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CROSSING THE LINE: THE POLITICAL AND MORAL BATTLE OVER LATE-TERM ABORTION

Rigel C. Oliveri[†]

"This is an emotional, distorted debate. We are using the lives of a few women to create divisions across this country . . . "

—Senator Patty Murray¹

I. INTRODUCTION

The 25 years following the Supreme Court's landmark decision in *Roe v. Wade*² have seen a tremendous amount of social and political activism on both sides of the abortion controversy. Far from settling the issue of a woman's constitutional right to an abortion, the *Roe* decision galvanized pro-life and pro-choice groups and precipitated many small "battles" in what many on both sides view to be a "war" between fetal protection and women's access to reproductive choice. These battles have occurred at the judicial, grassroots, and political levels, with each side gaining and losing ground. Pro-life activists staged a nation-wide campaign of clinic protests, which led to Congress's 1994 enactment of the Federal Access to Clinic Entrances law creating specific civil and criminal penalties for violence outside of abortion clinics.³ State legislatures imposed limitations on the right to abortion, including mandatory waiting periods and requirements for parental or spousal notification. Many of these limitations were then challenged before the Supreme Court, which struck down or upheld them according to the "undue burden" standard of review articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁴

Recent developments have shifted the focus of conflict from clinic entrances and state regulation of abortion access to the abortion procedures themselves. The most controversial procedures include RU-486—the "abortion drug"—and a particular late term surgical procedure called intact dilation and extraction ("D&X")—more popularly known as "partial-birth abortion." The controversy surrounding the D&X procedure escalated dramatically in June of 1995, when both houses of Congress first introduced legislation to ban the procedure. This

[†] Stanford Law School, candidate for J.D., 1999. I am indebted to Janet Halley for her advice, feedback, and encouragement. I am grateful to Ann Kolker for her assistance and for giving me the opportunity to work on this issue. I would also like to thank Blanche Fischer and Luis Li. Finally, I would like to dedicate this Article to my late grandmother, Stella Mantei, who never got the chance to read it and probably would not have agreed with everything in it, but would be proud of me for writing it, nonetheless.

1. 142 CONG. REC. S11337-01, S11348 (1996).

2. 410 U.S. 113 (1973).

3. See 18 U.S.C. § 248 (1994).

4. 505 U.S. 833 (1992).

touched off intense lobbying efforts on the part of both proponents and opponents of the bill, resulting in a fierce ethical, medical, political, and social debate that shows no signs of diminishing.

This Article will examine the proposed legislation, lobbying, and debate surrounding "partial birth abortion," and the representational difficulties faced by opponents of the Ban in this contest. Parts II and III examine the proposed Ban of the D&X procedure, including its language, legislative history, and ramifications. Part IV documents and critically assesses the advocacy and lobbying efforts surrounding the Ban, focusing on how groups on both sides of the issue framed the debate and the arguments, tactics, and rhetorical devices they used. Part V discusses the controversy over the incongruous statistics each side presented. This discrepancy came about in part because of the different ways in which advocates framed the debate, spurring even more intense political battles. In addition, the statistics dispute indicated deeper problems with the representational strategies that opponents of the Ban pursued. Part VI contains a focused critique of the strategies of those organizations and individuals who opposed the Ban, from both a tactical and a representational standpoint. I argue that opponents of the Ban had difficulty defining the group of women whose interests they were attempting to represent, and that this difficulty both illuminated and reinforced underlying tensions surrounding late term abortion and the very different groups of women who have them. Part VII contains a brief analysis of the inherent problems surrounding group representation in issue-based advocacy and lobbying, particularly in the area of abortion rights. I conclude with suggestions for more effective, comprehensive pro-choice advocacy which recognizes and takes into account the diverse nature of the women whose interests are represented.

II. THE HISTORY OF THE BAN

The first version of the legislation, House Resolution 1833, was introduced in the House on June 14, 1995 as an amendment to Title 18, the criminal section of the U.S. Code.⁵ The bill was sponsored by Representatives Canady, Vucanovich, Hall, and Hyde, with an incredible 162 cosponsors.⁶ HR 1833 imposed both criminal and civil penalties on doctors who performed a procedure defined as: "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."⁷ Doctors convicted under the proposed law would face a fine and up to

5. See H.R. 1833, 104th Cong. (1995).

6. See 141 CONG. REC. H11426 (1995) (statement of Rep. Canady).

7. H.R. 1833, 104th Cong. (1995). Although the legislation and the surrounding debates incorporated apparent medical and scientific terminology, in fact many of the terms used have multiple, ambiguous, and contested definitions. For an analysis of the competing definitions of the procedure and an attempt to clarify other important technical issues, see *infra* Section III and Appendix A.

two years in prison.⁸ The father of a fetus aborted through the D&X procedure, as well as the parents of a woman under the age of eighteen, would have a civil cause of action against the doctor, enabling them to claim damages for psychological injury and additional monetary damages of up to three times the cost of the procedure.⁹

HR 1833 originally contained a narrow affirmative defense for doctors who reasonably believe that the procedure is necessary to save a woman's life and that no other procedure would suffice for that purpose. There was no similar defense for circumstances in which the procedure would be considered necessary to preserve a woman's health or future fertility. Some members of the House tried to introduce an amendment that would create such a defense, but they were prevented from doing so because the bill came out of the Judiciary Committee under a closed rule, meaning that amendments and substitutions would not be allowed.¹⁰ On November 1, 1995, the House voted overwhelmingly to pass the bill.¹¹

The Senate version of the bill, S. 939, was introduced on June 16, 1995 by Senator Smith (NJ).¹² When it was first introduced, S. 939 was basically identical to the version that passed through the House. However, because this bill did not come to the floor under a closed rule, Senators were able to offer amendments on the floor. The most important of these amendments was offered by Sens. Smith (NH) and Dole, and Sen. Boxer. The Boxer Amendment, No. 3083, would have created an exception for abortions "prior to the viability of the fetus, or after viability where, in the medical judgment of the attending physician, the abortion is necessary to . . . avert serious health consequences to the woman."¹³ This amendment was defeated in the Senate by a close margin.¹⁴ The Smith-Dole Amendment, No. 3080-81, reformulated the maternal life affirmative defense into a maternal life exception.¹⁵ This Amendment passed, and the exception language replaced the affirmative defense language in the bill.¹⁶ The amended version was passed by the Senate on December 7, 1995.¹⁷ The bill then returned to the House, which concurred in the Senate amendments.¹⁸ On March 27, 1996 the House substituted the Senate version of

8. See H.R. 1833, 104th Cong. (1995).

9. See *id.*

10. See 141 CONG. REC. H11593-02, H11594 (1995) (statement of Rep. Beilenson).

11. See 141 CONG. REC. H11604-01, H11618 (1995).

12. See S. 939, 104th Cong. (1995).

13. Amendment read Dec. 5, 1995. 141 CONG. REC. S18002-02, S18004 (1995).

14. See 141 CONG. REC. S18183-01, S18198 (1995).

15. Amendment read Dec. 5, 1995. See 141 CONG. REC. S18002-02, S18003. The significance of this change was more than semantic. An affirmative defense is a tool that the doctor would be able to employ only during a trial—after he has been arrested or sued in a civil action. The exception would allow doctors to "plead their case" before a review board before any legal action is taken, possibly precluding such action if the review board deems that the actions were medically appropriate.

16. See 141 CONG. REC. S18183-01, S18198 (1995).

17. See *id.* at S18228.

18. See 142 CONG. REC. H2895-02, H2904 (1996).

the bill for its first version, with the new bill still called HR 1833.¹⁹ Thus, the "Partial Birth Abortion Ban of 1996," went to President Clinton with an exception for maternal life, but lacking one for maternal health.

HR 1833 was vetoed by President Clinton on April 10, 1996.²⁰ In his veto message, Clinton expressed his disappointment with Congress' refusal to include a maternal health exception.²¹ He indicated that the D&X procedure "troubled [him] deeply," and that he was willing to support a ban on the elective use of the procedure.²² However, he felt that the lack of a maternal health exception evinced "Congressional indifference to women's health,"²³ making the bill both morally and Constitutionally unacceptable. He concluded by stating that he could not, in good conscience, sign a bill that would "eliminate [the procedure] without taking into consideration the rare and tragic circumstances in which its use may be necessary."²⁴

The House overrode the veto on September 19, 1996.²⁵ However, a few days later the Senate's override attempt failed by a margin of thirteen votes.²⁶ For the time being, the fight appeared to be over, but the issue was far from settled. In the waning months of 1996, new information surfaced about the numbers of, and reasons for, "partial-birth abortions." Apparently reliable data, often from the clinics and doctors themselves, indicated that the procedure was performed far more often than earlier thought, and frequently on a purely elective basis. The first reaction from columnists and members of Congress alike was one of confusion. Much of the contest over HR 1833, particularly the arguments against the bill, had focused on technical information—the mechanics of the procedure, its statistical rarity, the precise nature of the fetal deformities and maternal health complications that prompted the need for it.²⁷ Having relied heavily on information supplied to them by lobbying groups, members of Congress (particularly those who had opposed the bill) were left wondering if their arguments had been built on a faulty foundation. Columnists who had confidently reported the statistics and anecdotes supplied by lobbying organizations and pro-choice experts began writing instead about their bewilderment.

19. See *id.* at H2928.

20. See Remarks on Returning Without Approval to the House of Representatives Partial-Birth Abortion Legislation, 32 WKLY. COMPILATION PRESIDENTIAL DOCUMENTS 645 (Apr. 10, 1996).

21. See *id.* at 646.

22. *Id.* at 645-46.

23. *Id.* at 646.

24. *Id.*

25. See 142 CONG. REC. H10621-01, H10642 (1996).

26. See 142 CONG. REC. S11366-01, S11389 (1996).

27. Other skirmishes centered around conflicting medical evidence. Hearings, testimony, and debates sought to discover whether or not the fetus was neurologically developed enough to feel pain from the abortion, and whether or not the anesthesia administered to the mother before the procedure killed the fetus before the actual procedure began. See, e.g., *Partial-Birth Abortion: Hearing on HR 1833 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 76 (1995) (statement of Mary Ellen Morton, R.N., neonatal specialist); *Effects of Anesthesia During a Partial-Birth Abortion: Hearing on HR 1833 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. (1996).

Then the other shoe dropped: Ron Fitzsimmons, the Executive Director of the National Council of Abortion Providers, admitted to the American Medical News that he “lied” about the numbers of and reasons for the procedure in a 1995 interview with ABC’s “Nightline.”²⁸ Instead of correcting or clarifying Fitzsimmons’ statements and statistics, opponents of the Ban had consistently repeated and relied on them through the years. Congressmen, columnists, and people across the country, some of whom were pro-choice and had opposed the bill, found their feelings shifting from confusion to betrayal and outrage.

The bill’s original supporters can best be described as “livid.” Convinced that bad facts and outright lies had defeated HR 1833, they were sure that a second attempt would prove more successful. The President had based his veto of HR 1833 on his belief that the procedure was only used in “rare and tragic circumstances.”²⁹ New statistics indicated that the procedure was not as rare nor as limited to tragic circumstances as lobbyists had led him to believe. The Ban’s supporters felt that the new information might change the President’s mind about banning the procedure, or change enough Senators’ minds to override another veto.³⁰

As a result, the Ban was revitalized on January 21, 1997, when Senator Santorum introduced S. 6.³¹ This bill was virtually identical to the final version of HR 1833, with the same definition of the procedure, the same penalties, a life exception, and no maternal health exception. Representative Canady introduced HR 929³² on March 5, 1997, which was also virtually identical to HR 1833, in the House. The House version had some new amendments attached to it before it went into the Judiciary Committee. One amendment would have provided for a stronger maternal life exception, and another would have prevented abandoning or abusive husbands from collecting damages in civil suits against abortion providers.³³ However, to prevent HR 929 from reaching the floor with the amendments attached for debate, the House Judiciary Committee substituted an amendment-free replacement bill, which was then re-introduced by Rep. Solomon.³⁴ The new version, HR 1122,³⁵ was basically identical to the original version, HR 1833. The House overwhelmingly passed this version on March 20, 1997, by a veto-proof majority.³⁶ The Senate adopted the House version on May

28. Diane M. Gianelli, *Abortion Rights Leader Urges End to ‘Half Truths’*, AM. MED. NEWS, Mar. 3, 1997, at 3.

29. 32 WKLY. COMPILATION PRESIDENTIAL DOCUMENTS 646 (Apr. 10, 1996).

30. See, e.g., Mona Charen, *Partial Truths*, DAYTON DAILY NEWS, Mar. 8, 1997, at 13A (“The only question that remains now is whether President Bill Clinton has enough integrity to reverse his position and his veto. He relied, after all, on the lies that Fitzsimmons has acknowledged.”).

31. See S. 6, 105th Cong. (1997).

32. H.R. 929, 105th Cong. (1997).

33. See 143 CONG. REC. H1192-01, H1193 (1997) (statement of Rep. Slaughter).

34. See 143 CONG. REC. H1184-01, H1184 (1997).

35. H.R. 1122, 105th Cong. (1997) (enacted).

36. See 143 CONG. REC. H1192-01, H1201 (1997).

20, 1997, although it was a few votes shy of the number needed to override the promised veto.³⁷

President Clinton vetoed House Resolution 1122 on October 10, 1997.³⁸ In his veto message, the President stated that his reasons for opposing the measure were identical to those he expressed in his veto of HR 1833, stressing again that he would be willing to sign a ban on "partial-birth abortions" if it contained a maternal health exception.³⁹ Without one, he worried that the bill would not "protect the lives and health of the small group of women in tragic circumstances who need an abortion performed at a late stage of pregnancy to avert death or serious injury."⁴⁰

III. A NOTE ON TERMINOLOGY

Although there have been two separate bills, I will refer to the general prohibition of D&X abortions as "the Ban." When it is relevant I will specify to which bill, and to which version of it, I refer. In this Article, I will not use the most commonly-accepted terms "pro-choice" and "pro-life" to describe the opponents and proponents of the Ban. I refrain because some people who would classify themselves as "pro-choice" also support the Ban,⁴¹ indicating that this controversy is qualitatively distinct from the broader abortion debate. This variance within the pro-choice movement creates complex representation and group-identity issues, which will be explored further in this Article. Accordingly, I will narrow the focus to the Ban itself, and use the term "pro-Ban" to describe political figures and lobbying organizations⁴² who worked to ensure the passage of the legislation, and the term "anti-Ban" to refer to the political figures and lobbying organizations⁴³ who worked to defeat the legislation.

The terminology used by both sides varies widely. There are many types of abortion procedures which are performed for varying reasons at different stages of pregnancy.⁴⁴ This creates ample opportunity for confusion, even without deliberate attempts by the interested groups to take advantage of the ambiguity presented by multiple overlapping definitions. Indeed, the rhetorical

37. See 143 CONG. REC. S4714-02, S3715 (1997).

38. See Message to the House of Representatives Returning Without Approval Partial-Birth Abortion Legislation, 33 WKLY. COMPILATION PRESIDENTIAL DOCUMENTS 1545 (Oct. 10, 1997).

39. See *id.*

40. *Id.*

41. This is not as true in the reverse—few if any "pro-life" individuals have opposed the ban.

42. Organizations in favor of the Ban include: the National Right to Life Committee (NRLC), the Association of Catholic Bishops, the Family Research Council, the Concerned Women for America, and the Physician's Ad Hoc Committee for Truth (PHACT).

43. Organizations opposed to the Ban include: the Center for Reproductive Law and Policy, the National Women's Law Center, the American College of Gynecologists and Obstetricians (ACOG), Planned Parenthood, National Abortion Rights Action League (NARAL), the ACLU Reproductive Freedom Project, and the National Abortion Federation.

44. See Appendix A, which sets forth the most commonly-used abortion procedures, describing the stage of pregnancy in which they are used, the reasons for their use, and their medical benefits and disadvantages.

manipulation of the description of the procedure itself, as well as the definitions of "maternal health," "late-term," and "fetal viability," have laid the groundwork for the debate on the acceptability of this particular method of abortion and much of the confusion that has arisen around the accuracy of the statistical evidence presented. Accordingly, for the purposes of this Article I will use a set of working definitions which are intended to increase clarity and a neutral understanding (to the extent that it is feasible) of the technical issues involved. While these are my own definitions, I have distilled them from a mass of legal and medical sources, attempting to capture the most complete and accurate descriptions possible.⁴⁵

The procedure at the center of this controversy is known by several different medical terms, including "intact dilation and evacuation," "dilation and extraction," and intrauterine cranial decompression. "Partial-birth abortion" is the term coined by the congressional proponents of the Ban. This is neither an accepted medical nor legal term, and is not used by abortion practitioners or the medical community at large. Rather, as I will discuss later, this term was purposefully created to be both inflammatory and misleading.⁴⁶ I will refer to the procedure by the more-accepted medical term "dilation and extraction" ("D&X").⁴⁷ The D&X procedure is used in the second and third trimesters of pregnancy, from 18 to 32 weeks of gestation.⁴⁸ The woman's cervix is partially dilated, enabling the doctor to move the fetus into the birth canal. At this stage of pregnancy, the fetus' head is usually too large to be removed from the uterus without inducing full-blown labor.⁴⁹ In order to remove it, the doctor may have to collapse the fetus' skull. This is usually accomplished by creating a puncture at the base of the fetus' skull, either with scissors or a scalpel, and suctioning out the brain and/or skull contents⁵⁰ with a vacuum aspirator. The fetus is then removed, largely intact, and the umbilical cord is cut.

The procedure is essentially the same regardless of when in the pregnancy it is performed. However, the timing of the procedure relative to fetal viability is of great moral and legal significance. Therefore, when I refer to the D&X procedure

45. Primary sources for technical information include: MODERN METHODS OF INDUCING ABORTION (David T. Baird et al. eds., 1995); WARREN M. HERN, ABORTION PRACTICE (1984); ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS (Jane E. Hodgson ed., 1981).

46. See *infra* note 62 and accompanying text.

47. In fact, the most common name for it is "intact dilation and extraction" ("IDE"). However, this is easily confused with another procedure that is known as "D&E" (dilation and evacuation), so I will use the less common, but more distinct term "D&X."

48. The description of the D&X procedure in this paragraph was taken from Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortion* (Presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992).

49. This is especially true for abortions that are performed because of severe anomalies. Many fetal defects, such as hydrocephaly (water on the brain), anencephaly (absence of brain and skull is filled with fluid), and holoprosencephaly (brain hemispheres fused and malformed) cause the fetus' head to be much larger than normal, and almost impossible to remove from the uterus intact.

50. As mentioned in the previous footnote, some of the more common fetal defects are the complete or partial lack of a brain, or the presence of a great deal of fluid within the skull cavity. Thus, in many cases, the "contents" that are removed are not brain material at all.

I will clarify whether it is a "pre-viability" or "post-viability" D&X. The term "viable" refers to the fetus' ability to survive outside of the womb, either with or without medical life-support. Specifically, doctors consider a fetus viable when there is some meaningful chance of survival beyond the 28-day neonatal period.⁵¹ In previous decades, 28 weeks was considered the threshold of viability, but current medical technology places viability as early as 23 to 24 weeks of gestation.⁵² It is important to note that viability varies from case to case; one fetus may be viable at 25 weeks and another may not. Difficulty in measurement also arises because, while the duration of pregnancy is counted from the first day of the woman's last menstrual period, conception actually occurs roughly two weeks after this date, while the woman is ovulating, "but the timing of ovulation and conception is not usually known."⁵³ In addition, even the most precise sonogram estimates of fetal age in the second trimester may be off by as many as eleven days. As the Supreme Court found in *Planned Parenthood of Missouri v. Danforth*, whether or not a fetus is viable is a "a matter for the judgment of the responsible attending physician."⁵⁴

"Late term" is another malleable phrase. Sometimes used as an imperfect proxy for fetal viability, it is also used to indicate the third trimester, the period after quickening (usually around 16-19 weeks), or the period after the first trimester. To the extent that I use the phrase "late term," I will be referring to abortions performed after the first trimester. There is a definite breaking point between the first and the second trimesters—abortions after 12 weeks are both more risky and far more rare.⁵⁵ Because the D&X procedure is only used in the second and third trimesters, it is by definition a "late term abortion procedure." Finally, it is important to note that, because the D&X procedure is only performed after 18 weeks of gestation, when I discuss it I will be referring only to abortions performed after 18 weeks. (I still consider the period between 12 and 18 weeks to be "late term," but this time period is not as relevant for the purposes of this Article.)

Finally, it is worth clarifying the phrase "maternal health" although it will be discussed in greater detail later in this Article. The Supreme Court first described the relevant components of "maternal health" in *Doe v. Bolton*, the companion case to *Roe v. Wade*, stating that "the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the

51. See Phillip G. Stubblefield, *Late Abortion and Technical Advances in Fetal Viability—Some Medical Considerations*, 17 FAM. PLAN. PERSP. 160, 161 (1985).

52. See *id.*

53. David A. Grimes, *Second-Trimester Abortions in the United States*, 16 FAM. PLAN. PERSP. 260, 260 (1984).

54. 428 U.S. 52, 64 (1976).

55. 89% of all abortions take place within the first trimester. See THE ALAN GUTTMACHER INSTITUTE (hereinafter AGI), WHEN DO ABORTIONS TAKE PLACE?, Fact Sheet, Mar. 1997. "Abortions performed at 16 or more weeks' gestation are 24 times as likely to result in fatal complications as abortions at eight or fewer weeks." Grimes, *supra* note 53, at 263.

woman's age—relevant to the well-being of the patient.”⁵⁶ Many proponents of the Ban invoked this phrase to support the notion that Ban opponents would use maternal “emotional distress” or “psychological problems” to justify post-viability abortions. In fact, the relevant interpretation of “maternal health” changes according to the stage of pregnancy. The phrase in *Doe*, which invokes a holistic image of mental, physical, and emotional health, would be applicable to pre-viability abortions, usually those in the first trimester. At this stage, abortions are safe enough that doctors will perform them even when mothers aren't facing severe physical health risks. However, after fetal viability, abortion becomes increasingly dangerous, complicated, and physically traumatizing. Thus, legal prohibitions aside, doctors are unwilling to perform the potentially dangerous procedure unless it is necessary in the face of more serious threats to the mother's *physical* health.⁵⁷ Therefore, when I refer to maternal health in the context of post-viability abortions I will always be referring to the physical health of the women undergoing the procedure. Other general references to maternal health in the earlier stages of pregnancy will include factors related to mental and emotional health, including youth, trauma, and depression.

Two other distinctions are important to a thorough understanding of “maternal health” as it is used in the abortion context. First, there are several ways that a woman's health can be jeopardized by a problem pregnancy, leading a woman to seek an abortion. The pregnancy itself may be dangerous to the woman's health, even if she is otherwise healthy, particularly if the fetus is severely deformed. Fetal death, seizures, stiffening, or malformation place the mother at risk of a variety of complications including severe hemorrhaging, amniotic embolism (the entry of amniotic fluid into the bloodstream), ruptured uterus, and blood poisoning and shock from the breakdown of fetal tissue. In addition, pregnancy can exacerbate pre-existing health problems such as diabetes. Also, the treatments of some life-threatening ailments, such as chemotherapy for cancer or intensive drug therapy for HIV, may be incompatible with pregnancy. For the purposes of this article, I will include all three types of health risk in my definition of “maternal health.”⁵⁸ Second, it is worth pointing

56. 410 U.S. 179, 192 (1973).

57. See, e.g. CHRISTOPHER TIETZE, *INDUCED ABORTION: A WORLD REVIEW*, 1983 65 (5th ed. 1983) (noting that, “[e]ven when not prohibited by law, abortions are infrequently performed at more than 20 weeks of gestation”); Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 FAM. PLAN. PERSP. 54, 56 (1995) (stating that, “[a]lthough abortions after 26 weeks of gestation are unrestricted in many states, they are rarely performed”). See also SEX DISCRIMINATION AND THE LAW 1043 (Barbara Allen Babcock et al. eds., 2d ed. 1996) (describing a study which indicates that, during a time in which Puerto Rico had no legal viability cutoff, its percentage of late abortions was comparable to that of states which limit post-viability abortions to situations where the life or health of the mother is endangered). But see *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1078-81 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997) (finding that, in extreme cases such as where a pregnancy was the result of rape or incest or where the fetus will be born with horrifying and fatal defects, doctors should be able to take the preservation of a woman's emotional health into account, even for post-viability abortions).

58. These distinctions are not purely diagnostic, but actually may have legal significance. Depending on how a statute restricting abortion is worded, it might be relevant whether or not the pregnancy itself is the source of the health risk or if the health problem was pre-existing. Also, some participants in the debate have

out that “maternal health” is often used, confusingly, to refer both to the health risks attendant with continued pregnancy and to the health risks attendant with a particular abortion method.⁵⁹ For example, a woman may opt for an abortion because continued pregnancy would cause serious damage to her health. However, certain methods of abortion—say, a hysterectomy—may also present a risk of serious health damage.⁶⁰ When I discuss health risks, I will make clear whether a woman’s health is jeopardized by the continuation of pregnancy or by a particular abortion method.

IV. STRATEGIC ANALYSIS

A. *Pro-Ban*

Proponents of the Ban used several rhetorical and tactical strategies in their push for HR 1833’s passage. These strategies are important to analyze because they shaped the debate, determined the manner in which the anti-Ban forces responded, and set the stage for the later conflicts.

1. *Defining the Terms and Framing the Issues*

In framing the issues, pro-Ban activists made it clear that, for them “this bill is not about health care, it is not about women’s issues, it is not about the ability for doctors to practice medicine, it is about babies, and it is about a very inhumane way to end their lives.”⁶¹ The most obvious and influential definitional move that the pro-Ban forces used was the equation of the D&X procedure with birth. The very name “partial-birth abortion,” which is not found in any medical dictionaries, textbooks, or coding manuals, was intended to draw this connection. As one Ob-Gyn testified, “I have not heard physicians who provided abortions talk about a partial-birth abortion. I suspect it is because the name did not exist until someone who wanted to ban an abortion procedure made up this erroneous, inflammatory term.”⁶² Rather than focus on fetal viability, or even the trimester scheme, they set up a framework in which the mere passage of a fetus through the birth canal, at whatever age or stage of development, was equated to

drawn a distinction between abortions that are prompted by risks to the mother’s health, as opposed to those sought because of severe problems with the fetus’ health.

59. See *Jane L. v. Bangerter*, 61 F.3d 1493, 1505 (10th Cir. 1995) (discussing confusion over the conflation of the two interpretations of the term “health risk”).

60. This distinction may be legally relevant in the context of “choice of method” statutes which require doctors performing post-viability abortions to use an abortion method which would be most likely to save the fetus’ life. Such laws allow women to seek abortions for grave threats to their health, but fail to take into consideration the threats presented by the preferred, “fetus-preserving,” abortion methods. See, e.g., *id.*; *Thornburgh v. Am. College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979).

61. 141 CONG. REC. H11426-02, H11429 (1995) (statement of Rep. Largent).

62. *Partial Birth Abortion Ban: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 104 (Nov. 17, 1995) (testimony of J. Courtland Robinson, M.D., MPH).

birth. In a “peculiar bit of alchemy,” the Ban makes the legality of the abortion turn not on the viability of the fetus or on the health of the mother, but rather on the physical location of the fetus within the mother’s body.⁶³

This had several advantages. First, it drew upon the powerful mental images and emotions evoked by birth. Where the “birth” of a healthy, nine-month fetus is usually viewed as a beautiful and sacred event, the abortion performed by the D&X method was portrayed as a perversion of the birth process—a “breech birth” during which the baby is killed rather than delivered. One statement of Representative Canady, made during floor debates in the House, was typical of the arguments made by Ban supporters: “The baby involved is not ‘unborn.’ His or her life is taken during a breech delivery.”⁶⁴ This enabled pro-Ban supporters to make many references to infanticide, describing the difference between abortion and infanticide as the mere “three inches” the fetus’ head would have to travel to be completely out of the birth canal. Ultimately, the rhetoric made the procedure sound as if it were taking advantage of a technicality, which allowed the doctor to deliberately hold the fetus inside the mother’s body in order to prevent it from emerging as a human being with full legal rights. As one columnist put it, “Stopping the head just short of birth is a legal fig leaf for a procedure that doesn’t look like abortion at all. It sounds like infanticide.”⁶⁵

Second, and perhaps more significantly for the debate, the focus on “birth” equated the 20-week old fetus with the 36-week old fetus—the pre-viable and the post-viable. By describing D&X procedures done throughout the last two trimesters as involving “birth,” the pro-Ban rhetoric eliminated viability as a determinative event and ignored differences in fetal age and development. Some members of Congress made clear their intentions to ignore the viability line, even if they had to confuse the facts to do so. One Congressman argued:

Viability and corresponding trimester of pregnancy have become the courts’ standard [for evaluating the legality of abortion]. As uncertain and arbitrary as that standard may be, since it has a fluctuation factor of months or weeks, there should be no disagreement that partial-birth abortions should be prohibited—for *here, the difference between life and death is not months or weeks or days, it is a few centimeters.*⁶⁶

This confusion made it sound as if the D&X procedure was being performed on healthy, fully-formed babies at the moment of a normal full-term birth. As one clinic employee protested, “I personally have never seen this procedure done near-term. It’s almost always much, much earlier. There’s a huge difference

63. See Memorandum from Laurence H. Tribe addressing constitutionality of S. 6 (Partial Birth Abortion Ban Act of 1997) (Mar. 6, 1997) (on file with author).

64. 141 CONG. REC. H11426-02, H1426 (1995) (statement of Rep. Canady).

65. John Leo, *Harder Hearts on Abortion*, U.S. NEWS & WORLD REP., Nov. 20, 1995, at 42.

66. 141 CONG. REC. H11593-02, H11598 (1995) (statement of Rep. Deal) (emphasis added).

between fetuses at five months and fetuses at nine months.”⁶⁷ This, combined with the emphasis on the “elective” nature of the procedure—which I will discuss in greater detail below—created a terrible picture. As a pro-choice member of the clergy said during a press conference, “You’d think doctors were partially delivering viable fetuses and then killing them so the pregnant woman wouldn’t have to go to the trouble of finishing the delivery.”⁶⁸

The emphasis on the elective nature of the procedure was another important framing technique. Pro-Ban activists introduced statistics indicating that upwards of 80 percent of D&X abortions are performed for purely elective reasons—poverty, youth, maternal depression, and the desire to just not have a child. The physical health reasons that underlie the remaining 20 percent were minimized to the extreme so that the abortions were still viewed as “elective.” Many of the health problems that led women to seek the procedure were judged not serious enough to warrant the abortion. One witness testified before a Senate committee: “An abortion advocacy organization asserts that late-term abortions are pursued by women with heart disease, kidney failure, or rapidly advancing cancer. But, in truth, these conditions . . . [are all] conditions frequently associated with the birth of a totally normal child.”⁶⁹ The argument seems to be that, as long as a maternal health problem poses no risk to the health of the *fetus*, the woman is seeking an “elective” abortion if it is to save her own health.⁷⁰

Even if the risk were admittedly serious, women were still expected to bear it for the sake of their unborn fetuses. The argument was that mothers should assume any risk that was not clearly fatal. “[A] life for a life,” argued one ardent supporter of the Ban during a House debate, “is certainly an even trade. . . . But when something less than a life is at risk, then I don’t think the trade is equal.”⁷¹

Finally, and most extreme, even fatal health problems were described as the sort of thing that a dedicated and caring mother would assume in order to assure her child’s safety. Again, the fact that a mother had the ability to carry a fetus to term, even though it would result in her own death, was portrayed as the type of “choice” that would make the decision to abort an “elective” one. One Senator described just such a sacrifice, relating the story of a constituent who discovered in the fifth month of her ninth pregnancy that she had rapidly metastasizing cancer.⁷² The woman refused chemotherapy, which would have saved her life but endangered that of her fetus, and refused to have an abortion. She gave birth to a

67. Personal communication with anonymous New York clinic employee (June 2, 1997). Notes on file with author.

68. Ellen Goodman, *Scrambling on the Low Road*, S. F. CHRON., May 7, 1996, at A19 (quoting Rev. Katherine Hancock Ragsdale).

69. *Hearing on S. 939 Before the Senate Comm. on the Judiciary*, 104th Cong. 169 (Nov. 17, 1995) (testimony of Douglas Kmiec, Professor of Law at the University of Notre Dame) (citation omitted).

70. See *supra* text accompanying notes 58-59 for a discussion of the distinction between abortions that are prompted by risks to the mother’s health alone, as opposed to those sought because of severe problems with the fetus’ health, and the distinction between pregnancies which themselves jeopardize a woman’s health and those which exacerbate or interfere with the treatment of pre-existing medical conditions.

71. 141 CONG. REC. S16761-03, S16764 (1995) (statement of Sen. Hyde).

72. See 143 CONG. REC. H930-02, H930 (1997) (statement of Rep. Christensen).

healthy child and died soon after—leaving behind nine children. Her sacrifice was portrayed as an “inspiration” to other women, and a reminder of “the value of the unborn child.”⁷³ The message is clear: if this woman did not “elect” to terminate her pregnancy, even though it ultimately resulted in her own death, then what other reason could possibly justify having an abortion?

Ultimately, maternal health problems were portrayed not as legitimate problems in their own right, but as selfish reasons for obtaining an abortion. Even more extreme, maternal health was also described as an escape clause that women take advantage of in order to have otherwise-prohibited abortions, with more and more trivial problems getting to qualify.⁷⁴ As one Senator argued on the floor, a health exception “allows partial-birth abortions on demand *throughout the full nine months of the pregnancy*. If a woman has any health problem that she so indicates, then any child could be aborted for any reason.”⁷⁵ As they narrowed the category of “necessary” abortions into non-existence, pro-Ban activists expressed fear that any “health exception” would be interpreted so broadly as to swallow the Ban. They seemed convinced that women and their doctors would collude to invent any number of false or trivial medical problems in order to fit into a health exception. A spokeswoman for the National Conference of Catholic Bishops, Helen Alvare, declared, “It is well-known that a ‘health’ exception is a legal term of art that means any abortion a woman elects to have.”⁷⁶

A final pro-Ban framing technique was the minimization of the fetal anomalies which lead some women to seek D&X abortions. The most severe of fetal anomalies were described as inconveniences which callous parents used to justify abortion, but that loving parents should confront and overcome. Fetuses, even those with genetic or developmental defects that made them incompatible with life,⁷⁷ were described as babies that were killed because they were not perfect. Pro-Ban activists also invoked the terms “disabled” and “handicapped” to describe the fetuses, attempting to create a tension between anti-Ban activists and disability rights activists.⁷⁸ During the floor debates, the idea of aborting a

73. *Id.* at H930-31.

74. One Congressman argued that “to add [a] ‘health’ [exception] would be tantamount to writing in a loophole through which a Mack truck could be driven.” 142 CONG. REC. H2895-02, H2898 (1996) (statement of Rep. Bryant).

75. 141 CONG. REC. S18183-01, S18195-96 (1995) (statement of Sen. Smith (NH)) (emphasis added).

76. *Clinton Presses Congress to Modify Ban on Abortion Procedure*, THE L.A. DAILY NEWS, Feb. 29, 1996, at 18.

77. Such defects may include the partial or entire lack of a brain or of internal organ systems, formation of the brain or important organs outside of the body, and non-formation of limbs, eyes, mouth, and heart chambers. Many of these anomalies are associated with the chromosomal defect Trisomy-21, metabolic diseases such as Tay-Sachs, and neural tube malformations such as spina bifida cystica and anencephaly. See HARRY HARRIS, *PRENATAL DIAGNOSIS AND SELECTIVE ABORTION* 8-35 (1975).

78. See, e.g., 141 CONG. REC. S17881-06, S17899 (1995) (statement of Sen. Smith (NH)) (“How can they claim to be defenders of the rights of the disabled and turn around and single out to target, to execute . . . disabled babies?”); 141 CONG. REC. H11426-02, H11427 (1995) (statement of Rep. Weldon) (“I have found that to be so ironic, that so many of the liberal-leaning Members of this body, and people in government who

fetus with severe and fatal defects was excoriated as "the inhumane notion that handicapped kids are throw-aways or are to be construed as so much garbage."⁷⁹ As one columnist asked:

Is America marching (or goose-stepping) forward in pursuit of people that are "perfect" according to standards arbitrarily established by a self-appointed elite with the power to decide who shall live and who shall die? What standard will you appeal to when your group falls out of favor and your life is deemed unworthy to be lived?⁸⁰

Mothers were vilified for not being willing to accept their babies as they were—even if the fetus' "disability" was the fact that it had no brain. Mothers were portrayed as making free and unencumbered "choices" to abort severely deformed fetuses—even if intense, painful, enormously expensive, and usually futile medical intervention would be necessary to allow the child even a few days of life. One of the more tragic stories related during the debate was that of "Baby Andrew," whose mother carried him to term despite the *in utero* diagnosis of severe genetic and developmental defects:

For two weeks Andrew lay still, incoherent from drugs, with his stomach, his liver, spleen and small and large intestines exposed. He was given drugs that kept him paralyzed, still able to feel pain but unable to move. Andrew had IV's in his head, arms, and feet. He was kept alive on a respirator for six weeks, unable to breathe on his own. He had tubes in his nose and throat to continually suction his stomach and lungs. Andrew's liver was lacerated and bled. He received eight blood transfusions and suffered a brain hemorrhage. Andrew's heart was pulled to the right side of his body. He contracted a series of blood infections and developed hypothyroidism. Andrew's liver was severely diseased, and he received intrusive biopsies to find the cause. The enormous pressure of the organs being replaced slowly into his body caused chronic lung disease for which he received extensive oxygen and steroid treatments as he overcame a physical addiction to the numerous pain killers he was given. The pain and suffering was [sic] unbearable to watch . . .⁸¹

are frequently some of the most vocal advocates for the disabled, are the ones who will say, This procedure is okay if the baby has a disability . . .").

79. 142 CONG. REC. H2895-02, H2901 (1996) (statement of Rep. Smith (NJ)). "I thought," said Rep. Smith, that "we took care of that with the passage of the Americans with Disabilities Act, which said that handicapped people have rights and they have inherent value, and we need to respect that." *Id.*

80. Cal Thomas, *First the Unborn, Then the Unwanted?*, NEWSDAY, Oct. 1, 1996, at A42.

81. 142 CONG. REC. S11278-01, S11283 (1996) (Sen. Santorum, reading a letter from Whitney and Bruce Goin).

Although this account is disturbing, it was in fact related as part of a speech in *support* of the Ban. The argument was essentially that, as long as there was a remote technological possibility that a severely deformed fetus could survive, even for only a few hours, “the situation is not as hopeless as you have heard.”⁸² Of course, many families in this situation lack the funds for such heroic medical intervention, and many more feel that abortion is ultimately more humane than subjecting a newborn to intense, invasive, and excruciating surgical procedures that may only briefly prolong life.⁸³ Nonetheless, the conclusion of this line of reasoning is that as long as the “hope” exists for a fatally abnormal fetus to live briefly outside the womb, the decision to abort is merely “elective.”

These arguments conflate the “choice” to undergo an abortion over serious injury or death with the freely made decision to do so. They equate the “choice” to abort a severely deformed fetus that only could survive for a short time through intense medical intervention with the “elective” decision to do so. By minimizing the health risks, and describing even abortions done to prevent maternal death as being a free choice, the pro-Ban activists were able to broaden the notion of “elective” abortions to consume virtually all abortions. The only truly “non-elective” abortion would be one done against the mother’s will. If the woman has any decision-making ability at all, she can be portrayed as “electing” an abortion when she had other options, no matter how terrible. One columnist commented angrily on this rhetorical spin, arguing “[t]o describe these third-term abortions as a ‘choice’ is cruel enough. But anti-abortion groups actually describe them as a frivolous choice.”⁸⁴

2. *Rhetorical Devices*

The pro-Ban forces focused heavily on the details of the procedure, with graphic descriptions as well as pictures, models, and simulations. Members of Congress “re-enacted” the procedure for their colleagues, stabbing models of fetuses in the head with scissors.⁸⁵ During floor debates, an attempt to have such visual aids withdrawn from the floor was soundly defeated.⁸⁶ The description of the D&X procedure was recited like a litany, repeated hundreds of times during the course of the debates. The focus on the awfulness of the procedure as a justification for the Ban was clearly effective. Hearing it understandably generates shock and horror in many listeners. Frequently members of Congress would simply describe the procedure in detail and sit down, as though the

82. Thomas, *supra* note 80.

83. Such sentiments are powerfully expressed by another couple, Robert and Peggy Stinson, whose own “Baby Andrew” was born with severe defects and died after agonizing and invasive medical treatment. See ROBERT & PEGGY STINSON, *THE LONG DYING OF BABY ANDREW* (1983).

84. Goodman, *supra* note 68.

85. See, e.g., 141 CONG. REC. S8541-02, S8542 (1995) (Sen. Smith (NH) demonstrating the D&X procedure).

86. See 141 CONG. REC. H11604-01, H11605 (1995) (Rep. Schroeder asking that visual aids be removed).

description spoke for itself. Others made analogies to other forms of violence and historic acts of genocide, invoking the mass slaughters committed by the Khmer Rouge and the Nazis, and likening the D&X procedure to infanticide, Mafia violence, child abuse, and even drive-by shootings.⁸⁷ The rhetoric reached such a fever pitch that calls came from both sides of the issue to tone it down for fear of inciting violent reactions by pro-life groups.

Besides the obvious emotional reaction that it generated, the focus on the details had other benefits for the pro-Ban activists. First, they saw it as a way to get at the truth about abortion, feeling that too many cold, clinical descriptions by pro-choice people had euphemized all abortion procedures. They felt that the American public needed to know the details of the D&X procedure so that they might be forced to confront the reality of what was happening. Descriptions of the procedure also shifted the focus away from women's reproductive rights and toward the details of fetal death. This technique proved very powerful, and it worried anti-Ban activists. At a National Abortion Federation meeting in San Francisco, Kathryn Kohlbert, vice-president of the Center for Reproductive Law and Policy, urged activists "not to get 'sidetracked' by their opponent's efforts to get them to discuss . . . the procedure," and to "focus on your message and stick to it, because otherwise we'll get creamed."⁸⁸

Second, the focus on the details of the D&X procedure set up an argument for the banning of other abortion procedures. If the awfulness of a particular abortion procedure is a sufficient reason to ban it, then most other procedures are vulnerable to prohibition as well.⁸⁹ For example, dilation and extraction (D&E)—which requires that the fetus be torn apart *in utero*, the skull crushed by heavy pliers so that it might be extracted, and the pieces suctioned out and reassembled—is just as awful-sounding, if not worse. Even dilation and curettage (D&C), the most common abortion procedure which is performed in the first trimester well before fetal viability, could be banned because of the disturbing nature of what it entails. One Congressman argued during the debates, "when you look at the methods of abortion, this is one of many that is a heinous act . . . look at [dilation and curettage] abortions . . . [t]he suction methods . . . to kill the baby."⁹⁰ The pro-Ban activists did not attempt to hide their agenda, proclaiming "we will begin to focus on the methods [of abortion] and declare them to be illegal."⁹¹

87. See, e.g., 143 CONG. REC. H1192-01, H1195 (1997) (statement of Rep. Dickey, comparing D&X abortions to "the genocide and infanticide that took place in Phenom Penh at the hands of the Khmer Rouge."); 141 CONG. REC. H11604-01, H11613 (1995) (statement of Rep. Myrick, arguing that "partial-birth abortions, drive-by shootings, cop-killings, they have all become a way of life."); 142 CONG. REC. H3559-06, H3559 (1996) (statement of Rep. Dornan, comparing D&X abortions to "organized crime . . . the Chinese Revolution, Stalin's purges, or Hitler's henchmen.").

88. Quoted in Gianelli, *supra* note 28.

89. See Appendix A, *infra*, for descriptions of the procedures.

90. 141 CONG. REC. H11426-02, H11430 (1995) (statement of Rep. Smith (NJ)).

91. Mimi Hall, "Partial Birth" Abortions Face House Vote, USA TODAY, Nov. 1, 1995, at 6A (quoting Rep. Smith (NJ)).

B. *Anti-Ban*

It is important to note that the anti-Ban activists were very much on the defensive. Rather than actively shaping and framing the debate, they were working within the system of meanings and priorities that had been set up by the pro-Ban forces. One activist observed that the whole contest took place on “the territory staked out by abortion opponents.”⁹² As a result, they did more “reacting” than acting, seeking to minimize the impact of the pro-Ban’s powerful appeals. They were also working against public opinion. Various polls placed public support for the Ban at between 71 and 78 percent.⁹³ To the extent that they were able to frame the debate and the issues, anti-Ban activists tried to emphasize that the Ban is “a dangerous and unwarranted interference into the practice of medicine [that] risks the health and possibly the lives of real women.”⁹⁴ Congressional opponents of the bill discussed it as harming the ability of women to receive the best, safest medical care under the direst of circumstances. As a result, they focused on the severe health reasons that could compel women to seek the procedure after fetal viability. They also emphasized the procedure’s rarity, stating that only 450 to 600 D&X abortions are performed annually. These statements and statistics were repeated continually by the press, congressional opponents of the Ban, and anti-Ban lobbyists.

1. *Tactical Decisions*

While the anti-Ban forces opposed the Ban for a variety of reasons, they recognized early on that the Ban’s weakest point was its lack of a maternal health exception. The vast majority of the American public, between 81 and 88 percent, supported the right to abortion in situations where the mother faced serious health damage.⁹⁵ These feelings were echoed by President Clinton, who gave fair warning that he would veto any Ban that lacked a maternal health exception.

As a strategic point, some anti-Ban activists decided to oppose the inclusion of the Boxer maternal health amendment in order to insure a presidential veto.⁹⁶ It is difficult to determine the impact their efforts had because many anti-Ban Senators were reluctant to give their opponents any victory in the bitter contest.

92. Karen Pearl, *Abortion Statistics Are a Quagmire*, *NEWSDAY*, Mar. 13, 1997, at A57.

93. See, e.g., Gianelli, *supra* note 28 (quoting Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, estimating public support of the Ban at 78%); Julia Duin, *Media Provide Better Coverage to Pro-Choice Side: Survey Finds Catholic Bishops Complain About Bias in Abortion Reports*, *WASH. TIMES*, Jan. 19, 1996, at A8 (estimating public support of the Ban at 71%).

94. NAT’L ABORTION FED’N, WHO WOULD BE HURT BY LEGISLATION BANNING SOME LATE ABORTIONS?, Fact Sheet, Feb. 1997 [hereinafter NAF Fact Sheet].

95. See *Majority of Americans Oppose Overturning Roe v. Wade and Banning Abortion Outright*, *Polls Show*, 21 *FAM. PLAN. PERSP.*, 138, 138-39 (1989).

96. Personal communication with anonymous anti-Ban lobbyist for women’s rights organization (Feb. 1995). Notes on file with author.

Also, many Senators may have feared that the President would not keep his promise to veto the Ban, and thus worked for the maternal health exception just in case. Nonetheless, the Boxer amendment was defeated by pro-life senators, in a 51-47 vote, which assured the veto of HR 1833.

2. Rhetorical Devices

The anti-Ban activists centered their intense lobbying efforts around the need for a maternal health exception. The most common tactic was based on the testimonials of real women who had undergone the procedure when they discovered, late in their pregnancies, that they were carrying severely deformed fetuses at great risk to their health. The stories of 10 to 15 women were gathered and distributed in fact sheets by the lobbying groups. The media focused heavily on these stories, and emotional newspaper articles came out which gave detailed accounts of women who chose the D&X procedure in the face of life-threatening pregnancy complications and severely deformed fetuses. Anti-Ban lobbying groups also had some of the women appear in person. A core group of roughly eight women were brought before Senate and House committees to testify about their agonizing experiences, and to meet with members of Congress one-on-one. In the Rose Garden Veto Ceremony, five of these women stood with President Clinton, and they again recounted their stories.

The narratives typically focused on the tragedy of the situations the women faced, their strong desire to have children, and their belief that they ultimately made the most humane decision in terminating their pregnancies. The following descriptions, taken from a National Abortion Federation fact sheet,⁹⁷ were representative:

VIKKI STELLA, FROM NAPERVILLE, ILLINOIS

Parents of two daughters, Vikki and her husband Archer discovered at 32 weeks of pregnancy that multiple, devastating anomalies afflicted their long-awaited third child – anomalies that were incompatible with life. Their son, whom they had named Anthony, had only fluid filling his cranium, where his brain should have been, as well as other major problems. She and her husband made “the most loving decision we could have made,” to terminate the pregnancy. Because the procedure preserved her fertility, Vikki was able to get pregnant again. She gave birth to a healthy boy, Nicholas, in December of 1995.

97. NAF Fact Sheet, *supra* note 94. See Appendix B for a summary of the testimonials given by five of the women who underwent the procedure who were with President Clinton during the veto ceremony.

COREEN COSTELLO, FROM AGOURA, CALIFORNIA

In April 1995, seven months pregnant with her third child, Coreen and her husband Jim found out that a lethal neuromuscular disease had left their much-wanted daughter unable to survive. Her body had stiffened and was frozen, wedged in a transverse position. In addition, amniotic fluid had puddled and built up to dangerous levels in Coreen's uterus. Devout Christians and opposed to abortion, the Costellos agonized for over two weeks about their decision, and baptized their daughter in utero, naming her Katherine Grace. Finally, Coreen's increasing health problems forced them to accept the advice of numerous medical experts that the intact D&E was, indeed, the best option for Coreen's own health. In June of 1996, Coreen gave birth to a healthy son.

This rhetorical approach was enormously successful. Even people who were disturbed by the descriptions of the procedure found it difficult to accept the severity of the Ban's consequences for very ill women. The Ban's congressional opponents relied on these narratives during the floor debates, telling and retelling the stories countless times. President Clinton used the narratives as a central part of his veto message, stating "[i]n the past several months, I have heard from women who desperately wanted to have their babies, who were devastated to learn that their babies had fatal conditions and would not live, who wanted anything other than an abortion."⁹⁸ There was little that pro-Ban activists could do to counter these emotional first-person accounts. A few members of Congress and a handful of lobbying groups attempted to argue that the women who testified hadn't actually undergone "partial-birth abortions" as the Ban defined them. This only highlighted the difficulty with the Ban's definition of the procedure. A very few pro-Ban activists attempted to argue that the women had not actually needed the procedure but had been misled by their doctors.⁹⁹ These arguments were met with outrage and were quickly dropped.

V. TWO VERSIONS OF THE TRUTH

It did not take long for the controversy to arise concerning both the number of D&X procedures that were performed and the reasons for them. Pro- and anti-Ban activists were presenting apparently inapposite sets of statistics, sending observers on a bewildering search for "the truth."

98. Remarks on Returning Without Approval to the House of Representatives Partial-Birth Abortion Legislation, 32 WKLY. COMPILATION PRESIDENTIAL DOCUMENTS 646 (Apr. 10, 1996).

99. See 142 CONG. REC. S11337-01, S11342 (1996) ("[T]he women who were trotted out to the White House, were misinformed about what health consequences beset them at the time of their abortion.") (statement of Sen. Santorum).

A. Disagreement and the Truth

During the lobbying period and the congressional debates, anti-Ban activists insisted that the procedure was rarely performed. They estimated the number of D&X abortions performed each year as between 450 and 600 nationwide. Meanwhile, pro-Ban activists produced their own statistics, including estimates from doctors and clinics who perform the procedure, and from Ron Fitzsimmons himself, indicating that the annual number of D&X abortions performed nationwide was between 3,000 and 5,000. As discussed earlier, anti-Ban activists seemed to argue that the D&X procedure is only performed when there are serious fetal defects or other severe risks to maternal health. Bill proponents, on the other hand, had evidence that the vast majority—between 80 and 90%—of D&X abortions are performed for purely elective reasons or for minor health indications.

While it seemed impossible to reconcile the two sets of information, in fact a simple explanation could account for both. It is probably true, as the pro-Ban activists argued, that between 3,000 and 5,000 D&X abortions are performed each year.¹⁰⁰ However, it is also probably true that of these, only between 450 and 600 (roughly 10-20%) are performed *after fetal viability*.¹⁰¹ Likewise, it is probably true that between 80 and 90% of *all* D&X abortions are performed on an elective basis.¹⁰² But, as the anti-Ban forces argued, 100% of *post-viability*

100. In newspaper interviews, doctors who use the D&X procedure report performing hundreds of D&X abortions each year. See, e.g., Ruth Padawer, *The Facts on Partial-Birth Abortion—Both Sides Have Misled the Public*, THE RECORD, Sept. 15, 1996 (finding that in New Jersey alone roughly 1,500 D&X procedures are performed annually, and that other doctors report doing roughly 130, 125, and 375 per year); Gianelli, *supra* note 28 (reporting on the number of procedures done in New Jersey, and on another doctor who performs around 500 D&X abortions per year); David Brown, *Late Term Abortions: Who Gets Them and Why*, WASH. POST, Sept. 17, 1996, at Z12 (reporting interviews with doctors who perform the D&X procedure, but who cannot—or will not—estimate with precision how many they perform). However, there are very few doctors who perform the procedure. One source estimates that there are less than 20. See Brown, *supra*.

A crude estimate could assume, then, that there are roughly 15 practitioners who currently use the D&X method, and that each performs somewhere between 100 and 500 per year—averaging out to around 300 per year per doctor. This would place the number of D&X abortions performed each year at roughly 4,500. This is consistent with Fitzsimmons' estimate that the number of D&X abortions performed annually is between 3,000 and 5,000 per year. See William Powers, *Partial Truths*, NEW REPUBLIC, Mar. 24, 1997, at 19.

101. See, e.g., Powers, *supra* note 100 (arguing that when Fitzsimmons claimed that only 450 D&X abortions were performed each year, he was referring only to those done in the third trimester). This is consistent with the breakdown of the percentages of abortions performed by weeks of gestation. Abortions after 20 weeks make up only 1.1% of the total performed annually; abortions performed between 21 and 24 weeks (pre-viability) make up 1%, and those performed after 24 weeks (post-viability) make up the remaining .1%. See Letter from Edward J. Sondik, Ph.D., Senior Advisor to the Secretary on Health Statistics and Director of the National Center for Health Statistics, CDC, to Senator Kennedy (Mar. 7, 1997) (on file with author).

Thus, the ratio between abortions (method nonspecific) performed shortly before viability to those performed after viability is roughly ten to one. Assuming that this holds for the D&X procedure specifically, the ratio of the former group of women (estimated to be roughly 4,500) to the latter group (estimated to be roughly 450) is consistent with the statistical breakdown of late term abortions generally.

102. See, e.g., Brown, *supra* note 100 (quoting Dr. Martin Haskell as saying that "probably 20 percent . . . are for genetic reasons. And the other 80 percent are purely elective"). Again, this is roughly consistent with

D&X abortions are performed because of serious fetal abnormalities and maternal health endangerment. Thus, both sets of data were accurate but based on different classifications of the measured group. Seekers of the “truth” would discover that finding the answer wasn’t as simple as picking a side; instead, a true understanding of D&X abortions would only come from understanding who the relevant groups of women were and why they were classified in different ways.

B. Reasons for the Confusion

This disparity came about for several reasons. The most basic reason is the fact that the definition of the procedure itself is not a medically-accepted term. Doctors and clinics may perform variations of the D&X procedure, during which the fetus may be moved down the birth canal before fetal death occurs. Some D&X-like procedures are done on an improvised basis, when complications arise during another type of abortion. Therefore, many types of procedures could qualify as “partial-birth” abortions. Even more confounding is the fact that abortion clinics usually keep data according to weeks of gestation, not the specific type of procedure they perform. Furthermore, collection of abortion statistics in general is difficult: five states do not report abortion data at all (one of which, California, accounts for 12% of the nation’s population), and at least twelve states’ rates are incomplete.¹⁰³ As a result, all of the data concerning the frequency of D&X abortions, including that which appears in this Article, must be given a large margin of error.

But the deeper explanation of how these two different pictures developed can be found within the framework of the debate itself. The Ban’s proponents combined information about the pre- and post-viability procedures to create the most damaging possible scenario. Their rhetoric centered around post-viability abortions, describing healthy fully-formed fetuses who they claimed were mere inches from being born infants. However, they used pre-viability data about the numbers of, and reasons for, the procedure—claiming that thousands were performed each year for elective reasons. As a result, they painted a completely inaccurate picture of an America in which tens of thousands of elective abortions are performed on healthy fetuses during the final weeks of pregnancy.¹⁰⁴ This type of confusion, deliberate or not, was extremely common during the floor debates in Congress, in articles written by proponents of the Ban, and in the pro-

the ratio of Group 1 (which requires the D&X procedure for health reasons) to Group 2 (which can have the procedure done on an elective basis).

103. *Welfare Reform, Marriage and Sexual Behavior*, ISSUES IN BRIEF (AGI, New York, N.Y.), May, 1997, at 2.

104. Katha Pollitt, *Secrets and Lies*, THE NATION, Mar. 31, 1997, at 9 (“The big anti-choice lie was obscured by the consistent merging of third-trimester abortions . . . with second-trimester abortions . . . as in live-baby-who-could-survive-if-not-murdered-by-doctor, and also as in, Gross!”).

Ban lobbying materials. Two revealing statements on the Senate floor illustrate this common mixing of information:

There we have it, Mr. President, *8½ months* [of gestation], bring the child 80 percent into the world, making sure you bring it out feet first so that it cannot breathe first, and kill it. That is exactly what we are doing. *That is what an elective abortion is, not for medical reasons.* Once in a while [a medically-necessary D&X abortion] is done. But that is not what we are talking about here in 80 percent of the cases.¹⁰⁵

[T]he opportunity for any woman to say—let us just use, for example, at *8½ months* gestation, [the justification] that this is a female child and ‘I don’t want it. Therefore, *because I don’t want it, because it is a female*, I am going to abort it [through a “Partial-Birth” abortion] . . . Let us talk about a healthy female child that somebody decides they do not want . . . and they abort it [at *8½ months*].¹⁰⁶

The anti-Ban forces responded to the mixed data by focusing solely on post-viability abortions. Narrowing the issue allowed them to refute the arguments that the procedure was used on fetuses that were both healthy and near-term. The Ban’s opponents instead were able to focus on the severe maternal and health indications that many of the Ban’s supporters minimized. As one commentator argues:

This was understandable—the anti-choicers claimed their however-many thousands of frivolously aborted fetuses were as good as born, so why not challenge them on the numbers and the reasons for these very late abortions that the anti-choicers claimed to be talking about (but really weren’t)?¹⁰⁷

When they discussed the numbers of and reasons for the procedure, the anti-Ban activists used accurate information but only *for the third-trimester*. They could claim in all truthfulness that the procedure was only done for severe health reasons, and that only 450-600 D&X abortions were performed per year *if* they limited their discussion to post-viability abortions. They correctly characterized the post-viability scenario but completely ignored the numbers of and reasons for pre-viability D&X abortions. Consequently, both sides presented their data deceptively. Pro-Ban activists presented more complete information but did so in a confusing and inaccurate way. In responding, anti-Ban activists presented a partially-accurate but incomplete set of data. Even though both sides are to

105. 141 CONG. REC. S17881-06, S17900 (1995) (statement of Sen. Smith) (emphasis added).

106. *Id.* at S18073.

107. Pollitt, *supra* note 104.

blame for the dissemination of inaccurate and incomplete information and for the confusion that resulted in the debate over HR 1833, the resulting furor unquestionably harmed the anti-Ban forces more than their opponents.

VI. CRITIQUE OF THE ANTI-BAN STRATEGY

A. *Positive*

1. *Tactical Advantages*

As discussed above, the anti-Ban strategy was, at least temporarily, successful. Advocates made the decision to focus on the compelling stories of women who had the D&X procedure done after fetal viability because of severe health problems.¹⁰⁸ (I will call these women “Group 1,” as opposed to the women of “Group 2” who have the D&X procedure done prior to viability on an elective basis.) This could be seen as an intelligent tactical move given the limitations placed on the debate itself. In Congress, anti-Ban activists did not have a lot of time—the floor debates were restricted, with only one hour allowed in the Senate for debate over the Boxer Amendment. Like most legislation, HR 1833’s progress was manipulated through committees and rules, meaning that amendments were not even presented, much less debated, in the House. Most significantly, the powerful narratives of Group 1 may have been the only way for activists to counter the emotional and disturbing accounts of the procedure offered by the Ban’s supporters. Anti-Ban lobbyists recognized that the media would be more receptive to stories with a compelling personal “hook,” than to technical and complex constitutional and medical arguments.

2. *Representational Advantages*

There were also representational advantages to this strategy. Many anti-Ban activists saw the debate as an opportunity to demonstrate to Congress and to the American public that women can be loving, responsible, and family-oriented and still choose to have an abortion. One area that anti-Ban activists focused on was the motives of women who seek abortions. Pro-Ban activists had portrayed women who have abortions, particularly late-term abortions, as selfish and almost pathologically amoral. A notorious advertisement run by the National Conference of Catholic Bishops offered a list of reasons why a woman would and could obtain a legal “partial-birth” (viability unspecified) abortion. Under the heading of “Health of the Mother” they included reasons such as “Hates

108. The most common procedures for detecting fetal anomalies, amniocentesis and alpha fetoprotein testing, can only produce reliable results in the second trimester of pregnancy.

being 'fat'," "Had an unhappy childhood," and "Won't fit into prom dress."¹⁰⁹ In the wake of these offensive characterizations, the anti-Ban lobbyists sought to show the opposite—women who desperately wanted children, and made the decision after agonizing over it, usually so that they could preserve their fertility in order to have more children. The harrowing stories told by the women of Group 1 contrasted dramatically with the way they were being characterized by the pro-Ban forces. Anti-Ban activists used this opportunity to address these characterizations directly, arguing: "[t]he real women faced with this crisis wanted babies. These women were not afraid of bursting a prom dress. They were afraid of rupturing a uterus."¹¹⁰ This strategy also gave the women themselves an important chance to make their voices heard and to defend their decisions.

Another area that the anti-Ban activists concentrated on was the identity of women who seek abortions. The focus on Group 1 allowed the pro-choice community to "put a different face" on abortion. They selected women who were educated, in their thirties and late twenties, married and either with or planning to have children, middle to upper-class, who observed a religious faith, and who had never had abortions before. One woman was described on the House floor as, "a typical American person. . . . She was a cheerleader, she married her high school boy, . . . she volunteered in her Methodist church, taught sewing, and was a youth counselor. She had three cute sons."¹¹¹ These women, with their exemplary social positions, were able to show the members of Congress and the American public that women who have abortions are not only the stereotypical and much reviled poor, minority, uneducated teenagers who have multiple abortions while on welfare. The desire to shock conservative members of Congress with the fact that even "their" women could have had abortions proved tempting to some anti-Ban activists. One high-level lobbyist recounted the following anecdote:

We brought [a woman] around. She was great. She was cute and blonde and she was wearing pearls. And we were in the hallway when she saw [a pro-Ban Senator]. She ran up to him and she said, "Hi! I'm a conservative Republican. I voted for George Bush in the last election, and I just love Dan Quayle." [The Senator] was standing there, smiling at her and shaking her hand and then she says to him, "I also had what you call a partial-birth abortion last year, and I'd like to talk to you about the bill. It's a terrible, awful bill." You should have seen the expression on his face—how fast he tried to get out there! He was totally speechless!¹¹²

109. National Council of Catholic Bishops, advertising campaign, Mar.-Apr. 1996. See e.g., THE WASH. POST, Mar. 25, 1996, at A14.

110. Goodman, *supra* note 68.

111. 141 CONG. REC. H11462-02, H11462 (1995) (statement of Rep. Lofgren).

112. Personal communication with anonymous anti-Ban lobbyist for abortion rights organization (Mar. 1996). Notes on file with author.

The strategy was also successful in that the anti-Ban message had more credibility coming from women of such social status. When the women were able to present themselves as articulate members of the community who shared the same values and priorities as the majority of the members of Congress, their message had a much greater impact. One Senator described how “members of that [Senate] Judiciary Committee, even on the other side of the issue, . . . were riveted to hear a story from a pro-life Republican about how she faced this and had to choose this procedure.”¹¹³

B. *Negative*

Despite the beneficial aspects of the focus on Group 1, the strategy proved ultimately to be harmful to the anti-Ban cause and may have negative implications for the broader abortion rights movement. Tactically, the strategy’s backfire resulted in a terrible public relations and legislative backlash. From a broader representational perspective, the contest over the Ban highlighted the fact that a significant number of women are being ignored by the movement which purports to speak for their interests.

1. *Tactical Disadvantages*

By failing to explain their statistics adequately, the anti-Ban forces gave the appearance that they were hiding something. In presenting their stories and statistics, they appealed to complex moral impulses, probing areas of ethics and priorities that many people would prefer to ignore, often leading people to conclusions that would otherwise be very difficult to accept. The appearance of deception made them appear as the pro-Ban side portrayed them: callous, cold and manipulative, unwilling to accept the reality of their positions. Their attempts to clarify the terms and methods supporting their arguments came only after the furor had erupted and were viewed by many as an attempt to cover up their deceit. This damaged their credibility, confused the debate, and incited anger amongst both supporters and opponents. Ron Fitzsimmons himself acknowledged that “[t]he pro-choice movement has lost a lot of credibility during this debate, not just with the general public, but with our pro-choice friends in Congress.”¹¹⁴ Ellen Goodman, an opponent of the Ban herself, wrote “[b]oy do we hate being lied to. If you want to see the ‘pack mentality’ of journalists in full operation, lie to one of us, sit back, and wait for the howl.”¹¹⁵

Furthermore, although it is likely that another version of the Ban would have resurfaced later, the anti-Ban strategy practically invited the re-introduction of

113. 141 CONG. REC. S17881-06, S17896 (1995) (statement of Sen. Boxer).

114. Gianelli, *supra* note 28.

115. Ellen Goodman, *Abortion Spin-Cycle is Nonstop*, DAYTON DAILY NEWS, Mar. 8, 1997, at A13.

the Ban in the very next congressional term. By misrepresenting the number of D&X abortions performed each year, and the reasons for most of them, the lobbyists set themselves up to be challenged in a future contest. One observer noted, "[t]he failure to discuss openly and to defend second-term procedures helped create the circumstances in which Fitzsimmons's 'revelation' could do its immense damage."¹¹⁶

2. Representational Disadvantages

While the immediate fallout from the statistics scandal damaged the anti-Ban activists' credibility, their choice of tactics may have indicated and re-enforced deeper representational problems within the broader pro-choice community. The whole controversy boiled down to the fact that the anti-Ban forces had attempted to minimize (or deny) the existence of thousands of women whose interests were directly implicated in the D&X debate. Women in Group 2 make up roughly nine-tenths of the approximately 4,000 women who seek the procedure each year.¹¹⁷ That a powerful coalition of abortion-rights lobbyists and representatives of abortion providers should deliberately ignore such a big segment of a group whose interests they were purportedly representing indicates that the pro-choice movement may be uncertain about how—or whether—to represent these women.

That the anti-Ban lobbyists failed to represent Group 2 in the contest over HR 1833 is clear. The oft-repeated D&X narrative was in fact the "medically necessary post-viability termination of a wanted pregnancy" narrative. The "elective D&X abortion of a pre-viable fetus" narrative was never told. No one sought to identify or interview women from Group 2 to assist in the lobbying efforts. The women of Group 2 were not asked to testify before congressional committees or brought around to meet members of Congress for one-on-one lobbying sessions. Their stories were never circulated in anti-Ban fact sheets or press releases. Their numbers, purposely left out of the totals compiled by the anti-Ban statistics gatherers, surfaced later as an embarrassment to be explained away.¹¹⁸ Despite the fact that the women of Group 2 outnumber the women of Group 1 ten to one, the anti-Ban forces scarcely acknowledged their existence, even as Ban proponents were touting the statistics that proved it.

Although they may have felt backed into a rhetorical corner, the truth is that anti-Ban activists were not "forced" into the representational strategy they pursued. Anti-Ban lobbyists could have addressed the existence of Group 2. They could have embarked on a more comprehensive public education campaign

116. Pollitt, *supra* note 104.

117. *See supra* note 101.

118. Renee Chelian, the president of the National Coalition of Abortion Providers and a member of the National Abortion Federation, stated, "I got caught up: What do we do about this secret? Who do we tell and what happens when we tell?" Ruth Padawer, *Pro-Choice Advocates Admit to Deception*, THE RECORD, Feb. 27, 1997.

by working to clarify who gets D&X abortions, at which stage of pregnancy, and for what reasons. The lobbyists could have picked apart the tangled arguments made by the Ban's proponents, forcing them to acknowledge that the shocking picture they had drawn was inaccurate. Even further, anti-Ban lobbyists could have tried to include Group 2 women *in* the debate.¹¹⁹ They could have introduced testimonials from some of the thousands of women in Group 2, and brought some of them to meet with members of Congress. They could have released fact sheets on pre-viability D&X abortions. Instead, lobbying organizations made the calculated decision to focus entirely on the very small sub-group of women in Group 1 and to virtually ignore women who had the procedure done prior to viability for elective reasons.

To the extent that they publicly recognize this exclusionary strategy, anti-Ban activists are both defensive and evasive. "Choice proponents," one clinic director writes, "never tried to hide the fact that these abortions were also done during the second trimester. They shaped their arguments to counter their opponents' objections and focused on the third trimester because that's where their opponents drew the lines."¹²⁰ Another anti-Ban lobbyist spoke more candidly about the exclusion, explaining:

We felt like [our opponents] had set up a bear trap. They totally ignored the viability line. The only thing to do was to bring out [women from Group 1] to show that these Congressmen care more about fetuses than they do about women. We never really said that they were the only ones who had the procedure done.¹²¹

The defensive response to criticisms of a defensive strategy indicate just how difficult it was for the anti-Ban activists to control the debate and the role of Group 2 within it.

Indeed, the pro-choice movement as a whole seems to have a blind spot when it comes to women who have second-term, pre-viability, elective abortions—D&X or otherwise. These women occupy a netherworld between the millions of women who undergo brief elective abortions at around 6-8 weeks gestation and the handful of women who have three-day-long post-viability abortions under the most tragic of circumstances. They are women who have, frustratingly, waited until the latest stage of pregnancy in which it is possible to legally obtain an elective abortion. Pro-choice advocates seldom talk to or about

119. Of course, many of the characteristics of the women and girls in Group 2 (discussed in greater detail below) would make it difficult or undesirable to find them and include them in the debate. For example, privacy concerns for minors and victims of incest or rape would make it unwise to include them in the debate, and lack of resources and stability would make it very difficult for other women to participate. I found it difficult to find any detailed narratives of women or girls undergoing second-trimester elective abortions. For one such account, see Appendix B.

120. Pearl, *supra* note 92.

121. Telephone interview with an anonymous anti-Ban lobbyist from a women's rights organization (Mar. 5, 1997). Notes on file with author.

these women; often the very reasons that they wait so long to have abortions—youth, ignorance, trauma, poverty¹²²—make them both unlikely participants in the organized pro-choice movement and unattractive “faces” to put on it. While there are a variety of explanations for their behavior (detailed further below), and despite the fact that Supreme Court precedent protects the right to elective abortions at *any point prior to viability*, the women of Group 2 have become the pro-choice movement’s “dirty little secret.”¹²³

a. Problems of Non-Representation: Reinforcement

The “invisibility” of the women in Group 2—to the anti-Ban activists, the pro-choice movement, and society as a whole—is self-perpetuating. The consequences are at once immediate and far ranging, practical and theoretical. Practically, it means that their needs have not been met—on the immediate issue of the Ban as well as in broader social, economic and medical contexts. On a more theoretical level, it means that women in Group 2 are conceptually isolated from and played against the women of Group 1 in a manner that reinforces traditional attitudes about abortion and the role of women in society.

i. Practical Issues: The Need for a Voice in Politics and Beyond

The anti-Ban activists’ failure to acknowledge the women of Group 2 effectively “disenfranchised” them. Because the anti-Ban activists conducted their research, lobbying, and public relations as though Group 2 did not exist, they may be forced to disregard the group’s interests in later political contests. The most obvious “worst-case” scenario would be if a maternal health exception were added to the Ban, eliminating the threat of a Presidential veto. This would give the women of Group 1—all of whom require post-viability abortions because of severe health risks—access to the D&X procedure. But the women of Group 2, who for the most part do not suffer from severe health risks, would be denied such access and so would be left worse off than before. By setting up the lack of a maternal health exception as the sole stumbling block for the legislation, anti-Ban advocates presented their foes with a powerful opportunity to limit abortion access for the much larger group of women who would be unable to claim the exception.

Continuing with this scenario, it is difficult to image the anti-Ban forces, should they achieve the “victory” of a maternal health exception, mobilizing another campaign on behalf of this “forgotten” group of women. Much of the opposition to the health exception centered around the possibility that women with trivial health problems might attempt to claim the need for a D&X abortion. The anti-Ban response to these arguments was to emphasize the severity of the

122. See *infra* notes 139-61 and accompanying text.

123. Ron Fitzsimmons described this deception as making him feel like “a dirty little abortionist with a dirty little secret.” Gianelli, *supra* note 28.

health problems that necessitate the D&X procedure.¹²⁴ Should this response finally be accepted, it is difficult to imagine that the activists would have any success arguing that women with *no* health indications be allowed access to the procedure under a kind of “pre-viability exception.” Put another way, it would be very difficult for anti-Ban activists to shift from making emotional, health-based appeals to more technical viability-based arguments. One pro-Ban activist even anticipated such a shift in arguments, warning that opponents of the Ban might be using the tragic health stories as “a public relations ploy to tug at people’s heartstrings while diverting attention” away from another demand—that the Ban be limited to the third trimester.¹²⁵

It is important to note at this point that, while such a shift in argument may be unacceptable to politicians or the American public, courts are likely to protect the rights of women to choose the safest available method of abortion and to obtain elective pre-viability abortions in the second trimester. This prediction is based on how federal courts have ruled on state prohibitions of specific abortion methods as well as more general restrictions on second-trimester abortions.

In *Women’s Medical Professional Corp. v. Voinovich*,¹²⁶ the district court found that, in light of evidence that the D&X procedure could be safer than the alternatives, an Ohio ban on pre-viability D&X abortions would require some women to choose an abortion method that would be more dangerous for them.¹²⁷ The court held that limiting available abortion methods to those which could entail greater risks to the life and health of the mother would constitute a substantial obstacle under the *Casey* undue burden formula.¹²⁸ On appeal, the Sixth Circuit affirmed. However, it relied on the vagueness of the definition of the procedure in the Ohio law. The appellate court argued that the ban’s definition could be read to include both D&X and D&E abortions, thus including *two* of the most medically accepted techniques for performing late-term abortions.¹²⁹ This, the court found, would certainly present a substantial obstacle in the path of women seeking late-term abortions in Ohio, by forcing them to choose less common and more dangerous abortion procedures.¹³⁰

124. Of course, the anti-Ban activists were talking about post-viability D&X abortions.

125. Katherine Seelye quoting Douglas Johnson, spokesman for the National Right to Life Committee, *Abortion Method is Back in Focus*, L.A. DAILY NEWS, Mar. 3, 1997, at N8.

126. 911 F. Supp. 1051 (S.D. Ohio 1995), *aff’d* 130 F.3d 187 (6th Cir. 1997).

127. See 911 F. Supp. at 1070.

128. See *id.* at 1067-71.

129. See 130 F.3d. at 198-201.

130. Both the *Voinovich* decisions and *Danforth* might be seen as resulting in a somewhat troublesome emphasis on the specific “lay of the land” regarding the technology and availability of abortion procedures at a given time in order to determine whether or not a specific abortion technique should be legal. While this criticism has merit, medical reality renders this problem essentially moot. The argument is as follows: In order to ban “Procedure A,” under *Danforth* it would have to be proven that Procedure A was not the safest abortion method for the gestational period at which it was used, and that safer alternatives were available to all women seeking abortions at that stage. In such a case, a ban on Procedure A would be a rather empty legislative act; it would prohibit a method that physicians had already abandoned and that no woman would choose.

Both *Voinovich* decisions relied on an earlier case, *Planned Parenthood of Missouri v. Danforth*.¹³¹ In *Danforth*, the Supreme Court reviewed a state prohibition on the use of saline amniocentesis, which at the time was by far the safest and most common method of performing abortions between twelve and eighteen weeks gestation.¹³² The Court found that, because the only alternatives—hysterectomy and hysterotomy—were much more dangerous and complicated, the prohibition was clearly dangerous to maternal health, and violated the maternal health protections set forth in *Roe v. Wade*.¹³³ Thus, case law surrounding attempts by legislatures to prohibit particular abortion methods seems to reflect a judicial reluctance to put any segment of the group of women seeking abortions at greater physical risk.

In *Jane L. v. Bangerter*, the Tenth Circuit specifically defended the rights of women to obtain non-therapeutic pre-viability abortions in the second trimester.¹³⁴ At issue was a Utah statute that prohibited all abortions after twenty weeks, except to save the life of the mother or to prevent the birth of a fetus with grave defects.¹³⁵ In essence, the Utah law treated the twenty-week gestational mark as the legal point of viability. Striking down the prohibition, the court made clear that a ban on non-therapeutic abortions after twenty weeks would impermissibly interfere with the rights of the small group of women who might seek abortions between the twentieth and twenty-fourth weeks of pregnancy.¹³⁶ The court recognized that this group might be small—indeed the record indicated that only about fifteen women in Utah sought such abortions each year.¹³⁷ Nonetheless, the court emphasized that such a group of women does exist, and the *Casey* precedent clearly entitles them to be free of substantial obstacles in seeking abortions up to the point of viability.¹³⁸ This is the first judicial pronouncement that the fact that there are relatively few women in Group 2, and that their fetuses are closer to viability than those of most women seeking abortions, does not change the doctrinal analysis. Thus, even if continued anti-Ban advocacy fails to persuade lawmakers or the public, the federal judiciary may well serve as the guardian of the rights of Group 2 women who seek pre-viability elective abortions in the second trimester, and ensure that they can choose the safest available method of abortion.

Possible judicial protection notwithstanding, the representative gap is important because it has had negative consequences beyond the struggle over the Ban. Few attempts have been made to determine who the members of Group 2 are and why they wait so long to have abortions. Even fewer attempts have been made to help these women, or to address the circumstances that lead them to

131. 428 U.S. 52 (1976).

132. *See id.* at 77-78.

133. *See id.* at 76-79.

134. *See* 102 F.3d 1112 (10th Cir. 1996).

135. *See* UTAH CODE ANN. § 76-7-302(3) (1995).

136. *See Jane L.*, 102 F.3d at 1116-18.

137. *See id.* at 1117.

138. *See id.*

seek such late abortions. "Instead of brushing those second-trimester abortions to the side," one critic recognized, "we should talk about the women who have them and why they have them so late."¹³⁹ Of course, talking *about* the women of Group 2 will only produce meaningful results if pro-choice advocates talk *to* them as well. Evidence from a variety of sources indicates that many of these women are vulnerable due to their age and/or lack of resources, and delay abortion, not because of apathy but because of the inability to recognize pregnancy and difficulty arranging and paying for the abortion.

For example, many of the women in Group 2 delay abortion because they are extremely young and are likely either to have irregular menstrual cycles that make it difficult to recognize pregnancy, or to be uneducated and inexperienced in recognizing the signs of pregnancy.¹⁴⁰ In addition, teenagers, especially the very young, are more likely to experience confusion, fear, and denial over an unwanted pregnancy than adult women.¹⁴¹ Dr. James McMahon, a practitioner who used the D&X method, stated that, "if there is any . . . single factor that inflates the number of late abortions, it is youth. Often, teenagers don't recognize the first signs of pregnancy."¹⁴² In 1981, forty-three percent of abortions after twenty weeks were performed for minors, as compared to twenty-eight percent of all abortions.¹⁴³ For girls fourteen and under, the proportion of late abortions is almost four times the national average.¹⁴⁴ In fact, nearly one in four abortions performed on girls below the age of fifteen are performed in the second trimester.¹⁴⁵ Joyce Strauss, a clinic administrator in Los Angeles, explains that "[t]he doctor does abortions up to 26 weeks because he does not feel he can turn a 12 . . . year-old away and send her to be a mother."¹⁴⁶

Parental consent laws have also had the unintended effect of causing many minors to delay abortion until the second trimester. Sixty-three percent of minors surveyed said that difficulty notifying and obtaining consent from their parents

139. Pollitt, *supra* note 104.

140. See, e.g., TIETZE, *supra* note 57, at 65 ("The strong inverse association of period of gestation and woman's age probably reflects the inexperience of the very young in recognizing the symptoms of pregnancy, their unwillingness to accept the reality of their situation, their ignorance about where to seek advice and help, and their hesitation to confide in adults.").

141. One doctor who performs second-trimester abortions describes the reasons why many of his patients delay abortion: "A lot of it is denial. They don't want to face their parents. Or they're broke. Maybe a teen's boyfriend walked out on her and suddenly she says 'Oh no, I can't have this baby.'" Dr. Don Sloan quoted in Peter Hellman, *The Hardest Choice: Women Who Have Faced Late-Term Abortion*, REDBOOK, Jan. 1, 1997, at 84.

142. Dr. James McMahon, quoted in Karen Tumulty, *Abortions of Last Resort*, L.A. TIMES MAG., Jan. 7, 1990. But see Grimes, *supra* note 53, at 262 (arguing that a history of irregular menses is the most important determinant of delay).

143. See UNITED STATES CENTERS FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1981, 37, tbl. 14 (Nov. 1985).

144. See *id.*

145. See Grimes, *supra* note 53.

146. Quoted in Tumulty, *supra* note 142. Strauss describes bringing coloring books and teddy bears to the clinic for 10- and 11-year old girls having second-trimester abortions because of sexual abuse. See *id.*

caused them to delay until after sixteen weeks.¹⁴⁷ This is significant, given the fact that thirty-nine states have passed laws requiring consent or notification of one or both parents before a young woman can have an abortion.¹⁴⁸ While most of these states have judicial bypass provisions, the process of going to court and obtaining the consent of a judge also leads to delays.

Other women in Group 2 may not have had the money on hand to pay for an earlier abortion or the means to travel promptly to an abortion clinic. In one 1988 survey of women obtaining abortions after sixteen weeks, fifty percent of the participants indicated that they delayed abortion in part because it was difficult for them to make arrangements.¹⁴⁹ Sixty percent of this group said that problems coming up with the money for an abortion lead to the delay.¹⁵⁰ By 1996, thirty-four states severely limited Medicaid funding for abortions, restricting it to cases in which the mother's life or health is in jeopardy, or when the pregnancy was the result of rape or incest.¹⁵¹ It is estimated that twenty-two percent of women having second-trimester abortions would have had them in the first trimester if funding had been available.¹⁵² A clinic administrator for a Manhattan abortion clinic declares bluntly, "This is a poverty issue. Don't let anybody tell you any different. You don't see a lot of middle-class women having second-trimester abortions. . . . The nice folks who are debating this, who want to draw the line and put a limit on gestational age, will just be putting a restriction on poor women."¹⁵³

Other women may lack the means to travel to an abortion clinic. In the 1988 survey, over half of the women who indicated problems making arrangements (twenty-six percent of the total surveyed) said that difficulties getting to an abortion clinic had lead to the delay.¹⁵⁴ This is not surprising, as the numbers of abortion clinics diminish as medical schools stop teaching abortion procedures,

147. See Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20 FAM. PLAN. PERSP. 169, 174-75, (July-Aug. 1988).

148. The states are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. See The Alan Guttmacher Institute, *The Status of Major Abortion-Related Laws and Policies in the United States* (visited Nov. 5, 1998) <http://206.215.210.5/pubs.abort_law_status.html>. Only 30 states are currently enforcing these laws, however; parental notice and consent requirements are enjoined in Alaska, Arizona, California, Colorado, Illinois, Montana, Nevada, New Mexico, and Tennessee. See MS., Sept.-Oct. 1997, at 25.

149. See Torres & Forrest, *supra* note 147 at 174.

150. See *id.*

151. The states are: Alabama, Mississippi, and South Dakota (public funds may be used only when the woman's life is endangered); Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Wyoming (public funds may be used in cases of life endangerment, rape, or incest); and Iowa, New Mexico, Virginia, and Wisconsin (funds may be used in cases of life endangerment, threats to health, rape, or incest). See *State Abortion Laws: A Survey* (visited Dec. 7, 1998) <<http://members.aol.com/abtrbng/stablw.htm>>.

152. See AGI, *Facts in Brief: Abortion in the United States* 2 (1995).

153. Anne Walshe *quoted in* Tumulty, *supra* note 142.

154. See Torres & Forrest, *supra* note 147, at 175.

and existing clinics close down because of harassment and violence. In 1988, fifty-one percent of metro counties and ninety-three percent of non-metro counties were without an abortion provider.¹⁵⁵ In 1992, forty-one percent of women of reproductive age lived in a county without a facility that performed at least 400 abortions during the year.¹⁵⁶

Other demographic factors associated with late abortion are race and level of education. Nonwhite women are significantly more likely than their white counterparts to have second-trimester abortions.¹⁵⁷ In addition, education has an inverse effect, meaning that more highly educated women tend to have abortions at earlier gestations.¹⁵⁸ Finally, because race and level of educational attainment are themselves correlated, it is disproportionately likely that a woman seeking a late-term abortion will be both nonwhite and have a lower level of education than a woman seeking abortion at an earlier stage of pregnancy.¹⁵⁹

Thus, while it is true that a woman can legally receive a second-trimester pre-viability abortion for purely elective reasons, the evidence indicates that the women and girls getting these abortions are likely to have compelling physical, mental, emotional, economic, and other reasons for seeking them so late in the term. All of the above-discussed data have led researchers to the conclusion that young women under eighteen (particularly the very young), nonwhite women, poor women, less educated women, and women who live in rural areas are significantly more likely than others to obtain late term abortions.¹⁶⁰ Dr. David Grimes, a leading expert on late term abortion, sums up this situation, saying "[a]lthough these late abortions are infrequent, they are terribly important, because the women who need them need them desperately."¹⁶¹

Whether it is a lack of economic resources, family structure, medical assistance, or education, many of these women have needs that are not being met. These unmet needs contribute to both their difficulties in obtaining early abortions, as well as the deeper issue of their inability to avoid unwanted

155. See AGI, *ABORTION FACTBOOK: READINGS, TRENDS, AND STATE AND LOCAL DATA TO 1988*, 204 (Stanley Henshaw & Jennifer Van Vort eds., 1992).

156. See Henshaw, *supra* note 57, at 54.

157. See Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women*, in *REPROD. LAWS FOR THE 1990S* 23, 25 (Sherrill Cohen & Nadine Taub eds., 1989).

158. See Grimes, *supra* note 53, at 262.

159. Of course, these factors can also intersect in the opposite direction for some reproductive decisions. In some minority communities, particularly where adolescent and out-of-wedlock childbearing are less stigmatized and the average level of educational attainment is low, women and girls may feel less pressure to terminate their pregnancies. Women and girls from more affluent white communities may feel greater social stigma at the prospect of an unplanned pregnancy, and may have more to lose in terms of educational or professional opportunities. However, this analysis fails to comprehend both the differential likelihood of unplanned pregnancy in these two hypothetical communities, as well as the reasons for the timing of the decision to terminate a pregnancy. It is simply worth noting that the intersection of the factors which place someone at risk for late-term abortion may have additional synergistic effects.

160. See, e.g., Torres & Forrest, *supra* note 147, at 174 (finding that teenagers under 18, black women, unemployed women, and women covered by Medicaid are significantly more likely than others to delay abortion); Grimes, *supra* note 53, at 261 (citing a study which found women who were young, black, single, or poor to be more likely to delay abortion).

161. Quoted in Tumulty, *supra* note 142.

pregnancy. Indeed, the fact that some of the very young women in Group 2 were even having sex at all is cause for concern. Refusing to acknowledge the members of Group 2 is analogous to ignoring the symptoms of a much larger societal ailment. As long as the women of Group 2 remain invisible, they will continue to experience unwanted pregnancies and to seek late abortions, their powerlessness becoming more entrenched. Somewhat belatedly, Kate Michelman, president of the National Abortion Rights Action League and one of the most vocal opponents of the Ban, recently acknowledged that "if the problem is late second-trimester procedures, we need to get at that and figure out what conditions cause women to have abortions after 20 weeks."¹⁶²

ii. *Theoretical Issues: Dichotomy and the Status Quo*

Rather than enjoying any meaningful inclusion in the D&X narrative, Group 2 served merely as the necessary implicit foil for Group 1 in defining who should have access to the D&X procedure, and why. The anti-Ban forces set up the women in Group 1 as deserving of access to the D&X procedure because they are everything that the women in Group 2 are not. The plea made by one congresswoman during the debates was typical: "The women involved are *older*, they are *married*, the pregnancies are wanted, planned for, joyously anticipated. . . ."¹⁶³ Anti-Ban activists carefully selected a group of women who exemplified the characteristics of "good women"—all were wives, most were mothers, they were professionals or did volunteer work, and most observed a religious faith. Activists highlighted the fact that almost all of the women either bore or adopted more children soon after their abortions. Indeed, four out of the five women who were present in the Rose Garden for the veto ceremony had either recently given birth to or adopted children.¹⁶⁴ The sense from the stories and descriptions of the women in Group 1 was that they were all "good women" who were forced to make "bad" choices by a set of terrible circumstances. Their social, familial, and religious commitments made it clear that they operated within a strong, generally shared value structure. They were people with whom many of the members of Congress could identify, and their motives were difficult to question. Their lack of options made their choices more easily forgiven. Ironically, the very fact that none of the women wanted to have an abortion made their decisions to do so more acceptable.¹⁶⁵

162. Quoted in Goodman, *supra* note 68.

163. 141 CONG. REC. H11604-01, H11614 (1995) (statement of Rep. Rivers) (emphasis added).

164. One of the five women was pregnant while lobbying against the Ban on Capitol Hill, and brought her newborn to the Veto Ceremony.

165. In his veto message, President Clinton stressed the fact that the women he met with (who were all in Group 1) "wanted anything other than an abortion." Remarks on Returning Without Approval to the House of Representative Partial Birth Abortion Legislation, 32 WKLY. COMPILATION PRESIDENTIAL DOCUMENTS 646 (Apr. 10, 1996). Likewise, there is a prevailing and documented sense that women who are pregnant because of unwanted sexual encounters (rape and incest) should also be allowed access to abortion.

The implied converse of these arguments focuses on the group of women against whom Group 1 is being compared. One easily drawn conclusion is that a woman with an unwanted pregnancy who seeks to terminate it for elective reasons does not deserve access to a second-trimester abortion. Unlike the women of Group 1, who have tragic circumstances making their choices more acceptable, the majority of women in Group 2 seek D&X abortions for elective reasons (although some of these may be quite serious). By seeming to condition access to late-term abortion on severity of circumstances, anti-Ban forces may have unwittingly bought into the pro-Ban arguments that an abortion performed for any other than life-threatening health problems is unjustified.

Similarly, it is not too much of a stretch to conclude from the glowing portrayals of the Group 1 women that “bad women”—the unwed, the uneducated, the unemployed—should be denied access to abortion. This could be because their motives are suspect. If a woman has not shown herself to be dedicated to something—family, church, education, work or community—it is easier to assume that her decision to abort is a selfish or frivolous one. As the previous section of this Article points out, many women in Group 2 have characteristics such as youth, poverty, and lack of education that already take them out of the “mainstream.” One doctor who performs late term abortions describes his typical patients as “young, frequently not married, and many have a child already, or more. . . . Many are poor, [and] have not completed school or established themselves in the work force.”¹⁶⁶ A clinic administrator argues, “[i]t’s not that these women are bad, or they’re wrong. They’re just poor. They don’t lead organized, routine lives.”¹⁶⁷ When the anti-Ban activists focused so heavily on the “good” characteristics of the women they had chosen from Group 1, they set up an argument in which such characteristics lend credibility to a woman’s decision to terminate a pregnancy. This is a problem when most of the women seeking the procedure lack these traits.

In setting up a dichotomy between groups of women, the anti-Ban activists may have inadvertently played into the same sets of assumptions and stereotypes that limit women’s reproductive options and confine their roles within society as a whole. First, this approach sets women against one another in a competition for social, medical, and legislative resources. Such a “contest” only makes sense against a backdrop in which abortion is a limited commodity. One author argues that, “[a]ny access to abortion other than in those instances . . . where pregnancy endangers a woman’s life or where conception resulted from certifiable rape . . . is a matter of legislative grace and subject to majoritarian preferences.”¹⁶⁸ The anti-Ban strategy seems to accept this backdrop, and, working within it, sets up a system for allocating access based on the moral weight behind each woman’s

166. Dr. Steve Lichtenberg, *quoted in Brown, supra note 100*.

167. Anne Walshe, *quoted in Tumulty, supra note 142*.

168. Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 AM. U. L. REV. 77, 123 (1995).

claim. The logical result of such assumptions is the sacrifice of some women's rights to abortion for those of others. The statements of Ellen Goodman, a pro-choice columnist, illustrate this danger. She muses that, "[i]f I could make a trade-off that would limit late second-trimester abortions for healthy women with healthy fetuses in return for freely and widely available abortion in the first trimester, I would be sorely tempted."¹⁶⁹ Ron Fitzsimmons himself now says that, if he could do it all over again, he would "roll over and play dead," and devote his energies to other, less controversial, abortion issues.¹⁷⁰

Second, the weighing of moral worthiness places all of the focus on the character of the women themselves. This diverts attention from other important pieces of the abortion puzzle, such as the institutional and social barriers that make raising a child as a single parent so difficult, the persistent lack of access to reliable birth control technology, and the ridiculously high rate of unwanted pregnancy in the United States.¹⁷¹ As one scholar observes, "[r]ights are by definition claims staked within a given order of things. They are demands for access for oneself, or for 'no admittance' to others; but they do not challenge the social structure, the social relations of production and reproduction."¹⁷² The approach taken by the anti-Ban lobbyists failed to implicate the larger issues. Rather, it made each individual woman a crucible in which all of her life circumstances and qualities were boiled down to answer one basic question: has she shown herself worthy of having an abortion?

An analogy can be made here to the discourse on rape.¹⁷³ In the recent past, popular and legal perceptions classified rape victims according to a similar model. In the rape scenario, legal protection (rather than abortion) was the limited commodity, and sexual danger (rather than unwanted pregnancy) was the problem. In order to avail herself of legal protection, or even just to be taken seriously, a rape victim had to conform to an extremely high set of standards of "goodness" and sexual virtue. A woman could be considered "bad" and therefore undeserving of legal protection if she were unmarried or divorced, went to bars, had a bad reputation or a nontraditional job, had had more than one sex partner, or had born a child out of wedlock. Like a "bad" woman who has an unwanted pregnancy, a "bad" rape victim was often the target of scorn. The idea was that she had gotten what she deserved.

169. Goodman, *supra* note 115.

170. Quoted in Gianelli, *supra* note 28.

171. It is a sad, and well-documented fact that roughly half of all pregnancies in the US are unplanned, and over half of those—more than one quarter of the total—end in abortion. See, e.g., Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSP. 24, 26 (1998).

172. ROSALIND PETCHESKY, *ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM* 4 (rev. ed. 1990).

173. Many of the ideas in this section have been inspired by various writings on sexual violence, including: SUSAN BROWNMILLER, *AGAINST OUR WILLS* (1975); SUSAN ESTRICH, *REAL RAPE* (1987); PEGGY REEVES SANDAY, *A WOMAN SCORNE* (1996); Helen Benedict, *When to Blame the Victim—the Media's Rules on Rape*, MS., (July-Aug. 1991).

This dichotomy had two negative consequences that are relevant to the D&X abortion debate. First, setting up credibility and legal protection as scarce resources for which women had to compete encouraged women into traditional sexual, familial, and social roles. Although they may not have consciously decided to conform their behaviors to the cultural expectations of “good” women, many women were careful not to step outside their carefully defined roles. To do otherwise entailed a two-pronged risk. Nonconformity was seen as: a) increasing one’s chances of being sexually victimized, and b) a bar to social and legal resources should one be victimized. Similarly, nonconformity (in the form of sexual promiscuity or engaging in pre/extramarital sex) can be seen as both an increase in one’s chances of getting pregnant, and limiting the resources available should one get pregnant.

The second negative consequence rape discourse had was the fact that it diverted attention away from the underlying problem of sexual violence against women. When women claimed to have been victimized, attention focused immediately on *them*. People focused particularly on the woman’s character, her credibility, and what she may have done to provoke or deserve the attack. The reasons for the relatively high rate of rape in the United States did not have to be examined; nor did the overall sexism of American society. Sometimes, even the rape suspect himself would escape scrutiny. Similarly, in their rush to prove the moral worth of the Group 1 women, the anti-Ban activists may have fallen into the trap of ignoring the causes and circumstances that form the background of unwanted pregnancy and delayed abortion.

b. Problems Underlying Non-Representation: Moral Uncertainty

The problems the anti-Ban activists encountered in representing the full range of women who undergo D&X abortions bespeak a deeper tension within the pro-choice movement. Abortion means many things to the pro-choice movement: it is an intimate personal right, a means for reproductive control and biological self-determination, and a practical necessity for women who are too young, poor, or overwhelmed with the children they already have. Still, it goes without saying that abortion is a morally disturbing practice. It grows more offensive as the fetus gets later in the term, or when we feel the decision to abort is made frivolously, or serially. Supporters of abortion rights believe in a woman’s right to choose, but most also hope that the woman herself will exercise this right with the circumspection and deference that such a serious decision warrants. Pro-choicers often find it difficult to understand, much less defend, women who don’t seem to take the decision seriously, or who don’t seem to learn from their mistakes. And of course, this becomes even more difficult when the decision is made very late in the term, as the fetus approaches viability. Ethicist Daniel Callahan admits that:

As much as I would prefer to avert my moral gaze, a late abortion forces me to confront the reality of abortion and my own incompletely suppressed doubts. . . . I suspect that for all but a small minority of those who, like myself, count themselves on the pro-choice side in the abortion debate, the matter of late abortions cannot help triggering distress. It stretches our commitment to the breaking point.¹⁷⁴

This underlying tension—the clash between the political conviction that a woman must have the right to choose and the personal belief that some abortions are just *wrong*—provides the deeper explanation of why the D&X debate happened the way it did. As one writer observed, “[t]his ‘partial-truth’ abortion debate comes out of our deep discomfort about abortion, especially the second-term abortions.”¹⁷⁵ A pro-Ban senator explained that pro-choice people “know that their Achilles heel in this debate, in the debate not just on partial-birth abortions but, frankly, on all abortions, is late term abortion. This is . . . something the American public overwhelmingly rejects. They think it goes too far.”¹⁷⁶

The focus on Group 1 gave the anti-Ban activists a way out. It enabled them to argue against the Ban without having to delve into the more complicated territory of elective second trimester abortions. As one detractor points out, “[the] strategy is no surprise, given Americans queasiness about later-term abortions. Why reargue the morality of or the right to a second-trimester abortion when anguishing examples . . . can more compellingly make the case?”¹⁷⁷ But doing so caused the anti-Ban activists to fall into another sort of representational “trap” in which they can only talk about the “hard cases,” the extreme situations in which the woman is clearly a tragic figure.¹⁷⁸ When the “hard cases” are outnumbered by cases that aren’t so “hard” by a margin of ten to one, such a strategy is bound to fail.

Naomi Wolf argues that “[a]ll abortions occupy a spectrum, from full lack of alternatives to full moral accountability.”¹⁷⁹ Furthermore, the lateness of the term heightens the moral accountability involved—the later the term, the better a reason a woman must have to justify obtaining an abortion. The women of Group 1 clearly occupy the less culpable end of the spectrum, where the lack of any “good” choice relieves them of much of the responsibility for their abortions.

174. Daniel Callahan, *quoted in* Tumulty, *supra* note 142. Callahan also writes that, a “late abortion . . . drives home how fine the line between the tolerable and the intolerable, the merely disturbing and the genuinely revolting, can be.” Daniel Callahan, *Late Abortion and Technological Advances in Fetal Viability: Some Moral Reflections*, 17 FAM. PLAN. PERSP. 160, 163 (1985).

175. Goodman, *supra* note 115.

176. 143 CONG. REC. S2632-02, S2633 (1997) (statement of Sen. Santorum).

177. Padawer, *The Facts on Partial Birth Abortion*, *supra* note 100.

178. See Pollitt, *supra* note 104. Fitzsimmons himself even argued that abortion rights advocates look like they are apologizing for the procedure when they highlight only the extreme cases. See Gianelli, *supra* note 28.

179. Naomi Wolf, *Our Bodies, Our Souls*, THE NEW REPUBLIC, Oct. 16, 1995, at 26.

Meanwhile, because most of their decisions to abort were not based on such circumstances, the women of Group 2 occupy places on the spectrum that are far more culpable.

It is not surprising that pro-choicers find it difficult to completely conceal the ambivalence they feel about the women in Group 2. Perhaps this is because many of the people involved in the pro-choice movement are themselves part of a relatively elite group. Particularly at the upper levels of the various pro-choice organizations, members are often well-educated, well-off, adult women. Such women may not be able to identify with the women of Group 2, and may not understand the life circumstances which would lead a woman to delay an abortion until the twenty-second week of pregnancy. Pro-choicers are not necessarily alone in this sentiment. Polls indicate that only sixteen percent of the American public thinks that abortion should be elective into the second trimester.¹⁸⁰ In light of this, it seems that the pro-choice movement is not so much out of touch with the women of Group 2, but rather that the movement is in tune with the moral position that a majority of Americans take on the issue. If anyone is "out of touch," it may be the women in Group 2.

However, assigning culpability is not the mission of the pro-choice movement. The movement seeks to guarantee reproductive freedom to all women, regardless of who they are and what the circumstances surrounding their decision might be. Indeed, one of the underlying principles of the abortion rights movement is that the reproductive decisions are intensely personal, and that women seeking abortions should have the freedom to do so without having their lives, morals, and motives scrutinized by doctors, legislators, or the public. The effectiveness of the pro-choice message comes, in part, from the fact that abortion access is technically a broad-based, and not an individually-determined, right. Kathryn Kohlbart, vice president of the Center for Reproductive Law and Policy, points out that, "[i]f the debate is whether or not women ought to be entitled to late abortion, we will probably lose. But if the debate is on the circumstances of individual woman . . . and [how] the government shouldn't be making those decisions, then I think we can win these fights."¹⁸¹ The right to obtain an abortion is already a qualified one.¹⁸² States may impose various regulations prior to viability and may prohibit all but medically necessary abortions after viability.¹⁸³ However, within these limitations women are free to exercise their constitutional right, no matter how difficult it may be to defend in individual cases.

In order for the right to abortion to remain meaningful, it must exist for all women. An analogy to another Constitutional protection is useful. The First Amendment protects the rights of pornographers as well as political activists,

180. *Hearing on HR 1833 Before the House Subcomm. On the Constitution*, 104th Cong. (1996) (testimony of Kimberly Schuld, Vice President of The Polling Company).

181. *Quoted in* Gianelli, *supra* note 28.

182. *See infra* note 202.

183. *See* *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

Klansman as well as civil rights marchers. Any poll taken of the American public would no doubt reveal that the vast majority of citizens are offended by pornography, or groups such as the Ku Klux Klan. But First Amendment rights are guaranteed to all precisely because the selective protection of individuals would distort the very purpose of the right—freedom of expression no matter who the expressor is and what he is saying. Similarly, women who seek Constitutionally-permitted abortions must be free to do so no matter who they are and why they want one. The act of choosing to terminate a pregnancy is the relevant concept -- the identity of the chooser is not. If we allow individual analyses of women's motivations and justifications, we find ourselves back in the value-laden rhetorical fray that marked so many of the congressional debates over HR 1833. As one abortion rights supporter argues, "[w]e need to defend women's freedom to choose when and if to become mothers—not just the right of women to choose abortion over serious injury or death."¹⁸⁴

Senator Carol Moseley-Braun powerfully summarized this sentiment during one of the earliest Senate debates on HR 1833. She expressed her concern about the gradual erosion of abortion rights, with the most vulnerable groups of women facing the most restrictions. To illustrate the situation, she paraphrased a poem written by Martin Niemöller, a Protestant minister held in a German concentration camp for seven years. Her version, entitled "The Assault on Reproductive Rights" read in part:

First they came for poor women
and I did not speak out—
because I was not a poor woman.
Then they came for teenagers
and I did not speak out—
because I was not a teenager.
Then they came for the doctors
and I did not speak out—
because I was not a doctor.
Then they came for me—
and there was no one left
to speak out for me.¹⁸⁵

Still, the pro-choice movement is left in an admittedly uncomfortable situation. By protecting the rights of women in Group 2, the movement risks

184. Pollitt, *supra* note 104.

185. 141 CONG. REC. S16761-03, S16796 (1995) (statement of Sen. Moseley-Braun).

alienating millions of Americans who support abortion as a legal right but still need to condemn late-term abortions as a moral inequity. Furthermore, if the movement defends the rights of Group 2 by emptying late-term abortions of their moral gravity, it risks "cultivating a hardness of heart."¹⁸⁶ The solution to this dilemma is not clear or simple, particularly in the face of strong and violent opposition to abortion rights. When pro-choice people critically assess their own positions, they open themselves up for a flood of opportunistic pro-life criticism. Indeed, a thoughtful article by Naomi Wolf,¹⁸⁷ in which she urges the pro-choice movement to reassess some of its rhetoric, was subsequently cited by supporters of the Ban as evidence that the movement was admitting its own moral bankruptcy. In such an atmosphere, it is difficult for the anti-Ban activists to probe their own feelings about late term abortions without damaging their position in the debate.

Perhaps the best solution would be for anti-Ban advocates and the broader pro-choice movement to admit that pre-viability late term abortions are tragic choices. Rather than continuing to present America with only the "hard cases," the activists might be better served by simply telling Americans what they already know: that some abortions, even second-trimester ones, are not performed for "good" reasons, and that nobody applauds this. But, rather than allowing such an admission to be used as an argument for banning late term abortions or certain procedures, activists will have to change the focus. They will have to start talking more about improved education and health care to decrease the number of women and girls who delay abortion because of ignorance, poverty, or lack of health facilities. They could start focusing on the disturbingly young age of many of the girls who are seeking D&X abortions, emphasizing that it is not just the fact that these girls are pregnant or seeking abortions that is a social problem, but the fact that they are having sex in the first place.¹⁸⁸ And they might try to highlight the lack of options that such women face should they carry their babies to term, and their improved prospects should they delay childbearing until they are ready.¹⁸⁹ As one scholar argues, "[t]hat individuals do not determine the social framework in which they act does not nullify their choices nor their moral capacity to make them. It only suggests that we have to focus less on 'choice' and more on how to transform the social conditions of choosing."¹⁹⁰ Anti-Ban activists can recognize elective late term abortions as the tragedies that they are, while simultaneously focusing on the backdrop of youth and poverty in which they occur. "Those circumstances," argues one commentator, "are the real abortion scandal."¹⁹¹

186. Wolf, *supra* note 179.

187. *Id.*

188. See *supra* notes 139-45 and accompanying text.

189. Studies indicate that teenagers who have abortions do better economically and educationally than their counterparts who choose to have children, and have fewer subsequent pregnancies. See Steven Holmes, *Teen-Age Study Hints Gain for Those Having Abortion*, N.Y. TIMES, Jan. 25, 1990, at A13.

190. PETCHESKY, *supra* note 172.

191. Pollitt, *supra* note 104.

Of course, such a tactic would probably have little force within a pro-life, pro-Ban discourse that makes fetal life the most important priority and abhors any abortion which could be considered "elective." But these individuals are unlikely to change their views regardless of the way in which anti-Ban advocates make their arguments. (The contest over HR 1833 was at least valuable in that it revealed the starkness of the pro-Ban position.) Anti-Ban advocates should recognize that the pro-Ban framework is not the only way to incorporate "morality" into the debate over late term abortions. Perhaps it is possible to both express discomfort with the procedure while at the same time arguing that banning it is not the solution. While they may not succeed in changing their opponents' minds, anti-Ban activists might at least retain a sense of honesty within the tangled discourse on abortion, and may even help change the way some members of the public view late term abortions. As Naomi Wolf argues, the pro-choice movement can "defend[] its moral high ground by being simply faithful to the truth: to women's real-life experiences."¹⁹²

VII. ADVOCACY ISSUES

It is worth making a final note on how the representational problems were able to occur during the debate over HR 1833. While many of the difficulties can be attributed to complex moral issues and rhetorical maneuvering, others revolved around the nature of the type of advocacy involved. Interest-group advocacy has become a fixture within the American political process, and in many ways it has taken on a life of its own. There are currently a huge number of lobbying organizations. Some represent the diverse interests of a particular group; others represent a "single-issue" with a large affected class. Sometimes several organizations will represent a single group or issue, with each one pursuing a slightly different agenda. Often, it is difficult to know whose interests are being represented, and whether the representation is truly an accurate reflection of the needs of a particular group. This is complicated further when the topic is a troublesome social issue like abortion, in which "group membership" of the affected class is almost impossible to define.

A. Difficulties with Advocacy Groups in General

The most basic problem with the type of interest group lobbying that occurred during the contest over HR 1833 is a lack of rules and guidelines. This is not to say that there is no structure whatsoever. There are many rules regarding *how* lobbying is carried out: there are limits on the gifts that groups can give to members of Congress, and rules regarding the tax-exempt status of any organization which employs lobbyists. However, there is a distinct lack of rules regarding the *type* of representation that the organizations provide. For example,

192. Wolf, *supra* note 179.

there are no guidelines for defining who is in the “interested class” when a particular issue surfaces. In the context of class-action litigation, Rule 23 of the Federal Rules of Civil Procedure sets forth an protocol for how a class is to be defined, and what attorneys should do if the interests of different sub-groups in the class diverge.¹⁹³ Both the ABA Model Code of Professional Responsibility and the ABA Model Rules of Professional Conduct contain rules for attorney conduct when there are actual or potential conflicts of interest between multiple clients. No such guidelines exist for lobbying organizations. If a particular interest group is organized, with a defined membership and a set of discrete issues, it can convey its opinions and suggestions to its representatives. Examples of such groups include trade unions, the NRA, and the AARP. However, when a large group is more loosely-defined around an issue—as is the case in abortion rights, civil rights, and a whole range of “identity-based” political issues—representation becomes far more complex.

Furthermore, there is often nothing more than the judgment of the advocate to determine the lobbying strategy that a particular group will pursue. There are no rules to insure that the tactics a lobbyist chooses will be beneficial for all members of the group. Again, if the group is well-organized it may have a decision-making body or some type of democratic structure in which members can literally have a vote. If a sub-group feels as though its interests could be jeopardized by a lobbying strategy, it can work within the structure or retain an advocate for its own specific needs. However, if the group is not an organized one, decision-making authority becomes much more centralized with the advocates. The advocates may recognize that the interests of the group as a whole would be better served by jettisoning the interests of a particular sub-group. Or, advocates may forgo immediate benefits to a sub-group in hopes of attaining more lasting gains for the class. While such tactical decisions may be the best for the overall cause, they may hurt the smaller group, which then has no one representing its interests.

B. Difficulties Inherent in the Abortion Issue

Perhaps nowhere are the difficulties inherent in advocacy representation clearer than in the abortion context. The nature of the abortion issue is such that it makes group membership almost impossible to define, group interests difficult to discern, and individual voices easy to ignore.

193. Even these rules become frustrated when class-action litigation is pursued by interest groups, where differences can arise between “constituents” (members of the interest group) and “clients” (named plaintiffs in the litigation). The paradigmatic case in point is detailed by Derrick A. Bell, Jr., *Serving Two Masters: Integration Ideals and Client Interests in School Desegregation Litigation*, 85 YALE L.J. 470 (1976). For a discussion of this phenomenon in abortion rights litigation, see Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 AM. U. L. REV. 77, 100-14 (arguing that, because most large abortion-rights cases are brought on behalf of abortion doctors rather than women seeking abortions, women’s stories and voices are ignored, and court opinions fail to understand women’s experiences) (1995).

The most obvious difficulty in abortion-rights advocacy is the definition of the "interested" group. The group could be defined as the class of women who have had or may seek abortions in the future. This class alone is diffused across all demographic lines; the women in it would be from all racial and ethnic groups, social classes, marital statuses, religions, and ages. But the class could further be expanded to include individuals—be they feminists, health care providers, or civil libertarians—who feel that reproductive rights must be safeguarded. For example, in the contest over HR 1833, lobbyists opposing the Ban included medical organizations, women's and civil liberties groups, and organizations dedicated specifically to abortion rights.¹⁹⁴ People who fall into this second category are also diffused along many other demographic lines. Moreover, they may themselves be personally opposed to abortion, yet still believe in protecting a woman's right to choose for herself.¹⁹⁵

But the difficulty is compounded further by the nature of abortion as an unexpected, temporary and crisis-filled phenomenon. Because abortion is a very private and highly stigmatized event, many women who choose it do not want their choice to become public. This makes it hard for representatives to identify the women in the interested group, much less communicate with them. In addition, the temporal aspect of abortion is important. Prior to a crisis pregnancy, many women may not feel personally connected to the abortion issue enough to identify with it or become involved in it. One abortion provider estimates that as many as 90% of her patients have told her that they thought they would never have an abortion.¹⁹⁶ Many women may not even consider themselves pro-choice until faced with a crisis pregnancy. One study found that one-fourth of women surveyed who had obtained abortions had previously felt that abortion was morally wrong.¹⁹⁷ In fact, some women are actively pro-life before they experience an unwanted pregnancy and seek abortion. The same study found that eight percent of women surveyed who had obtained abortions had previously felt that abortion should not be legal.¹⁹⁸ One abortion provider, working at a clinic in Ohio that had been the target of anti-abortion protest, reported that two of the women who had regularly picketed the clinic came in for abortions.¹⁹⁹ Another doctor says that "many of my patients come from among those groups who scream the loudest against abortion."²⁰⁰ She describes the typical counseling session that occurs before an abortion: "The counselor in our office often opens her interview by asking, 'So, how long have you been pro-

194. See *supra* note 43.

195. A supporter of the Ban refers to this type of belief as "intellectual schizophrenia." See testimony of Kimberly Schuld, *supra* note 180.

196. Elizabeth Karlin, MD, *An Abortionist's Credo*, N.Y. TIMES MAG., Sept. 16, 1995, at 32.

197. Susan Neiburg Terkel, ABORTION: FACING THE ISSUES 86 (1988) (internal citation omitted).

198. *Id.* Several of the women in Group 1, whose stories were recounted during the lobbying and debate, were themselves opposed to abortion before their crisis pregnancies. See Appendix B.

199. Terkel, *supra* note 197, at 87. One woman is reported to have said, "I always felt abortion was wrong until I found myself in this situation." *Id.*

200. Karlin, *supra* note 196.

choice?" Laughter and the answer, "About 10 minutes" is the healthiest response."²⁰¹ Even if the crisis pregnancy and abortion have altered or strengthened a woman's commitment to abortion rights, there is no guarantee that she will take an activist role in the issue. Once the abortion is over, many women prefer to get on with their lives, rather than dedicating their energy to the very subject.

Finally, the whole issue is conceptually confused by the fact that abortion rights are inextricably bound up with individual choice. Because women have infinitely diverse life experiences and needs, no one woman is representative of all those who might seek abortion and no reproductive solution is best for all women. However, sometimes individuals have to represent the needs of the group, as they did in the contest over HR 1833. Faces are needed to testify before Congress, bodies are needed for the lobbying rounds, and histories are needed for the media. The advocates' decisions as to which individuals should represent the group of "women who have had or may seek D&X abortions," had a tremendous impact on the way the group was defined. While the use of individual narratives was both powerful and empowering, it was also inherently limiting.

C. Suggestions for More Effective Advocacy

Although advocacy groups and lobbying organizations occupy a large and important position in the American political process, it seems unlikely that any rules regarding the adequacy of their representation will be forthcoming. In the absence of formal rules, some groups may need to start policing themselves, implementing systems to define the groups they represent and discern the real interests of those groups as new issues arise.

Pro-choice advocates would especially benefit from such practices. Because they frequently work in coalition with other organizations, and because the group that they represent is so diffuse, it is important that they periodically take stock of their goals and priorities. First, pro-choice advocates should take care to define all the potential groups of women whose interests are at stake and between whom there could be tension before embarking on a legislative or judicial course of action. For example, certain actions may have different implications for women of different ages, women with different access to monetary resources, women at different stages of pregnancy and women seeking abortions for different reasons. Such a process is crucial to insuring that advocates are not caught off-guard by later developments.

Second, advocates should map out a particular plan of action in case tensions do develop between various sub-groups. Because of the diffuse and disorganized nature of the affected population, it would be difficult for sub-groups to split off in the middle of a political contest and secure their own representation. Thus pro-

201. *Id.*

choice advocates should recognize that they are essentially responsible for representing all the interested sub-groups of women. Furthermore, and perhaps most importantly, recent attacks on abortion rights have taken place incrementally, as pro-life lawmakers push for measures that restrict access to abortion for minors, married women, American service-women stationed overseas, and poor women.²⁰² Given the danger of a gradual “chipping away” of reproductive rights, advocates should be wary of sacrificing the interests of any sub-group if they can help it. Instead, they should map out rhetorical and lobbying strategies that will do the least damage to all of the women involved.

Finally, advocates should be cautious not to fall into the rhetorical traps that their opponents may set in framing the debate. While this may sound like a truism, it is particularly salient when there is a possible conflict of interest among different sub-groups of the interested population, and the opposition’s rhetorical framework may seek to exploit the conflict. Advocates must do the best they can to mitigate the perception that different groups should be pitted against one another in a competition for reproductive rights and resources. Whenever possible, advocates should attempt to address the underlying issues that affect all of the interested groups of women, rather than picking out the most sympathetic sub-group and focusing on its particular needs. This may lessen the emotional impact of some of the advocates’ arguments, but will prevent them from perpetuating the broad perceptions that sustain their opponents argumentative framework. This may prove more beneficial in the end. As one pro-choice columnist observed about the arguments against the Ban, “we wouldn’t be forced into this ridiculous corner . . . had we not ceded a lot of ground already by failing to defend abortion as an essential—indeed normal—aspect of women’s reproductive lives: every kind of woman in every social class.”²⁰³

VIII. CONCLUSION

The contest over HR 1122 ended as its predecessor did—vetoed because of the lack of a maternal health exception. Again, the House overrode the veto,²⁰⁴ but the Senate was (just barely) unable to do the same.²⁰⁵ However, the issue is far from resolved. It is likely that members of Congress will continue introducing similar legislation, particularly if a change in the presidential administration

202. While spousal consent provisions have been found unconstitutional by the Supreme Court, parental consent requirements, waiting periods, and mandatory biased counseling requirements have been upheld. The Hyde Amendment prevents the use of federal Medicaid money to fund abortions for poor women, even when the procedure is medically necessary. Provisions in the military budget prevent the performance of abortions in military hospitals, meaning that American service-women stationed overseas may be denied access to abortions, even if they can pay for them independently.

203. Pollitt, *supra* note 104.

204. 144 CONG. REC. D821-01 (Jul. 23, 1998).

205. 144 CONG. REC. D1004-01 (Sept. 18, 1998).

produces an Executive more sympathetic to their arguments.²⁰⁶ In addition, in the absence of a federal ban, state legislators have worked to pass similar bans in individual states. Since 1995, at least 26 states have passed legislation to ban D&X abortions,²⁰⁷ although many of these state laws have been enjoined or struck down.²⁰⁸

Given the amount of controversy and acrimony raised in the first two contests, the future look contentious indeed. Neither side has escaped unscathed, but the anti-Ban activists have been particularly harmed. Their credibility has been doubted and the morality of their positions called into question. This happened largely because of their own inability to articulate their goals and define the groups they represented, and because of their unwillingness to grapple with the deeper moral issues raised by late term abortion. Hopefully, anti-Ban activists and the broader pro-choice community will be able to learn from these experiences. They must not only work to win the immediate contests as they arise, but also take care to clarify the goals and priorities of the pro-choice movement at the same time. Anti-Ban advocates must continually examine whose interests they represent and what those interests are. And they also must reconcile within themselves just how to deal with the marginal specter of late term abortion. Without a clear-headed approach, effective and comprehensive representation and advocacy will be almost impossible to achieve. But with some degree of hard self-analysis, thoughtful group definition, and principled argument, the anti-Ban activists may continue to prevail.

206. As one Senator said after the Senate failed to override the President's veto of H.R. 1122, "We will continue this fight until we have succeeded, and I urge the Senate leadership to make the ban on partial-birth abortions the first piece of legislation we take up in the 106th Congress." 144 CONG. REC. S10656-02, S10656 (1998) (statement of Sen. Grams).

207. See, ALA. CODE §§ 26-23 1-6 (1997); ALASKA STAT. § 18.16.050 (Michie 1997); ARIZ. REV. STAT. § 13-3603.1 (1997); ARK. CODE ANN. §§ 5-61, 201-204 (Michie 1997); FLA. STAT. ANN. §§ 390.0111-390.0112 (West 1998); GA. CODE ANN. § 16-12-144 (1997); IDAHO CODE § 18-613 (1998); ILL. COMP. STAT. 720 §§ 513/1, 5, 10, 15, 20 (West 1998); IND. CODE 16-18-2 § 267.5 (1997); KAN. STAT. ANN. § 18 65-445 (1998); LA. REV. STAT. ANN. §§ 14:32.9, 40:1299.35.16 (West 1997); MICH. COMP. LAWS ANN. §§ 333.17016, 333.17516 (West 1997); MISS. CODE ANN. §§ 41-41-71, 72, 73 (1997); MONT. CODE ANN. § 50-20-401 (1997); NEB. REV. STAT. §§ 28-326, 28-328 (1997); N.J. STAT. ANN. §§ 2A-65A-5, 6, 7 (West 1997); OHIO REV. CODE ANN. § 2919.15 (West 1998); OKLA. STAT. tit. 21, § 684 (1998); R.I. GEN. LAWS §§ 23-4.12-1, 23-4.12-5 (1998); S.C. CODE ANN. § 44-41-85 (Law Co-op. 1997); S.D. CODIFIED LAWS §§ 34-23A-27-32 (Michie 1997); TENN. CODE ANN. § 39-15-209 (1997); UTAH CODE ANN. § 76-7-310.5 (1996); VA. CODE ANN. § 18.2-74.2 (Michie 1998); W. VA. CODE §§ 33-42-3, 33-42-8 (1998); WIS. STAT. § 940.16 (1998). Ballot initiatives which would have created such bans failed in both Colorado and Washington on November 3, 1998. Several other states have "Partial-Birth" abortion bans pending in their legislatures.

208. See James Bopp, Jr. & Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 ISSUES L. & MED. 3, 57 n.3 (1998) for a list of many of the states and cases.

APPENDIX A

*Abortion Procedures—Definitions and Descriptions**INTACT DILATION AND EXTRACTION (D&X)*²⁰⁹

This procedure is extremely rare, comprising less than 1% of all abortions performed annually in the United States. It is performed between eighteen and thirty-two weeks of pregnancy.

For the first two days, the doctor inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are deliberately ruptured. With the guidance of ultrasound, the doctor inserts forceps into the uterus, grasps a lower extremity of the fetus, and pulls it into the birth canal. The skull, which is too large to pass through, lodges in the cervix. The doctor then presses a scalpel or pair of surgical scissors against the base of the fetus's skull, creating an opening. The doctor then inserts a catheter into the opening and evacuates the skull contents. With the head decompressed, the doctor removes the fetus completely from the patient.

The biggest advantage to the procedure is that it requires a minimal amount of cutting and few sharp objects in the uterus. At the later stages of pregnancy, the uterine wall is stretched thin, and is easily torn. This procedure is especially advantageous for women who have uterine scars (from a cesarean section) and are thus more vulnerable to uterine injury, and for diabetics, who are at greater risk of hemorrhaging with other methods. Insuring an intact delivery is beneficial because it prevents pieces of the fetus from being left behind in the mother's uterus: fetal bones could tear the uterine wall, and fetal tissue will break down and cause infection. Finally, many families need to have an intact fetus for the purposes of genetic testing.

The only relative medical disadvantage to the D&X procedure is that it requires a longer time than other methods to dilate the cervix, because the fetus must pass through essentially intact.

*INTACT DILATION AND EVACUATION (D&E)*²¹⁰

This is the more well-known and most common of the late term abortion procedures. Still, it accounts for a very small percentage of the abortions

209. Dr. Martin Haskell, *Dilation and Extraction for Late Second Trimester Abortions*, presented at the National Abortion Federation Conference Fall Risk Management Seminar (Sept. 13-14, 1992).

210. The descriptions of the abortion procedures in the remainder of this appendix were culled from several practitioners' guides, including MODERN METHODS OF INDUCING ABORTION (David T Baird, David A. Grimes, & Paul F.A. Van Look, eds., 1995); WARREN M. HERN, ABORTION PRACTICE (1984); ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS (Jane E. Hodgson, ed., 1981); TECHNIQUES OF ABORTION (Selig Neubardt, M.D. & Harold Schulman, M.D., eds., 1977).

performed in the United States. It is used from thirteen to thirty-two weeks gestation, and is the only procedure available between the thirteenth and sixteenth weeks of pregnancy.

Instead of using metal rods, the doctor inserts a seaweed derivative called laminaria into the cervix to dilate it, over a period of one to two days. A suction curette with a large diameter is then inserted into the uterus, and the doctor dismembers and removes the fetus in pieces. Forceps may also be necessary to effect the dismemberment, particularly for the torso and head. Some doctors crush the skull with forceps, while others use the curette to suction out some of the skull's contents in a manner similar to that used in the D&X procedure.

The D&E procedure causes less pain to the woman than does induced labor. Furthermore, it takes very little time to perform the procedure itself—only between ten and twenty minutes. Finally, it has low rates of complication relative to labor induction methods.

However, this method is still risky. The use of forceps can result in uterine and cervical injuries, and increased blood loss. Also, parts of the fetus, particularly jagged jawbones, may cut the uterus, and tissue left behind will quickly become infected. Fetal neurological tissue may impair a woman's ability to clot.

ASPIRATION/DILATION AND CURETTAGE (D&C)

This is the most common method of first-trimester abortion, used for over 85% of all abortions. The two terms are used interchangeably. In this procedure, the doctor mechanically dilates the opening of the cervix using metal rods. The doctor then inserts a vacuum apparatus into the uterus, and removes the fetus through suction.

Advantages of the procedure include its safety and quickness. D&C abortions are statistically safer for women than childbirth, and are the safest of all forms of abortion. The procedure takes roughly five minutes, and does not require the cervix to be dilated in the days prior to the abortion. The main disadvantage is that the procedure can only be performed within the first twelve weeks of pregnancy. Procedures have been performed up to fifteen weeks, but these are exceptions. Once fetal tissue develops to a certain degree, it becomes too large and "tough" to aspirate from the uterus.

INSTILLATION/INDUCTION—POSTGLANDIN AND SALINE

These are the main alternatives to the surgical D&X and D&E procedures in the late term. They were the most common methods of second trimester abortion in the 1970s, but have since declined in number. In this procedure, the doctor induces full-blown labor. This can be accomplished through either injecting a substance (usually saline or a mixture of postglandin and urea) into the amniotic

cavity of the woman, or by placing postglandin suppositories into the woman's vagina. These substances cause the uterus to start contracting, and the fetus is expelled.

Two advantages to these procedures are that they do not require much skill to perform, and they don't involve the placement of any sharp instruments into the uterus.

The obvious disadvantage is that these procedures result in labor, with all of its potential complications, such as extreme pain, nausea, vomiting, and diarrhea. More serious problems may occur if the amniotic fluid is forced into the mother's bloodstream, resulting in an embolism, or if clotting factors in the blood fail, resulting in disseminated intravascular clotting. These methods may thin out the uterine wall to the extent that the fetus comes through the uterus, rather than down the birth canal. They cannot be performed on dead fetuses, or women who have had previous cesarean sections. These cannot be performed on an out-patient basis. Finally, these procedures are long and painful—labor typically lasts between twelve and twenty-four hours, but make take up to thirty-six.

HYSTEROTOMY/HYSTERECTOMY

These procedures are rarely used today because of their severe risks and harm to fertility. They are late term procedures, usually performed between twenty-two and thirty-two weeks.

Hysterotomy is essentially a Cesarean section performed before term. However, because the uterine wall is still relatively thick, the incision causes more bleeding and may jeopardize future fertility. A more extreme alternative is hysterectomy, in which the doctor removes the uterus completely. Both of the methods entail all the risk of major surgical procedures, and hysterectomy (obviously) destroys a woman's fertility. Neither procedure is performed on an out-patient basis.

APPENDIX B

*Narratives of Women who had the D&X Procedure
(post-viability)²¹¹*

VIKKI STELLA

Parents of two daughters, Vikki and her husband discovered at thirty-two weeks of pregnancy that multiple, devastating anomalies afflicted their long-awaited third child—anomalies that were incompatible with life. Their son, whom they had named Anthony, had only fluid filling his cranium, where his brain should have been, as well as other major problems. She and her husband made “the most loving decision we could have made,” to terminate the pregnancy. Because the procedure preserved her fertility, Vikki was able to get pregnant again. She gave birth to a healthy boy, Nicholas, in December of 1995.

MARY-DOROTHY LINE

In the summer of 1995, Mary-Dorothy was told at twenty-one weeks of pregnancy that her son had an advanced, textbook case of hydrocephalus—an excess of fluid on the brain. Hydrocephalus is sometimes treatable through in utero surgery or treatment after birth. Further testing in the Lines’ case, however, revealed that the hydrocephalus was so advanced that it was untreatable. Practicing Catholics, she and her husband Bill sought a medical miracle, but were told that no surgery or therapy could save their baby. Indeed, the medical experts who reviewed her case told her that her own health was at risk, and so the Lines decided to end the pregnancy. Mary-Dorothy was able to become pregnant again, and gave birth to a healthy baby girl in September 1996.

COREEN COSTELLO

In April 1995, seven months pregnant with her third child, Coreen and her husband Jim found out that a lethal neuromuscular disease had left their much-wanted daughter unable to survive. Her body had stiffened and was frozen, wedged in a transverse position. In addition, amniotic fluid had puddled and built up to dangerous levels in Coreen’s uterus. Devout Christians and opposed to abortion, the Costellos agonized for over two weeks about their decision, and baptized their daughter in utero, naming her Katharine Grace. Finally, Coreen’s increasing health problems forced them to accept the advice of numerous medical experts that the (D&X) was, indeed, the best option for Coreen’s own health. In June of 1996, Coreen gave birth to a healthy son.

211. These descriptions have been reproduced, *verbatim*, from a fact sheet distributed by the National Abortion Federation entitled *Who Would be Hurt by Legislation Banning Some Late Abortions?* (Feb. 1997). These are five women who attended the Rose Garden veto ceremony with President Clinton.

CLAUDIA CROWN ADES

In 1992, in the twenty-sixth week of a desperately wanted pregnancy, Claudia and her husband Richard were told after an ultrasound that their son had a genetic condition called trisomy-13. His anomalies included extensive brain damage, serious heart complications, and liver, kidney and intestinal malformations. His condition was incompatible with life. After consulting with many physicians, Claudia and Richard chose (D&X) as the medically appropriate procedure for Claudia, and the most dignified, compassionate procedure for their son. Claudia and Richard adopted a son in 1996.

TAMMY WATTS

In March 1995, Tammy and her husband Mitch made the agonizing decision to end a wanted pregnancy at twenty-eight weeks gestation. It would have been their first child. The fetus had extensive, ultimately lethal anomalies related to trisomy-13, the same condition that afflicted Claudia Ades' baby. The Watts' daughter, Mackenzie, was missing chambers in her heart. Her brain was severely damaged, and her skull had not formed in the back. Her liver and kidneys were oversized and already failing irreparably. Her bowel, bladder and intestines were formed on the outside of her body and had grown into a non-functioning mass of tissue. Doctors also told the couple that Tammy's health was at risk from a continued pregnancy, especially if the baby died in utero.

*Narrative of a Girl Who had the D&X Procedure*²¹²*"GIRL DOE"*

Doe is a twelve-year old girl whose family recently immigrated from India to Sterling Heights, Michigan. In July of 1998, the girl visited the doctor and was told that her abdominal pains, previously misdiagnosed as digestive problems, were really caused by the fact that she was over twenty weeks pregnant. The father of the fetus was the girl's seventeen-year old brother, who had raped her the previous winter. A family court judge temporarily removed the girl from her parents' custody after being tipped off that the family was planning to travel to a nearby state to obtain an abortion. At a court hearing on the matter, her doctor argued that the pregnancy could imperil the girl's physical and mental health. A psychologist testified that, as a Hindu, having an out-of-wedlock child would make her an outcast unfit for marriage. The girl's family raised the possibility that the baby could suffer genetic abnormalities, such as retardation, as a result of the incest. Ultimately the judge returned custody of the girl to her parents, and she was able to obtain the abortion in Wichita, Kansas. Prosecutors are considering criminal charges against the brother.

212. This account was taken from Bill Roy and Suzanne Siegel, *Youth, Incest - And Abortion*, NEWSWEEK, Aug. 10, 1998, at 52.