the heartbeats of infants will be maintained by medicines, not nature; their breathing may be present but ineffective as they die; they may move voluntary muscles during the dying process.

As a physician who cares for ill newborn infants, I feel that I have the greatest practice in medicine, because my practice permits me to participate in miracles everyday. Thanks to significant advances in technology over the last 20 years, babies whose parents could have been offered no hope can now see their babies survive and, for the most part, exceed both their parents' and their doctors' expectations as they develop. Unfortunately, even today's most advanced medical science is still a long way from being able to offer every sick infant a reasonable chance for survival. In fact, in our neonatal intensive care unit, approximately 10% of the infants do not respond to advanced technology and pass away. These deaths result from accidents of nature that are no one's fault, and they are excruciatingly difficult for parents, doctors, and nurses. Frequently, the emotional pain of the decision to terminate treatment in such cases is compounded by the fact that the technology that we provide babies requires painful, invasive procedures. When parents and physicians together decide that life support technology is futile for an infant and is only prolonging the pain of the dying process, parents have a moral and legal obligation to minimize the suffering of their baby, regardless of the pain such a turn of events brings to them in their loss.

The language of H.R. 2175 will, in my view, significantly interfere with the agonizing, painful and personal decisions that must be left to parents in consultation with their physicians. Imposing the proposed definition of "alive" or "life" for statutory purposes may cause parents to prolong the medically inevitable dying process of their infants out of fear that terminating that process might be deemed to be, for legal purposes, the termination of a life, when in fact all that would be terminated would be the painful process of death. Prolonging treatment in such case would be not the saving of a "life," but the prolonging of the pain and suffering of inevitable death. As a physician whose career has been dedicated to the welfare of newborns, and especially critically-ill newborns, I urge the Subcommittee not to inject an unnecessary and unrealistic definition of "life," with all its legal implications, into the already agonizing and heart-breaking situation faced by parents of infants in the dying process.

PREPARED STATEMENT OF GORDON B. AVERY

As a physician and neonatologist with 40 years of practice experience, I write to express my concern with HR 2175, the "Born-Alive Infants Protection Act of 2001." My credentials include authorship of a major textbook, *Neonatology: Pathophysiology and Management of the Newborn,* the fifth edition of which was published in 1999 by J. B. Lippincott, Co. I have also been Professor of Pediatrics for 30 years at the George Washington University School of Medicine and Health Sciences.

The powerful tools of neonatology (respirators, total intravenous feedings, life support systems, etc.) have reduced neonatal mortality and saved countess infants. But they are also subject to overuse in futile situations which inflict pain and suffering on the infant, agony on the families, prolongation of dying, extreme cost and resource utilization, all without changing the fatal outcome. The humane and successful management of these situations requires a delicate balance in decision making, which has been recognized by the Congress in the amendments to the Child Abuse Act, the judiciary, including the Supreme Court, and various Administrations. I enclose an article I published entitled "Futility Considerations in the Neonatal Intensive Care Unit," to illustrate some of these issues.

The current proposed legislation defines as "born alive" any product of conception with a single muscle twitch or any indication of heart beat, regardless of stage of development. The term "born alive" is then declared equivalent to "person," "human being," "child," and "individual." Presumably every miscarriage, even in the first trimester, would be considered a child and would require a birth and death certificate. The definitions make no distinction as to whether there is any possibility of survival or not. Needless to say, rather than clarifying things, this set of definitions will immensely cloud the work of medical personnel and families in determining what measures are indicated and what would be futile and actually dehumanizing.

For centuries, different terms have been used to denote an embryo, a fetus, a neonate, an infant and a child. An embryo is pre-viable outside the uterus, and is in such a rudimentary state of development that a human embryo more closely resembles the embryo of a pig than it does a term newborn of either species. Yet embryos have beating hearts and muscles which can twitch.

A fetus has reached the third trimester and still has much growth and development to achieve before normal birth. However, many such fetuses can be stabilized and supported after premature birth and even discharged home as infants who can take their place in families. To blur these distinctions seems to work against tradition, sound medical practice, and the struggle of parents to understand what is facing them and what the practical alternatives are.

I strongly urge you to oppose this measure, which I consider regressive and ill considered. Thanks for your consideration.