RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Relating also to the conscience issue, some groups that advocate for abortion have asserted that federal law already requires that hospitals, including private religious hospitals, must perform abortions in circumstances that someone considers to be "emergencies," however that term might be defined under the laws of a given state or under federal regulatory guidance, now or in the future. The federal law that they cite as support for this assertion is the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act. Do you agree with this characterization of current federal law?*

We are aware that some pro-abortion groups have adopted this tortured misconstruction of federal law. The law in question, EMTALA [42 U.S.C. 1395dd] requires a hospital to treat a patient, regardless of ability to pay, if she shows up at an emergency room with an "emergency medical condition." This law explicitly defines "emergency medical condition" to include a condition "placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy," and it requires the hospital to stabilize the condition before transferring any such patient. The notion that a law that explicitly seeks to protect the "unborn child" from medical jeopardy and that requires hospital personnel to stabilize the conditions of both patients (mother and child), actually requires medical personnel to *kill* that unborn child, is absurd on its face.

Certainly, EMTALA does obligate hospitals to provide emergency treatment for women who are injured while undergoing abortions or attempted abortions, but it does not require health-care providers to violate their consciences by killing one of their patients. The adoption of this interpretation of EMTALA by groups such as the ACLU merely provides another illustration of how far these groups are prepared to go in their attempts to coerce medical personnel into collaborating in the killing of unborn children. S. 1696 would provide these pro-abortion ideologues a much more powerful legal weapon to use for their coercive purposes.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *During the hearing, Senator Blumenthal suggested that S. 1696 contains an exception to protect current laws against government funding of abortion. Do you agree with Senator Blumenthal on this point? If not, please explain why.*

There is no such exception in S. 1696. There are a number of federal laws that limit funding of abortion under various federal programs. The majority of states also have in place laws that exclude elective abortion from various government entitlement programs that provide coverage of medical services in general, or of "family planning" services in particular. Most of these laws would be subject to legal attacks based on the provisions of S. 1696.

Section 4(d) of S. 1696 is a "Limitation" that incorporates four exceptions to the prohibitions contained elsewhere in the bill; these are summarized in endnote no. 6 of my written testimony. One of these exceptions is for "insurance coverage of abortion." This language would apparently shield from S. 1696-based legal attacks those state laws, now enacted by half of the states, that limit coverage of abortion under health insurance plans sold on the Obamacare exchanges. ((Most of these laws were enacted in response to a provision of Obamacare, 42 U.S.C. §18023(a), although some states had enacted such laws even before enactment of Obamacare.)) However, there is no reason to suppose that laws such as the Hyde Amendment would be protected by this reference to "insurance coverage of abortion." The Hyde Amendment is a limitation attached to the annual Department of Health and Human Services appropriations bill, which prohibits funds that flow through that bill from paying for abortions or for health plans that cover abortions, except in cases of rape, incest, or to save the life of the mother. The most important single effect of the Hyde Amendment is to prevent federal reimbursement for elective abortions, or for health plans that cover elective abortion, under Medicaid. But Medicaid is not an "insurance" program as the term is usually used in federal or state law – it is a government health-care entitlement program. It is not at all clear that courts would find that entitlement programs such as Medicaid fall within the scope of what is covered by the phrase "insurance coverage of abortion," especially in view of other language in S. 1696 that instructs the courts that "in interpreting the provisions of this Act, a court shall liberally construe such provisions to effectuate the purposes of the Act." The purposes of the act are clearly to remove impediments to access to abortion, explicitly defined by S. 1696 to include any government policy that increases the costs of abortion to an individual, even indirectly. Thus, any ambiguity will be resolved by nullifying the laws

that impede access to abortion, such as the Hyde Amendment and its state-level counterparts.

The ambiguity is, of course, by design. It is clear that the drafters of S. 1696 wish to keep the door open to attack the Hyde Amendment and the similar laws, in effect in most states, that prohibit government funding of elective abortions under entitlement programs such as Medicaid. If they had really wished to shield such laws from the prohibitions in S. 1696, they could easily have included unambiguous language to do so. Indeed, the antecedent to the "Women's Health Protection Act," which was the "Freedom of Choice Act" (FOCA), when it was approved by the Senate Committee on Labor and Human Resources on April 29, 1993, contained an unambiguous exception for state laws limiting government funding of abortion, which read: "Nothing in this Act shall be construed to . . . prevent a State from declining to pay for the performance of abortions."

Even if, for the sake of argument, one were to accept the notion that the laws that limit Medicaid coverage of abortion would be considered laws dealing with "insurance coverage of abortion," there are other existing prohibitions on government funding of abortion that nobody could argue have anything to do with "insurance coverage," and that clearly would be subject to legal attack and invalidation under S. 1696. To cite just two examples at the federal level: (1) The Helms Amendment of 1973, a provision of the Foreign Assistance Act of 1973 [22 U.S. Code §2151b(f)(1)] prohibits U.S. foreign aid funds for development from being expended for abortion. (2) A major federal "family planning" program, Title X of the Public Health Service Act, contains a provision enacted in 1970 that states, "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." [42 U.S.C. § 300a–6.]

Thus, it is quite clear that S. 1696 would result, at a minimum, in federal taxpayer funding of abortion through both the major domestic family planning program and through U.S. foreign aid programs.

Response from NRLC President Carol Tobias to question from Senator Charles Grassley regarding the relative "safety" of abortion
August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Nancy Northup, president and CEO of the Center for Reproductive Rights, in her written testimony to the Committee, on pages 5-6, stated that Mary Spaulding Balch, state legislative director for National Right to Life, recently "openly criticized the [pro-life] movement's cynical focus on women's health because it is so clearly unconnected to the reality of how safe abortion is." Ms. Northup asserted that Ms. Balch "conceded that data show that abortion, even after the first trimester, carries a lower risk of serious complications than vaginal births, cesarean sections, and even plastic surgery procedures such as facelifts and liposuction. And she recognized the absurdity of asserting women's health as a rationale for some of the stringent laws legislators have been leveling at abortion care . . ." These statements by Ms. Northup were all based, according to a footnote, on a single article by Sofia Resnick that appeared on the "pro-choice" advocacy website RH Reality Check on July 2, 2014. Did Ms. Northup's testimony accurately reflect the position of your organization? Please offer any additional observations that would clarify, give context to, or otherwise illuminate the statements made by Ms. Northup or the thrust of the underlying article by Ms. Resnick.*

Response of Carol Tobias, President, National Right to Life Committee:

Is abortion safer than childbirth? Looking at the medical evidence, National Right to Life doesn't think so. Obviously, abortion is not safer for the unborn child, reason enough to oppose the practice. Moreover, claims that the abortion procedure is seven,[1] eleven,[2] fourteen,[3] twenty-three,[4] or "hundreds of"[5] times safer for the mother than childbirth, don't hold up to scrutiny.

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[1] S.A. LeBolt, David A. Grimes, Willard Cates, Jr., "Mortality from abortion and childbirth. Are the populations comparable?" *Journal of the American Medical Association*, Vol. 248, No. 2 (July 1982), pp. 1880191.

[2] Susanne Pichler, "Medical and Social Health Benefits Since Abortion Was Made Legal in the U.S." Planned Parenthood Federation of America, Fact Sheet (December 2004), available at http://mcadams.posc.mu.edu/blog/fact-abortion-medical-social-benefits.pdf, accessed 7/24/14.

[3] E.G. Raymond, David A. Grimes, "The comparative safety of legal induced abortion and childbirth in the United States," *Obstetrics & Gyncecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

[4] Original cite of ACOG Amicus Brief for *Doe v. Bolton*, cited by Willard Cates, Jr. David A. Grimes, L. Lynn Hogue, "Topics for Our Times: Justice Blackmun and Legal Abortion – A Besieged Legacy to Women's Reproductive Health," *American Journal of Public Health*, Vol. 85, No. 9 (September 1995), pp. 1204-6.

[5] Leroy Carhart, speaking on "A Woman's Choice, a Nation Divided," Anderson Cooper 360 Degrees, CNN, June 5, 2009.

Even ignoring the bias of the researchers responsible for publishing these estimates, many of them longtime pro-abortion activists, there are a number of problems with statistics making this claim.

Most of these claims, if they involve data of any kind, rest at some point on maternal mortality rates and abortion mortality figures from the U.S. Centers for Disease Control (CDC). Though the data represent real lost lives, use of these figures is problematic. As CDC Director Dr. Julie Gerberding acknowledged in a July 20, 2004 letter (attached): "These measures are conceptually different and used by the CDC for different public health purposes."[6]

As the CDC letter states, "maternal mortality is computed as all maternal deaths per 100,000 live births," while "the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions." The Pregnancy Mortality Surveillance System used by the CDC to track maternal mortality says that "a pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[7]

Under such circumstances, efforts to contrast maternal and abortion mortality are akin to comparing apples to oranges. Why?

> 1) Most dramatically, if pregnancy-related maternal deaths *include maternal deaths from abortions*, this makes pregnancy in general appear more dangerous by including those maternal abortion deaths along with those that occur during childbirth.
>
> 2) While abortion maternal mortality is compared to the total number of abortions, the pregnancy-related maternal death statistic is *not* compared to the total number of pregnancies – it is based on the number of live births, omitting miscarriages and induced abortions. The inaccurately smaller denominator inflates the value of the numerator, making the fraction -- in this case, maternal mortality -- seem higher than it actually is, e.g., ½ is greater than 1/3.

Moreover, to accurately compare mortality rates from abortion and childbirth requires that we have complete and accurate data on deaths related to each outcome. While an attempt has been made to identify and collect data on pregnancy-related deaths,[8] efforts to get a full count of abortion-related deaths are hampered by a number of problems.

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[6] Letter of July 20, 2004 from Julie L. Gerberding, M.D., M.P.H., Director of U.S. Centers for Disease Control, to Walter M. Weber, American Center for Law & Justice.

[7] CDC webpage for Pregnancy Mortality Surveillance System at http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html, accessed 7/29/14.

[8] The Centers for Disease Control and Prevention began its Pregnancy Mortality Surveillance System in 1986. See information of the government program at http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html, accessed 7/24/14.

While women giving birth are followed for a year after, women who have abortions and die may never be counted in U.S. abortion mortality statistics.[9] If they contract a fatal bacteria or bleed to death as a result of their abortion procedure, the death will be attributed to the infection or the hemorrhage, but there may not even be any notation of the abortion, or perhaps even the pregnancy on the death certificate.[10]

On occasion, it may be that the omission is deliberate, in order to spare families embarrassment or the reputation of abortionist involved,[11] but with the advent of chemical abortions, it is entirely possible that the physician handling the fatal complication may have no knowledge of the abortion.[12]

Given the problems and limitations of U.S. maternal mortality data, any claim of abortion's relative safety against childbirth is suspect with many abortion related deaths unreported and uncounted.[13]

A much better gauge comes from countries which track each patient encounter across the entire health system, so that individual outcomes can be reported over time even where there are multiple providers.

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[9]Many government and medical sources are cited in examples by David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy,* Vol. 20, No. 2 (2002), pp. 279-327.

[10] *Ibid*, and A.P. Mackay, R. Rochat, J.C. Smith, C.J. Berg, "The check box: determining pregnancy status to improve maternal mortality surveillance." *American Journal of Preventive Medicine*. Vol. 19, Supplement 1 (July 2000), pp. 35-9.

[11] David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy,* Vol. 20, No. 2 (2002), pp. 279-327.

[12] One group, Women on Waves, specifically tells women that if they need to go to the hospital they do not need to say that they took misoprostol pills to induce an abortion.

> Misoprostol causes a miscarriage. The symptoms of a miscarriage and an abortion with pills are EXACTLY the same and the treatment is EXACTLY the same. **You do not need to say that you took the medicines**. If you took the medicines as instructed at www.womenonwaves.org, they dissolve and there is no test that can tell a doctor or nurse that you took medicines.

http://www.womenonwaves.org/en/page/711/in-collection/702/using-medications-pills-to-end-an-unwanted-pregnancy-in-the-usa, accessed 7/24/14.

[13] In *Victims of Choice* (1996), private investigator Kevin Sherlock examined death certificates and other public information and matched these against state statistics and found that there were many abortion related deaths that were not reported.

Studies from Finland, where there has been a nationwide and modern healthcare system and reporting in place for a number of years, provide more reliable data.

Linking data from national birth, death, abortion, and hospital discharge records in Finland from 1987 to 2000 for all deaths for females of reproductive age (15-44), Mika Gissler and colleagues from the National Research and Development Centre for Welfare and Health found data showing mortality rates at one year out for aborting women more than three times what it was for women giving birth.[14]

One thing the Finnish data makes plain is that pregnancy-related mortality is more than just a matter of the relative safety of a given medical procedure. And in this regard, the heavy psychological and social costs of abortion over childbirth become readily apparent.

In a second study using the same data set, Gissler and colleagues found that mortality rates for abortion were 11 times higher for homicide, more than six times higher for suicide, and even more than five times higher for unintentional injuries than they were for pregnancy or birth one year after the event. For each cause, the mortality rate was also higher for abortion than it was for non-pregnant women or those dealing with miscarriage or even ectopic pregnancy.[15]

State data from California are consistent with this result. A study looking at maternal deaths associated with Medicaid-eligible women having abortions or delivering babies in 1989 one year out found the aborting women nearly three times (2.88) as likely to die a violent death than those giving birth. Researchers found a good portion of this higher rate associated with suicide.[16]

Activist researchers defending the abortion industry may have reason to be selective in their data sets, but when outcomes are more consistently and completely tracked, it is clear that abortion is *not* safer than childbirth.[17]

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[14] Mika Gissler, Cynthia Berg, Marie Hélène Bouvier-Colle, Pierre Buekens, "Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000," *American Journal of Obstetrics and Gynecology*, Vol. 190, No. 2 (Feburary 2004), pp. 422-7.

[15] Mika Gissler, Cynthia Berg, Marie Hélène Bouvier-Colle, Pierre Buekens, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European Journal of Public Health*, Vol. 15, No. 5 (October 2005), pp. 459-463.

[16] David C. Reardon, Priscilla Coleman, "Pregnancy-associated mortality after birth," Letter to the Editors, *American Journal of Obstetrics and Gynecology*, Vol. 191, No. 4 (October 2004), pp. 1506-7.

[17] There is a dramatic inconsistency between abortion advocates'claims concerning the physical safety (for the mother) of abortion, coupled with their repeated assertions that health regulations proposed for abortion are unnecessary, on the one hand, and their oft-repeated argument that if legal protection against abortion is provided to unborn children in the future, a result will be maternal mortality from illegal abortion comparable to what occurred in the pre-penicillin early years of the 20th century, on the other hand. As comprehensively demonstrated

That said, there are practical and principled reasons why National Right to Life believes that it is not wise to make the relative safety of childbirth over abortion the over-arching theme for advancing pro-life legislation. If one treats the abortion debate purely as a matter of relative safety, it makes the policy beholden to whatever the latest popular study might say, no matter how poor the data or methodology.

NRLC's state legislative director Mary Spaulding Balch, J.D., speaking at National Right to Life's convention in Louisville in June 2014, pointed out that there are studies that exist showing procedures with higher mortality rates than abortion (if the nearly 100% mortality of the unborn child is excluded).

Balch also included statistics from one hospital in India showing a higher mortality rate from cesarean sections than from vaginal deliveries, which she noted would be not be expected to lead to a statute prohibiting c-sections.[18] That context has been largely missing in most coverage of those remarks.

Defenders of abortion will produce, as the need requires, inadequately backed studies, such as the latest by Raymond and Grimes.[19] The mainstream news media and the medical establishment can be expected to cite claims that "abortion is X times safer than childbirth" as an undisputed fact, without reflecting the gaps in the data on which these claims are based.

The debate over relative safety should not obscure the fundamental problem with abortion, which is that it is the intentional destruction of human life.

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by Cynthia McKnight in "Life Without Roe: Making Predictions About Illegal Abortions" (available at www.nrlc.org/uploads/stateleg/LifeWithoutRoe1992.pdf) "the continuing decrease in maternal deaths related to abortion–both legal and illegal–was the result, not of the legalization of abortion, but of continued medical progress.

[18] The study reported a maternal death risk of 27 per 13, 637 c-sections versus 19 per 30,215 vaginal deliveries However, the cited article [G. Kamilya, S.L. Seal, J. Mukherji, S.K. Bhattacharyya, A. Hazra, "Maternal mortality and cesarean delivery: an analytical observational study," *The Journal of Obstetrics and Gynaecology Research*, Vol. 36, No. 2 (April 2010), pp. 248-53] reports a study specifically intended to fill "a dearth of data from developing countries" and covers results from one hospital in Kolkata, India from 2003 to 2006. It cannot be directly applied to the United States; indeed, the article itself cites a "'literature review' from developed countries [which] concluded that there may not be an increased risk of maternal mortality with elective CD compared to VD." In any event, neither the maternal mortality rate associated with vaginal delivery nor that associated with cesarean sections reported in this one hospital in India can reliably be used in direct comparison with maternal mortality from abortion in the United States.

[19] E.G. Raymond, David A. Grimes, "The comparative safety of legal induced abortion and childbirth in the United States," *Obstetrics & Gynecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 6

Pro-lifers care about the life and safety of the mother, because we care about the life of each and every human being, no matter their age or stage of development. But it will not be enough to make abortion safe or safer for the mother, since it still fundamentally entails the death of the innocent child.

One expects that there will always be risk involved in both abortion and childbirth. Though the psychological ramifications for those women having abortions or giving birth will be quite divergent and are likely to entail significant consequences, it is true that within both groups most women are unlikely to encounter any immediate medical crises. There is much dispute over whether the aborting women or the childbearing women are likely to experience the most complications and negative consequences. National Right to Life firmly believes that the heavier burden will be borne by those who abort.

But even for a woman who suffers no immediate physical consequences, there is a huge difference between an outcome that leaves her with a dead baby and a live one. The lives of both the mother and the child are precious to National Right to Life, and so we will continue in our efforts to oppose abortion and to see every child welcome in life and protected in law.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

JUL 20

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:

1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions) in the United States have been published only since the 1970s.
2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 150 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Nancy Northup, president and CEO of the Center for Reproductive Rights, repeatedly indicated that a law would be permissible under S. 1696 if regulated abortion is done in the same manner as other "similar" procedures. She said, "I think what's really critical about the bill . . . is right from the start, if this is something that is treating medically similar practices and procedures and services the same, there's no objection, nothing's going to be struck." The bill itself uses the term "medically comparable procedures," and in your written testimony, you discuss the ambiguity of the term "medically comparable," and difficulties in applying that term to abortion. Taking this into consideration, consider this possibility: Law X is a state law that regulates all centers in which surgical procedures are performed, and although Law X does not mention abortion, surgical abortion centers are obviously within the scope of the law. Let's even go a step further and stipulate, purely for purposes of my question, that a federal court finds that for purposes of reviewing this Law X under the terms of the federal law, S. 1696, abortion is indeed a "medically comparable procedure." Is Ms. Northup correct in suggesting that, once a court has concluded that Law X treats abortion the same as other "medically comparable procedures," Law X is therefore permissible under S. 1696?*

Regarding the manner in which S. 1696 would operate, Ms. Northup's testimony was an exercise in indirection. Under S. 1696, even a law that treats abortion exactly the same as other "medically comparable procedures" is presumptively invalid, if that law in any way diminishes access to abortion, or is claimed to do so.

For purposes of this analysis, one should ignore the verbose "findings and purposes" section of the bill, and go directly to key operative language, which is found in Section 4 of the bill. Section 4(b)(1), headed "Other prohibited measures or actions," provides that any "measure or action" that restricts abortion is unlawful if it "singles out abortion services" *or* if it would "make abortions services more difficult to access . . ." Likewise, Section 4(b)(2) says that a law is *prima facie* unlawful if the plaintiff demonstrates that the measure "singles out the provision of abortion services" *or* "impedes women's access to abortion services . . ."

In her verbal testimony, Ms. Northup sought to leave the impression that an abortion-impacting law is presumptively invalid only if it both singles out abortion *and* diminishes access – but in reading a statute, the difference between "or" and "and" is often all

important, and in S. 1696, the conjunction is "or." In short, S. 1696 is clearly and deliberately structured to create two separate and distinct routes for attacking a state or federal law that directly or indirectly affects abortion providers.

The "Law X" postulated in the question treats abortion exactly the same as other surgical procedures. Yet that fact would be essentially irrelevant under the actual language of S. 1696, because Law X would simply be attacked under the separate and distinct prohibition on laws that diminish "access" to abortion.

Section 4(b)(3) provides a list of seven "factors for a court to consider in determining whether a measure or action impedes access to abortion services." The first factor on the list is "whether the measure or action interferes with an abortion provider's ability to provide care and render services in accordance with her or his good-faith medical judgment." That single factor alone is so open-ended – essentially directing the federal courts that the "medical judgment" of any given abortionist should be deemed to trump a state's regulatory requirements – that the rest of the list hardly matters. Still, it should be noted that the rest of the list condemns, among other things, any regulations that might "delay some women in accessing abortion services" or are "reasonably likely to directly or indirectly increase the cost of providing abortion services or the cost for obtaining abortion services . . ."

Once a law is found to be *prime facie* invalid, *either* because it "singles out" abortion *or* because it is deemed to affect the provision of abortion services "directly or indirectly," it will be nullified unless the government can demonstrate by "clear and convincing evidence" (a high standard of proof) that the measure "significantly advances the safety of abortion services or the health of women," *and* that these interests "cannot be advanced by a less restrictive alternative measure or action."

Thus, a challenged law will not be saved by production of "clear and convincing" proof that it does no harm to the health of women (or actually advances health and safety of women, but not "significantly"), and that it advances other important governmental interests – for example, the value that a state sees in the life of an unborn child, at least after viability, or the sincerely held conscience rights of pro-life doctors, nurses, and other health care providers. In fact, the challenged law will not be saved even by production of "clear and convincing" proof that it actually protects the "health of women," or even by a demonstration that it "significantly advances" the health of women, unless the government can also prove that there is no "less restrictive alternative measure . . ." of advancing safety. Section 5 of the bill further instructs that "a court shall liberally construe" all of these requirements "to effectuate the purposes of the Act" – those purposes being, of course, to remove any requirement that would directly or indirectly

delay access to or increase the cost of any abortion, sought for any reason, at any point in pregnancy.

In summary: S. 1696 is not a formula for requiring that abortion be treated exactly the same as other "medically comparable procedures." (As I explained in my written testimony submitted for the July 15 hearing, that would be bad enough, since abortion is different from all other "medical procedures" and the U.S. Supreme Court has recognized that difference, as do most Americans.) Rather, S. 1696 would shield abortion providers from regulation and oversight to a unique degree, with the judgment of abortion providers substituted for the judgment of legislative and regulatory bodies that regulate all other fields of medical practice.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *At the hearing I asked Ms. Northup whether a waiting period for elective abortion would be permissible under S. 1696. She said it would depend on various factors, yet she evaded my repeated requests that she name a single state waiting-period law that might survive under the bill. Do you believe that a state law requiring a waiting period prior to an elective abortion could survive under the prohibitions that S. 1696 would impose, and if not, why not?*

The waiting-period or reflection-period laws are specific to abortion, and therefore are presumptively invalid under S. 1696's prohibition on singling out abortion. If a state somehow crafted a law that required a waiting period not only for abortion but also for all other "medically comparable procedure[s]," that law would simply be attacked under the separate and distinct alternative prohibition contained in S. 1696, which renders presumptively invalid any law that directly or indirectly reduces "access" to abortion. The bill explicitly provides that "whether the measure or action is reasonably likely to delay some women in accessing abortion services" is a factor to be considered by a court "in determining whether a measure or action impedes access to abortion services for purposes of" the prohibition. It seems self-evident that a mandatory delay violates this prohibition.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *In your testimony to the Committee, both verbal and written, you asserted that S. 1696 would result in invalidation of federal and state laws that protect individual doctors, nurses, and other health-care providers, and usually private institutions as well, from being penalized for declining to participate in the providing of abortions. These are often referred to as "conscience protection laws," although some of the critics of such laws call them "refusal clauses." During the question period at the hearing, when I suggested to Nancy Northup, president and CEO of the Center for Reproductive Rights, that the bill would result in invalidation of the conscience laws, she said, "I don't agree. This legislation doesn't address the issue of conscience objection." However, she did not explain how these laws could survive scrutiny under the tests imposed by the bill, and she was evasive when I asked her if she would endorse an amendment to S. 1696 exempting these laws from the scope of the bill. Do you have any comment on Ms. Northup's claim that the bill "does not address" the issue of conscience protection laws, and could you please explain the process of judicial analysis that you believe would result in invalidation of these laws under S. 1696?*

S. 1696 "doesn't address" conscience protection laws only in the sense that they are not explicitly mentioned, but of course this is completely irrelevant, since they clearly fall within the general prohibitions in the bill, which render presumptively invalid any laws that either treat abortion differently from other "medically comparable procedures" *or* that directly or indirectly reduce "access" to abortion services.

I will use as examples the two conscience protection laws in effect in South Carolina. South Carolina Code Ann. § 44-41-50 states in part:

> (a) No physician, nurse, technician or other employee of a hospital, clinic or physician shall be required to recommend, perform or assist in the performance of an abortion if he advises the hospital, clinic or employing physician in writing that he objects to performing, assisting or otherwise participating in such procedures. Such notice will suffice without specification of the reason therefor.
>
> (b) No physician, nurse, technician or other person who refuses to perform or assist in the performance of an abortion shall be liable to any person for damages allegedly arising from such refusal.
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> (c) No physician, nurse, technician or other person who refuses to perform or assist

> in the performance of an abortion shall because of that refusal be dismissed, suspended, demoted, or otherwise disciplined or discriminated against by the hospital or clinic with which he is affiliated or by which he is employed. A civil action for damages or reinstatement of employment, or both, may be prosecuted by any person whose employment or affiliation with a hospital or clinic has been altered or terminated in violation of this chapter.

South Carolina Code Ann. § 44-41-40 states:

> "No private or nongovernmental hospital or clinic shall be required to admit any patient for the purpose of terminating a pregnancy, nor shall such institutions be required to permit their facilities to be utilized for the performance of abortions. No cause of action shall arise against any such hospital or clinic for refusal to perform or to allow the performance of an abortion if the institution has adopted a policy not to admit patients for the purpose of terminating pregnancies; provided, that no hospital or clinic shall refuse an emergency admittance."

These statutes clearly provide certain specified immunities, with respect to refusal to participate in abortion, that do not apply to other "medically comparable procedures." Therefore, under S. 1696, anyone challenging such a law would easily establish a *prima facie* case that the laws are invalid. The laws would then be nullified unless the state can convince a federal judge, by clear and convincing evidence, that these laws significantly increase the safety of abortion practice or otherwise advance women's health, and that there is no "less restrictive" way to accomplish those purposes. But of course, these laws were enacted for the purpose of protecting conscience rights. It will avail the state nothing to show that they do no harm to women's health – they will be invalidated.

Nor would it change the situation if the state legislature were to enact new laws that would apply to a broader range of medical procedures. Any conscience law that could be invoked by a health care provider to avoid participation in providing abortions would be subject to attack under the alternate prohibition in S. 1696, which is the prohibition on laws that directly or indirectly reduce "access" to abortion – whether or not they single out abortion. It would be easy for those attacking the new law to show that it was being used or would be likely to be used by health care providers who object to participating in abortion. It is self evident that the effect "is reasonably likely to result in a decrease in the availability of abortion services in the State," at which point the law is presumptively invalid under S. 1696.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *Regarding the impact of S. 1696 on the ability of states to limit late abortions: In her testimony, Nancy Northup, president and CEO of the Center for Reproductive Rights, suggested that S. 1696 simply reiterates the current "constitutional standard," which, she suggested in her written testimony, draws a sharp demarcation at "viability." Do you agree with Ms. Northup's reading on what the current "constitutional standards" are, regarding limits on late abortions, and do you agree with those who suggest that S. 1696 does nothing more than codify the current "constitutional standard" with respect to regulation of abortion?*

It is striking that in purporting to explain to the Committee the "constitutional standard" regarding regulation of abortion, particularly late abortion, Nancy Northup made no reference in either her written or verbal testimony to the most recent U.S. Supreme Court decision concerning abortion – *Gonzales v. Carhart*, the 2007 ruling in which the Supreme Court upheld the federal Partial-Birth Abortion Ban Act [550 U.S. 124 (2007)].

When Congress was still considering enactment of that statute, Northup's organization – among others – told Congress that it was unconstitutional, because it placed an "undue burden" on abortion before "viability," and because it contained no open-ended "health" exception. In short, they said pretty much the same things they are now saying about the Pain-Capable Unborn Child Protection Act, S. 1670/H.R. 1797, and about the Pain-Capable Unborn Child Protection bills that have been considered in various state legislatures and enacted in ten states, beginning with Nebraska in 2010.

Does Northup neglect to mention *Gonzales* because she considers the Supreme Court's holdings in *Gonzales* to be insignificant, or irrelevant to determining the current "constitutional standard"? This seems unlikely. In her dissent to *Gonzales,* Justice Ruth Bader Ginsburg (the Supreme Court justice who most vigorously articulates the doctrines also embraced by the Center for Reproductive Rights) vehemently denounced Justice Kennedy's majority opinion, which she clearly viewed as a highly significant shift in the Court's doctrine on regulation of

abortion. Justice Ginsburg wrote:

> The Court's hostility to the right *Roe* and *Casey* secured is not concealed. . . . A fetus is described as an "unborn child," and as a "baby," . . . second-trimester, previability abortions are referred to as "late-term," . . . and the reasoned medical judgments of highly trained doctors are dismissed as "preferences" motivated by "mere convenience." . . . Instead of the heightened scrutiny we have previously applied, the Court determines that a "rational" ground is enough to uphold the Act. . . And, most troubling, *Casey*'s principles, confirming the continuing vitality of the "essential holding of *Roe*," are merely "assume[d]" for the moment . . . rather than "retained" or "reaffirmed."

Law Professor Khiara M. Bridges of Boston University, who was previously an academic fellow with the Center for Reproductive Rights, elaborated on the perceived shift in Supreme Court doctrine in her article "Capturing the Judiciary: *Carhart* and the Undue Burden Standard" (*Washington & Lee Law Review*, 67 Wash & Lee L. Rev. 915, Summer 2010). (Prof. Bridges specifically thanked the Center for Reproductive Rights "for providing financial support during the writing of this article.") Referring to the ruling as *Carhart,* Bridges wrote:

> Note that when Blackmun [in *Roe v. Wade*] announces one of the fundamental holdings of the decision, he refers to previable fetuses as in possession of "potential life" and postviable fetuses as in possession of a, without qualifications, "life." Viability, then, is the point at which the *potential life* of the fetus emerges as a *life,* thereby affording the fetus a whole or quasi-whole membership within the human community – and thereby making it a legitimate target for regulations designed to protect it. If we accept the above reasoning as justification for assigning constitutional significance to viability, then one understands as highly significant Justice Kennedy's casual assertion in [*Gonzales v.*] *Carhart* that the "fetus is a living organism while within the womb, whether or not it is viable outside the womb," as well as his relatively cavalier description of the pre- and post-viability abortion procedures at issue as concerning "a particular manner of ending fetal *life*." **With these simple pronouncements, the majority asserts the *insignificance* of viability as a site distinguishing potential life from unqualified life.** With this pronouncement, *Carhart*

> makes the "bright line" of viability no more than an arbitrary moment, a moment among moments, within the continuous, always already "life" of the fetus. **As such, *Carhart* can be read to eliminate the significance of viability as a marker, and therefore eliminate the significance of the distinction between the pre-viable and post-viable stages of pregnancy.** What follows from the evanescence of the distinction between pre- and post-viable stages of pregnancy and the differing levels of gravity that have been attributed to them is that the justification for curbing the ability of the state to proscribe abortions outright during pre-viability is also eliminated. [boldface added for emphasis]

Consider also the analysis of Randy Beck, associate professor of law at the University of Georgia Law School, a former clerk to Justice Anthony Kennedy, in his essay "*Gonzales,* Casey, and the Viability Rule" (*Northwestern University Law Review*, Vol. 103, No. 1, 2009). Beck notes that Justice Kennedy, in his dissent in *Stenberg* in 2000, 530 U.S. 914, 962, wrote that "[a] State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others."

Beck goes on to argue that in the 2007 *Gonzales* ruling, Kennedy and the other four justices in the majority merely "assumed" the continued application of the viability doctrine but did not actually reaffirm it. (Even in the 1992 *Casey* ruling, which reaffirmed the "core holdings" of *Roe v. Wade*, "the plurality's retention of the viability rule can be viewed as dicta," Beck asserts -- meaning language that was not essential to the issues in the case and that therefore has no precedential force.) More importantly, Beck argues that the overall logic of the *Gonzales* ruling will make it difficult for the Court to articulate a convincing constitutional principle as to why future laws protecting unborn children *prior to viability* are constitutionally invalid.

> The Court's conclusion [in *Gonzales v. Carhart*] that Congress can legitimately protect the previable fetus from a brutal death through the intact D&E [partial-birth abortion] procedure raises the question why a legislature may not protect the same fetus from other brutal abortion techniques. The possible distinction the majority perceived between intact D&E and standard D&E abortions offers little assistance in justifying the viability

> rule. To say that a legislature *may* distinguish between the two procedures for *legislative* purposes does not show why it *must* distinguish between them on *constitutional* grounds. If a legislature may view the previable fetus as a being that warrants protection against the intact D&E procedure, it should be able to protect the same fetus against the standard D&E. The dignity of the not-quite-viable fetus does not change depending on the method by which it will be aborted.
>
> Prior to *Gonzales*, if the Court sought to justify the viability rule, it would have needed to present a principled constitutional theory interrelating state power and fetal entitlement such that the state interest in protecting fetal life (a) exists at the outset of pregnancy, (b) grows in strength as the pregnancy progresses, but © does not become strong enough to warrant a prohibition of abortion until the precise moment that the fetus can survive outside the womb. In the post-*Gonzales* world, the task of establishing the legitimacy of the viability rule has become significantly more demanding. Now if the Court wishes to justify the viability rule in a manner consistent with its precedents, it will need an even more subtle and discriminating constitutional analysis, capable of explaining why the state may ascribe sufficient value to a previable fetus to protect it against death by one means, but may not value it sufficiently to protect it against death by other means. It must offer a principled constitutional theory interrelating state power and fetal entitlement, such that the state interest in protecting fetal life (a) exists at the outset of pregnancy, (b) grows in strength as the pregnancy progresses, (c) warrants protecting a previable fetus against an intact D&E abortion due to the similarity of that fetus to a newborn infant, but nevertheless (d) does not warrant protecting the fetus from other abortion methods until it can survive outside the womb.

Going all the way back to *Roe v. Wade*, the U.S. Supreme Court has recognized a compelling state interest in protecting the life of the unborn child after "viability." But the current Supreme Court recognizes that there are other compelling state interests pertaining to unborn children, and recognizes that they begin prior to "viability." Justice Anthony Kennedy – widely understood to be the decisive fifth vote in abortion cases – has written:

> [In *Casey v. Planned Parenthood,* 1992] We held it was inappropriate for

> the Judicial Branch to provide an exhaustive list of state interests implicated by abortion. 505 U.S. at 877. *Casey* is premised on the States having an important constitutional role in defining their interests in the abortion debate. It is only with this principle in mind that Nebraska's interests can be given proper weight. . . .
>
> States also have an interest in forbidding medical procedures which, in the State's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful, to life, including life in the human fetus. . . . A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others. *Stenberg v. Carhart*, 350 U.S. 914, 961-62 (2000)(Kennedy, J., dissenting)

While those statements were made while Justice Kennedy was in the minority in *Stenberg*, which struck down Nebraska's Partial-Birth Abortion Ban Act in 2000, in 2007, with a differently composed Court, he wrote for the majority in *Gonzales v. Carhart*.

It should be noted that the federal Partial-Birth Abortion Ban Act was upheld although it made no distinction based on viability:

> "The [Partial-Birth Abortion Ban] Act does apply both previability and postviability because, by common understanding and scientific terminology, a fetus is a living organism while within the womb, whether or not it is viable outside the womb." *Gonzales*, 550 U.S. at 147.

Indeed, in her dissent, Justice Ginsburg complained that the Court's ruling "blurs the line, firmly drawn in *Casey*, between previability and postviability abortions."

Thus, while Nancy Northup in her testimony attempted to maintain the pretense that the Supreme Court continues to adhere to a rigid demarcation at "viability," both the majority ruling and the dissent in *Gonzales* provide clear evidence that this is not the case. As a result, we believe that the Supreme Court would uphold, for example, the Pain-Capable Unborn Child Protection Act (S. 1670), which would generally protect unborn children of 20 weeks fetal age and greater, based on

findings that by this stage of development (if not sooner) they are capable of experiencing pain while being aborted.