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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

PLANNED PARENTHOOD
FEDERATION OF AMERICA, et al.,

Plaintiffs,

v.

JOHN ASHCROFT, Attorney General
of the United States, in his official
capacity,

Defendant.

No. C 03-4872 PJH

**ORDER GRANTING PERMANENT
INJUNCTION; FINDINGS OF FACT
AND CONCLUSIONS OF LAW IN
SUPPORT THEREOF**

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff Intervenor,

v.

JOHN ASHCROFT, Attorney General
of the United States, in his official
capacity,

Defendant.

INTRODUCTION

Before this court is the constitutionality of the Partial-Birth Abortion Ban Act of 2003 (“Act”). With the Act, Congress seeks to ban an abortion procedure it refers to as “partial-birth abortion.” The Act is very similar to a prior Nebraska statute banning so-called “partial-birth abortions,” which the United States Supreme Court held unconstitutional. *See Stenberg v. Carhart*, 530 U.S. 914 (2000). Plaintiffs in this case seek an injunction permanently enjoining enforcement of the Act.

For the reasons that follow, this court concludes that the Act is unconstitutional, and PERMANENTLY ENJOINS enforcement of the Act.¹

¹The court would like to take this opportunity to express its appreciation for the high quality of advocacy and the degree of professionalism and courtesy exhibited by all counsel.

TABLE OF CONTENTS

1

2 **BACKGROUND**.....3

3 I. FACTUAL BACKGROUND.....3

4 A. Established Abortion Procedure.....3

5 B. Contested Abortion Procedure.....8

6 II. LEGAL FRAMEWORK.....12

7 III. PROCEDURAL HISTORY.....13

8 **ISSUES**.....13

9 **DISCUSSION**.....14

10 I. STANDARD OF REVIEW.....14

11 II. UNDUE BURDEN.....15

12 A. Introduction.....15

13 B. Parties’ Positions.....15

14 C. Legal Background.....17

15 D. *Stenberg*: Comparison of Act’s Language to Nebraska Statute.....18

16 E. Findings of Fact.....19

17 F. Conclusions of Law.....23

18 III. CONSTITUTIONAL VAGUENESS.....26

19 A. Parties’ Positions.....26

20 B. Legal Standard.....27

21 C. Findings of Fact and Conclusions of Law.....28

22 IV. HEALTH EXCEPTION.....30

23 A. Parties’ Arguments.....31

24 B. Trial Evidence.....31

25 C. Findings of Fact61

26 D. Congressional Findings.....68

27 E. Conclusions of Law.....113

28 **CONCLUSION**.....117

BACKGROUND

I. FACTUAL BACKGROUND

The Act at issue in this case imposes criminal and civil penalties on “[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion.” 18 U.S.C. § 1531 (a). A brief summary of the various abortion procedures is set forth below to aid in an understanding of the Act’s scope and the procedure or procedures that it prohibits.²

A. Established Abortion Procedure

A full-term pregnancy lasts for approximately 40 weeks, measured from the date of the woman’s last menstrual period (“Imp”).³ Traditionally, pregnancy is divided into three trimesters, with the first trimester lasting until about the 13th or 14th week of pregnancy, the second lasting until about the 27th week, and the third lasting until birth. See, e.g., Trial Transcript (“Tr.”) Vol. 1 at 14:2-20 (Paul). A fetus is considered viable, meaning that it has a realistic chance of long-term survival outside the uterus, at approximately 24 weeks Imp. Tr. Vol. 1 at 14:21-15:5 (Paul); Tr. Vol. 7 at 1119:23-1120:3 (Sprang), Tr. Vol. 9 at 1355:18-22 (Cook, finding viability at 23 weeks).

If a woman chooses to terminate her pregnancy, a doctor will use different medical techniques depending on the gestational age of the fetus. Second trimester abortions, the main subject of this litigation, generally involve one of two procedures: dilation and evacuation (“D&E,” or surgical abortion) or induction (which is also known as a medical abortion, meaning that drugs are administered to abort the pregnancy).⁴ Other methods that are used

²In discussing the background regarding abortion procedures generally, the court relies in part on the testimony of the parties’ experts. The background and qualifications of those experts is set forth in this court’s findings of fact regarding the necessity of a medical exception. See fn 16 below.

³All gestational ages in this order are dated from Imp unless otherwise indicated. Some doctors date gestational age by the date of conception, which is approximately two weeks after a woman’s last menstrual period. See Tr. Vol. 10 at 1614:14-23 (Anand).

⁴As of 2000, first trimester abortions make up approximately 85% of the 1.3 million abortions performed per year in the United States. Exh. 7 at 31 (“Abortion Surveillance – United States 2000,” compiled by the Centers for Disease Control; table 16); see a/so Tr. Vol. 1 at 38:6-

1 much more rarely are hysterotomy (the caesarean removal of the fetus from the uterus) and
2 hysterectomy. Tr. Vol. 1 at 44:7-47:2, 46:8-46:22 (Paul); Exh. 7 (table 16).

3 1. D&E

4 A D&E abortion is a surgical procedure, which is performed in two steps: dilation of the
5 cervix and surgical removal of the fetus. See, e.g., Tr. Vol. 1 at 50:10-15 (Paul). About 85-
6 95% of all second trimester abortions performed in the United States are D&Es. Tr. Vol. 1 at
7 48:24-49:17 (Paul); Trial Exhibit (“Exh.”) 7 (table 18) (noting that D&Es make up 95% of all
8 abortions taking place between 16 and 20 weeks of pregnancy, and 85% of all abortions
9 taking place after 20 weeks); Tr. Vol. 5 at 804:2-3 (Westhoff).⁵

10 To begin the D&E process, the woman’s cervix is first dilated with osmotic dilators
11 used either alone or in conjunction with drugs known as prostaglandins (or misoprostyl).⁶ This
12 encourages the cervix to expand in width and shorten in length, as if in preparation for labor,
13 and will permit the doctor to introduce surgical instruments into the woman’s uterus. Tr. Vol. 1
14 at 50:25-62:6 (Paul); Tr. Vol. 1 at 167:5-10 (Sheehan); Tr. Vol. 3 at 400:18-402:22 (Doe); Tr.
15 Vol. 4 at 509:4-511:19 (Broekhuizen); Tr. Vol. 4 at 657:13- 662:25 (Creinin); Tr. Vol. 5 at
16 811:18-812:20 (Westhoff), Tr. Vol. 11 at 1718:4-1720:10 (Chasen). Doctors need more
17 dilation as gestational age increases, and generally try to achieve a minimum of one
18 millimeter of dilation for each week of gestation (for example, a doctor would try to achieve 20
19 millimeters, or 2 centimeters, of dilation for a 20 week fetus). Tr. Vol. 2 at 182:6-14

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21 _____
22 42:24 (Paul). For first trimester abortions, the doctor will either perform an early medical abortion
23 (up to 9 weeks) or a vacuum aspiration abortion (which is also known as dilation and curettage,
or D&C). Tr. Vol. 1 at 43:18-44:6 (Paul). These procedures are not at issue here.

24 ⁵Doctors report that women appear to strongly prefer D&E abortions to inductions for a
25 variety of reasons, including the fact that a D&E is significantly quicker than an induction, does
26 not require a hospital stay, and does not require that the woman go through labor to end the
27 pregnancy. See, e.g., Tr. Vol. 1 at 91:17-92:1 (Paul), Tr. Vol. 3 at 457:1-458:10 (Doe); Tr. Vol.
28 4 at 503:22-504:3 (Broekhuizen); Tr. Vol. 5 at 804:2-5 (Westhoff); Tr. Vol. 11 at 1773:23-1776:10
(Chasen); Tr. Vol. 6 at 946:24-947:3 (Bowes).

⁶Sometimes the misoprostyl will result in uterine contractions, which may result in either
the partial or complete delivery of the fetus before any surgery takes place. See, e.g., Tr. Vol. 1
at 59:16-60:17 (Paul); Tr. Vol. 3 at 405:4-6 (Doe); Tr. Vol. 4 at 511:23-512:25 (Broekhuizen).

1 (Sheehan); Tr. Vol. 3 at 402:3-5 (Doe); Tr. Vol. 4 at 661:22-662:1 (Creinin).⁷ However, the
2 amount of cervical dilation that can be achieved is individual to each woman and cannot
3 necessarily be controlled. Tr. Vol. 1 at 55:8-14 (Paul); Tr. Vol. 2 at 14-15 (Sheehan); Tr. Vol. 3
4 at 402:10-18 (Doe); Tr. Vol. 8 at 1283:3-8 (Shadigian); Tr. Vol. 4 at 661:19-21 (Creinin). For
5 instance, women who have previously undergone childbirth often will achieve greater dilation
6 in a shorter period of time than women who have not. Tr. Vol. 1 at 62:2-5 (Paul); Tr. Vol. 2 at
7 182:20-183:1 (Sheehan); Tr. Vol. 4 at 662:2-9 (Creinin); Tr. Vol. 5 at 812:12-13 (Westhoff); Tr.
8 Vol. 11 at 1723:17-1724:6 (Chasen).

9 Dilation can take place over a period of time ranging from 90 minutes up to one or two
10 days, depending on the practice of the physician. The process can be accelerated if drugs to
11 induce dilation are administered along with the placement of laminaria in the cervix. Tr. Vol. 1
12 at 55:4-7, 59:9-11 (Paul, using a half to one-day dilation procedure); Tr. Vol. 1 at 180:21-
13 183:10 (Sheehan, using a two-day dilation procedure); Tr. Vol. 3 at 401:7-402:22 (Doe, using
14 a one-day dilation procedure); Tr. Vol. 4 at 659:23-24 (Creinin, using a one-day dilation
15 procedure); Tr. Vol. 5 at 812:6-812:20 (Westhoff, using a two day-dilation procedure); Tr. Vol.
16 11 at 1719:10-25 (Chasen, using a two-day dilation procedure). If the doctor opts to perform
17 dilation over an extended period of time, the procedure often takes place in an outpatient
18 setting, so the woman can participate in her usual daily activities and spend the night at home.
19 See, e.g., Tr. Vol 1 at 45:15-19, 60:1-6 (Paul); Tr. Vol. 2 at 181:11-14 (Sheehan); Tr. Vol. 3 at
20 402:21-22 (Doe); Tr. Vol. 4 at 659:25-660:5 (Creinin).

21 The woman then returns to the clinic or hospital the next day, and, if sufficient dilation
22 has been achieved, she is then placed under some form of sedation, and the cervix is
23 prepared for surgery.⁸ The doctor will then place forceps in the uterus, and, usually under
24 _____

25 ⁷By comparison, the vaginal delivery of a full-term fetus requires 10 centimeters of dilation.
26 No doctor would dilate a woman's cervix to that extent for the purpose of performing a surgical
27 abortion. See Tr. Vol. 4 at 544:17-545:4 (Broekhuizen stating the maximum dilation he would
28 seek is 6-7 centimeters for an induction abortion, which requires more dilation than a D&E).

⁸If the doctor believes the cervix has not sufficiently dilated for the procedure to be
performed, the doctor may place more dilators in the cervix and wait another day before
beginning the surgical portion of the abortion. See, e.g., Tr. Vol. 4 at 518:23-519:2 (Broekhuizen);

1 ultrasound guidance, grasp the fetus with the forceps and then remove the fetus by pulling it
2 through the cervix and vagina. This process usually causes the fetus to disarticulate. It usually
3 takes about 10-15 “passes” through the uterus to remove the entire fetus. When the entire
4 fetus has been removed, the doctor then uses a suction tube, or cannula, to remove the
5 placenta from the uterus and to ensure that no fetal parts have been left behind. Tr. Vol. 1 at
6 62:7-68:21, 69:9-21 (Paul); Tr. Vol. 2 at 183:15-186:13 (Sheehan); Tr. Vol. 3 at 402:23-
7 404:12 (Doe); Tr. Vol. 4 at 514:20-526:17 (Broekhuizen); Tr. Vol. 4 at 663:1-668:4 (Creinin);
8 Tr. Vol. 5 at 812:21-818:7 (Westhoff). All the testifying experts who perform this procedure
9 use ultrasound to provide visual guidance for second trimester abortions. Tr. Vol. 1 at 67:6-7
10 (Paul); Tr. Vol. 1 at 168:6-13 (Sheehan); Tr. Vol. 3 at 403:16-19 (Doe); Tr. Vol. 4 at 515:15-24
11 (Broekhuizen); Tr. Vol. 4 at 668:13-17 (Creinin); Tr. Vol. 11 at 1721:11-15 (Chasen).

12 This process takes between 10-15 minutes on average, and can take place either in
13 an outpatient setting or in a hospital. Tr. Vol. 1 at 62:8-9, 73:2-4 (Paul); Tr. Vol. 2 at 186:12-13
14 (Sheehan); Tr. Vol. 3 at 407:24-408:1 (Doe); Tr. Vol. 4 at 524:11-14 (Broekhuizen, averaging
15 10-15 minutes, but noting range of 5 to 40 minutes); Tr. Vol. 5 at 741:5-742:2 (Creinin,
16 averaging 10-15 minutes, but noting range of up to 40 minutes).

17 Some doctors, but not all, also give an injection of either digoxin or potassium chloride
18 (“KCl”) either directly into the fetus’ heart or in the amniotic fluid surrounding the fetus to effect
19 fetal demise before the procedure is commenced. *Compare* Tr. Vol. 2 at 16-196:6 (Sheehan,
20 who routinely offers digoxin); Tr. Vol. 4 at 561:15-562:22 (Broekhuizen) *with* Tr. Vol. 2 at
21 328:24-329:18 (Drey, who only offers digoxin when specifically requested to do so), Tr. Vol. 3
22 408:7-13, 416:14-419:19 (Doe, who does not routinely effect fetal demise before procedure);
23 Tr. Vol. 5 at 819:20-820:5 (Westhoff); Tr. Vol. 11 at 1780:20-1782:21 (Chasen).

24 2. Induction

25 The second-most common method of second trimester abortion is induction. About
26 5% of all second trimester abortions from 14-20 weeks are by induction; after 20 weeks, that

27 _____
28 Tr. Vol. 4 at 660:23-661:14 (Creinin).

1 percentage increases to 15%. Tr. Vol. 1 at 48:24-49:17 (Paul); Exh. 7 (table 18).

2 Since the uterus in the second trimester of pregnancy is not inclined to expel the fetus,
3 contractions must instead be artificially induced through the use of chemical agents. In an
4 induction, the woman is given medication to induce labor to expel the fetus. Inductions were
5 previously triggered by saline injections into the uterus, but the most current medical
6 techniques now call for the administration of misoprostyl or oxytocin to induce contractions
7 and labor. Tr. Vol. 3 at 409:4-409:21 (Doe); Tr. Vol. 4 at 527:6-529:20 (Broekhuizen, noting
8 that “We are kind of overriding nature because . . . there are usually signals at this time that
9 suppress uterine activity”); Tr. Vol. 5 at 15:20 (Creinin, “We have to give very high doses of
10 medicines, much higher than you would give at term, just because we are trying to override the
11 fact that the uterus doesn’t want to do this process. So you have to make the uterus contract
12 so strongly that it can break apart”); Tr. Vol. 11 at 1777:12-1778:9 (Chasen); see *also* Tr. Vol.
13 6 at 948:3-9, 950:5-15 (Bowes). *But see* Tr. Vol. 7 at 1093:1-7 (Sprang, testifying induction is
14 more natural); Tr. Vol. 9 at 1391:21-1392:19 (Cook).

15 An induction abortion takes anywhere from 6 to 48 hours to complete, and in ten
16 percent of inductions, the woman must also undergo a D&E to remove unexpelled matter from
17 the uterus (usually the placenta). Tr. Vol. 3 at 409:18-410:9, 414:3-7 (Doe, stating that most
18 inductions occur within 24 hours and noting complications); Tr. Vol. 4 at 527:6-532:13
19 (Broekhuizen, giving range of time as 8 to 72 hours, and discussing possible complications
20 requiring subsequent D&E); Tr. Vol. 5 at 715:8-24 (Creinin); Tr. Vol. 8 at 1268:18-21,
21 1287:19-1289:5 (Shadigian) (stating that most inductions take place between 4 and 24 hours
22 but can take up to 2 and a half days). Because an induction requires around-the-clock
23 monitoring for at least 24 hours, these abortions can take place only in a hospital setting. Tr.
24 Vol. 1 at 45:20-46:7 (Paul); Tr. Vol. 4 at 526:8-527:2 (Broekhuizen).

25 An induction is more likely to result in the delivery of an intact fetus, so when a fetal
26 autopsy might be needed, doctors will recommend this procedure. Tr. Vol. 3 at 408:14-409:3
27 (Doe); Tr. Vol. 9 at 1399:11-1400:4 (Cook). However, if the induction takes too long to
28 complete, the fetal tissue breaks down and becomes unuseable for medical study. Tr. Vol. 11

1 at 1758:7-19 (Chasen).

2 3. Hysterotomy and Hysterectomy

3 Two other methods of second trimester abortion are also available, but are very rarely
4 used. A hysterotomy, like a caesarean delivery, involves the surgical removal of the fetus
5 through an incision in the uterus, and a hysterectomy involves the removal of the woman's
6 entire uterus. Tr. Vol. 1 at 46:8-47:2 (Paul); Exh. 7 (table 18, indicating these procedures
7 make up .01% of all abortions and .07% of all second trimester abortions).

8 Both of these procedures are considered major surgery and are not recommended
9 except in the case of extreme emergency. See *a/so, e.g.*, Tr. Vol. 1 at 82:9-12 (Paul, noting
10 that hysterotomy and hysterectomy are not really options because of their high rate of mortality
11 and morbidity); Tr. Vol. 11 at 1767:6-1768:4 (Chasen, stating that hysterotomy and
12 hysterectomy should only be used when fetus must be delivered immediately to save the life or
13 health of the woman); Tr. Vol. 6 at 972:6-8 (Bowes).

14 B. Contested Abortion Procedure

15 The government argues that none of these previously-described procedures (1st
16 trimester abortion procedures, D&E, induction, hysterotomy, or hysterectomy) are banned by
17 the Act. Rather, the Act prohibits a specific second trimester abortion technique, which the
18 Act refers to as "partial-birth abortion."

19 1. The Act

20 The Act defines "partial-birth abortion" as:

21 an abortion in which a physician deliberately and intentionally vaginally delivers
22 a living, unborn child until either the entire baby's head is outside the body of the
23 mother, or any part of the baby's trunk past the navel is outside the body of the
24 mother and only the head remains inside the womb, for the purpose of
performing an overt act (usually the puncturing of the back of the child's skull and
removing the baby's brains) that the person knows will kill the partially delivered
infant, performs this act, and then completes delivery of the dead infant.

25 Act § 2(1); see *a/so* 18 U.S.C. § 1531(b) (statutory definition). The term "partial-birth
26 abortion," however, is neither recognized in the medical literature nor used by physicians who
27 routinely perform second trimester abortions. See, *e.g.*, Tr. Vol. 2 at 200:23-201:4 (Sheehan);
28 Tr. Vol. 3 at 420:23-421:2 (Doe); *but see* Tr. Vol. 6 at 901:5-19 (Bowes); Tr. Vol. 8 at

1 1219:23-1220:8 (Shadigian); Tr. Vol. 9 at 1386:7-1387:7 (Cook) (arguing “partial-birth
2 abortion” is a medically recognized term). The language of the Act obviously omits any
3 reference to D&X, D&E, or “intact” extraction.

4 2. Dr. Haskell and ACOG

5 The debate over this procedure appears to have been initiated by a presentation given
6 by Dr. Marvin Haskell in 1992 before the National Abortion Federation (“NAF”). See Partial-
7 Birth Abortion Ban Act of 2002: Hearing on H.R. 4965 before the Subcomm. on the
8 Constitution of the House Comm. on the Judiciary, 107th Cong. 2nd Sess at 127-34 (2002)
9 (“Record Exh. C”) (copy of article).⁹ In that presentation, Dr. Haskell outlined a variant on D&E
10 abortions in which the fetus was removed either intact or nearly intact rather than through
11 disarticulation.¹⁰ To distinguish this variant from the standard D&E by disarticulation, Dr.
12 Haskell coined the term “D&X,” or “dilation and extraction.” *Id.* at 127.

13 Dr. Haskell described a procedure in which 1) the woman’s cervix is dilated through the
14 use of up to 20-30 osmotic dilators over a two-day period; 2) the physician inserts forceps into
15 the woman’s uterus and, if the fetus is not presented in a breech position (feet first), the
16 physician performs an “internal podalic version” of the fetus and inverts the fetus so that it is
17 presenting in a breech position; 3) the fetus is extracted intact through the cervix and vagina
18 until its head, or calvarium, is lodged at the cervical opening, or os; and 4) the physician
19 inserts scissors and a suction cannula into the fetus’ skull and drains brain tissue from the
20 calvarium, which causes the calvarium to collapse to the point at which it can be extracted
21 from the uterus. Record Exh. C at 129-131; see also, e.g., Tr. Vol. 8 at 1219:12-1220:4
22 (Shadigian), Tr. Vol. 9 at 1386:7-1387:7 (Cook).

23 In response to the subsequent debate over this procedure, the American College of
24 Obstetricians and Gynecologists (“ACOG”) subsequently coined the term “intact D&X,” which

25
26 ⁹The court takes judicial notice of this article’s inclusion in the Congressional Record, but
notes also that the article itself was not introduced into evidence at trial.

27 ¹⁰While Dr. Haskell first outlined this procedure in 1992, other physicians testified that they
28 have practiced some version of intact extraction since the 1970s. Tr. Vol. 2 at 187:15-19
(Sheehan); Tr. Vol. 4 at 584:16-585:3 (Broekhuizen).

1 was defined as: 1) deliberate dilation of the cervix, usually over a sequence of days, 2) internal
2 podalic version of the fetus to a breech position; 3) breech extraction of the fetus up to the
3 calvarium, and 4) the extraction of the fetal cranial contents to permit vaginal delivery of a
4 dead, intact fetus. Cain Depo. 164:8-166:17; Exh. 3; see *also, e.g.*, Tr. Vol. 5 at 735:8-736:2
5 (Creinin).

6 3. Trial Testimony

7 At trial, plaintiffs presented the testimony of a number of physicians who perform D&E
8 abortions by procedures which they believe might violate the Act. Several physicians report
9 that occasionally while performing a D&E, they encounter a situation where they believe it will
10 be possible to remove the fetus either intact or largely intact. This occurs when the woman's
11 cervix is dilated to such a degree that the fetus can be extracted up to the head, in either one
12 or two "passes" with the forceps. The potential for a largely intact removal cannot be
13 ascertained until the surgical procedure has already begun, and depends primarily on how the
14 cervix presents at the commencement of the procedure. Tr. Vol. 1 at 67:24-68:1, 71:17-24
15 (Paul); Tr. Vol. 2 at 205:16-24, 206:5-13 (Sheehan); Tr. Vol. 3 at 406:24-407:11 (Doe); Tr.
16 Vol. 5 at 784:-786:23 (Creinin); Tr. Vol. 5 at 815:3-816:22, 818:18-21(Westhoff).

17 The number of times this occurs varied per doctor, but ranged from between 5% to
18 33% of all D&Es performed, with most doctors reporting occurrences of around 5-15% of the
19 time.¹¹ Tr. Vol. 1 at 71:8-19 (Paul, estimating 5-10%); Tr. Vol. 2 at 188:13-12 (Sheehan,
20 reporting approximately 20% the week before); Tr. Vol. 3 at 406:10-16 (Doe, estimating 15-
21 20%).

22 Notably, since Dr. Haskell's paper and presentation, the process has evolved. While
23 some physicians perform abortions in this circumstance using the four steps outlined by
24 ACOG or Dr. Haskell, many others do not.

25 Some physicians insert up to 25 osmotic dilators over a two day period (known as
26

27 ¹¹Dr. Sheehan and Dr. Creinin reported that an intact D&E occurred less than 1% of the
28 time, but they were reporting incidents where the entire fetus, including the head, was removed
intact. Tr. Vol. 2 at 271:20-272:8 (Sheehan); Tr. Vol. 4 at 784:19-786:19 (Creinin).

1 “serial dilation”) to increase the likelihood of an intact D&E, while others simply proceed as
2 they do for a standard D&E by disarticulation. Some physicians perform podalic version,
3 while others do not. Some physicians puncture the calvarium and suction out the cranial
4 contents, others disarticulate the calvarium and crush it with forceps before extraction, while
5 yet others use forceps to collapse the calvarium while it is still attached. See, e.g., Tr. Vol. 1
6 69:22-70:6, 78:25-79:7 (Paul, who collapses the attached skull with forceps or disarticulates
7 at the neck); Tr. Vol. 2 at 184:15-17, 193:22-24 (Sheehan, who does same, and does not
8 perform podalic version); Tr. Vol. 3 at 405:19-406:9 (Doe, who disarticulates calvarium and
9 crushes with forceps, and sometimes performs podalic version); Tr. Vol. 4 at 516:8-24, 523:1-
10 524:10, 589:23-590:1, 615:7-13 (Broekhuizen, who sometimes practices serial dilation,
11 sometimes performs podalic version when grasping for fetal part, and punctures calvarium);
12 Tr. Vol. 4 at 668:18-669:19, 680:11-681:1 (Creinin, who performs podalic version and
13 punctures or disarticulates calvarium); Tr. Vol. 5 at 801:22-802:3 (Westhoff, who punctures
14 calvarium); Tr. Vol. 11 at 1718:4-1725:10 (Chasen, who uses up to 25 dilators, performs
15 podalic version, and punctures calvarium).

16 Furthermore, although Dr. Haskell inserted scissors or trocars by touch, all of the
17 physicians who testified stated that they could see the insertion point, either directly or through
18 ultrasound, before any insertions were made. Tr. Vol. 1 at 67:6-7 (Paul); Tr. Vol. 1 at 168:6-13
19 (Sheehan); Tr. Vol. 3 at 403:16-19 (Doe); Tr. Vol. 4 at 632:2-8, 638:18-640:7 (Broekhuizen);
20 Tr. Vol. 4 at 682:14-19 (Creinin); Tr. Vol. 5 at 801:25-802:5, 818:8-11 (Westhoff); Tr. Vol. 11
21 at 1722:10-13 (Chasen).

22 Most significantly, all of the testifying physicians who have performed intact extractions
23 refer to this procedure as a variant of D&E, and not as an entirely separate procedure. See,
24 e.g., Tr. Vol 1 at 44:14-45:14 (Paul); Tr. Vol. 2 at 188:20-189:2, 205:16-13 (Sheehan); Tr. Vol.
25 3 at 406:17-23 (Doe); Tr. Vol. 11 at 1721:16-23, 1723:4-1724:21 (Chasen). The only
26 physicians who referred to it as a separate procedure were witnesses who had never
27 performed the procedure. Tr. Vol. 6 at 959:10-960:3 (Bowes); Tr. Vol. 7 at 1034:8-1035:21,
28 1094:5-8 (Sprang); Tr. Vol. 8 at 1214:3-1215:3, 1232:14-1233:7 (Shadigian); Tr. Vol. 9 at

1 1374:4-9, 1380:7-18, 1389:8-13 (Cook). Accordingly, the court will refer to the procedure
2 throughout this order as “intact D&E.”

3 **II. LEGAL FRAMEWORK**

4 As noted, this case involves an issue similar to that confronted by the Supreme Court in
5 *Stenberg*. In 1997, Dr. Leroy Carhart, a medical doctor who provides late-term abortions,
6 sought a preliminary injunction enjoining Nebraska’s “partial-birth abortion” law. Carhart
7 argued that the state’s ban subjected women seeking abortions to a significantly greater risk
8 of injury or death than would be the case if he were permitted to perform the banned
9 procedure. The United States District Court for the District of Nebraska granted Carhart’s
10 request for a permanent injunction, and the Eighth Circuit affirmed.

11 The United States Supreme Court subsequently granted certiorari in 2000. *Stenberg*,
12 530 U.S. at 914. Before evaluating the Nebraska statute, the Court reiterated the standards
13 for evaluating abortion regulations and restrictions set forth by the Court previously in *Roe v.*
14 *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pa. v. Casey*, 505
15 U.S. 833 (1992), as follows:

- 16 (1) Prior to viability, a woman has a constitutional right to choose to
17 terminate her pregnancy. *Id.* at 921. And, while the state has interests in
18 protecting the health of the mother and the potentiality of human life, see
19 *id.*, “[t]he State’s interest in regulating abortion previability is considerably
20 weaker than postviability.” *Id.* at 930. Prior to viability, a law that places
21 an “undue burden” on a woman’s decision to terminate her pregnancy is
22 unconstitutional. *Id.* at 921.
- 23 (2) Subsequent to viability, the state may regulate and even proscribe
24 abortion “except where it is necessary, in appropriate medical judgment,
25 for the preservation of the life or health of the mother.” *Id.* (citations
26 omitted).

27 The *Stenberg* Court subsequently held that the Nebraska statute violated the
28 Fourteenth Amendment on two different bases. First, it concluded that the Nebraska statute
was unconstitutional because it lacked any exception for the preservation of the health of the
mother. See *id.* at 930-32. Second, it concluded that the state law placed an undue burden
on a woman seeking a previability abortion. See *id.* at 945.

1 **III. PROCEDURAL HISTORY**

2 Approximately three years after the Supreme Court decided *Stenberg*, the 108th
3 Congress passed the final version of the Act, which President George W. Bush signed into
4 law on November 5, 2003. Plaintiffs filed the instant lawsuit, claiming that the Act violates their
5 Fifth Amendment due process rights. At or around the same time that plaintiffs filed their
6 lawsuit with this court, plaintiffs National Abortion Federation, et al., and Dr. Leroy Carhart,
7 plaintiff in the *Stenberg* case, and other physicians, filed similar lawsuits challenging the Act in
8 the United States District Courts for the Southern District of New York (“New York court”) and
9 the District of Nebraska (“Nebraska court”), respectively. See *National Abortion Federation*
10 *v. Ashcroft*, No. 03-8695 RCC (S.D.N.Y.); *Carhart v. Ashcroft*, No. 4:03CV3385 (D. Neb.).

11 On November 6, 2003, one day after the President signed the Act into law, this court
12 issued an injunction temporarily enjoining enforcement of the Act. The New York and
13 Nebraska courts also temporarily enjoined enforcement of the Act.

14 At the request of the Attorney General (“the government”), the hearing on the plaintiffs’
15 motion for a preliminary injunction was merged with the trial on the merits, and with the
16 government’s consent, the matter was continued for approximately 120 days during which the
17 parties engaged in expedited discovery and trial preparation. On March 19, 2004, the court
18 extended the temporary restraining order to a reasonable time after trial on the merits, for
19 preparation of the instant findings of fact and conclusions of law. Subsequently, on March 29,
20 2004, the bench trial in this case commenced, lasting approximately three weeks.

21 In addition to the sizeable Congressional Record submitted by both parties, this court
22 heard testimony from a total of thirteen expert witnesses, and reviewed the deposition
23 testimony of an additional six expert witnesses.

24 **ISSUES**

25 Plaintiffs contend that the Act is unconstitutional, for the following reasons:

26 (1) the Act places an undue burden on a woman’s right to choose;

27 (2) the Act is impermissibly vague because it fails to clearly define the prohibited
28 medical procedures, thereby depriving physicians of fair notice and encouraging

1 arbitrary enforcement;
2 (3) the Act's failure to provide an exception for the health of the mother violates a
3 woman's Fifth Amendment due process rights as set forth by the Supreme Court in
4 *Casey and Stenberg*; and
5 (4) the Act violates a woman's due process right to bodily integrity.¹²

6 **DISCUSSION**

7 **I. STANDARD OF REVIEW**

8 The 108th Congress made numerous findings in support of the Act. The
9 government argues that this court must afford those findings substantial deference, while the
10 plaintiffs, on the other hand, contend that this court need not accord the findings any
11 deference. However, the congressional findings, the deference afforded them, and their
12 interplay with the trial evidence in this case, are relevant primarily with respect to the issue
13 regarding the necessity of a health exception, and are therefore discussed in the context of
14 this court's findings and conclusions in that section below.

15 The other issues involving the construction and validity of the Act: whether the Act
16 places an undue burden on a woman's right to choose, and the alleged vagueness of the Act,
17 are issues of law, which this court reviews *de novo*. See, e.g., *Taylor v. Delatoore*, 281 F.3d
18 844, 847 (9th Cir. 2002); *Free Speech Coalition v. Reno*, 198 F.3d 1083, 1090 (9th Cir.
19 1999) (construction and constitutionality of statute are issues of law reviewed *de novo*).
20 Accordingly, both plaintiffs and the government agree that this court "is tasked with
21 independently determining . . . the [constitutional] validity of the [A]ct." See Government's
22 January 30, 2004 reply brief at 10; see *also* March 1, 2004 amicus brief at 8 ("this Court must
23 make an independent legal judgment regarding whether the applicable law unduly burdens [a
24 woman's right to terminate her pregnancy]").

25 The court, therefore, discusses first the issues of undue burden and vagueness, setting
26 forth its findings and conclusions on the issues, and subsequently, turns to the necessity of a

27 _____
28 ¹²Because the court finds the Act unconstitutional on the three preceding grounds, it declines to reach this issue.

1 health exception. In the section regarding the health exception, the court sets forth its findings
2 of fact based on the trial evidence, and then discusses the legislative history of the Act and the
3 record before Congress supporting the congressional findings. The court then provides its
4 conclusion regarding the deference to be afforded the congressional findings, and its
5 conclusions of law, based on the congressional findings and the evidence before this court,
6 regarding the necessity of a health exception.

7 **II. UNDUE BURDEN**

8 **A. Introduction**

9 In *Stenberg*, one of the two bases for the Supreme Court’s holding that the Nebraska
10 statute was unconstitutional was that the statute “impose[d] an undue burden on a woman’s
11 ability to choose a D&E abortion, thereby unduly burdening the right to choose abortion itself.”
12 *Stenberg*, 530 U.S. at 930 (citing *Casey*, 505 U.S. at 874).

13 The Court noted that an undue burden is created by a law that “has the purpose or
14 effect of placing a substantial obstacle in the path of a woman seeking an abortion of a
15 nonviable fetus.” *Id.* at 921. It subsequently held that Nebraska’s partial-birth abortion ban
16 posed an unconstitutional undue burden on a woman’s decision because the language of the
17 statute was broad enough that it could be interpreted to include a ban on previability D&Es,
18 the most common second trimester abortion procedure, thereby unconstitutionally placing an
19 obstacle in the path of a woman seeking a previability second trimester abortion. *Id.* at 945.

20 **B. Parties’ Positions**

21 Plaintiffs claim that, similar to the Nebraska statute in *Stenberg*, the Act here poses an
22 undue burden on a woman’s decision to have an abortion prior to viability. Plaintiffs contend
23 that the Act likewise bans other safe second trimester procedures, including D&E and
24 induction abortions. They argue that the definition of “partial-birth abortion” in the Act is so
25 broad that any abortion performed by the two safest, most common abortion procedures used
26 in the second trimester of pregnancy, prior to fetal viability – D&E and induction – could
27 proceed so as to violate the Act. Accordingly, plaintiffs assert that the Act is unconstitutional
28 as a matter of law.

1 Moreover, plaintiffs contend that regardless of any interpretation that the government
2 may advance regarding the procedures banned by the Act, the court must follow the language
3 of the definition of “partial-birth abortion” in the Act. *Stenberg*, 530 U.S. at 942 (rejecting
4 Nebraska Attorney General’s suggestion that the term “partial-birth abortion” is “ordinarily
5 associated with the [intact D&E] procedure” because “[w]hen a statute includes an explicit
6 definition, we must follow that definition even if it varies from that term’s ordinary meaning”);
7 *see also Reno v. ACLU*, 521 U.S. 844, 884 n.49 (1997) (federal courts lack the authority to
8 rewrite a statute to conform it to constitutional requirements).

9 The government, on the other hand, devoted very little attention to the undue burden
10 issue at trial and in its pre-trial and post-trial submissions to the court. That was in spite of this
11 court’s conclusion in its order temporarily enjoining the Act that “the scope of the Act may
12 impermissibly encompass [all] D&E procedures and thus impose an undue burden on a
13 woman’s right to choose.” *See* November 7, 2003 Order.

14 Instead, as it did in its papers in opposition to the temporary restraining order, the
15 government continues to mistakenly conflate plaintiffs’ undue burden challenge with the issue
16 of vagueness. The government’s position is simply that Congress intended to ban only intact
17 D&Es, and that the Act is not vague and should be interpreted to apply only to intact D&E
18 abortions -- not to D&Es by disarticulation, inductions, or other abortion procedures.
19 Therefore, according to the government, there can be no undue burden.

20 The government’s approach, however, ignores the fact that the two issues, while
21 somewhat related, are nevertheless distinct. The Act may be unduly burdensome under
22 *Casey*, yet not unconstitutionally vague. For example, this court could find that the Act was
23 sufficiently specific regarding the description of the conduct that violates the Act; however, at
24 the same time, the court could conclude that the prohibited conduct may be interpreted to
25 encompass other safe second trimester abortion procedures besides intact D&E.
26 Accordingly, the court rejects the government’s framework for analyzing the undue burden
27 issue.

28

1 **C. Legal Background**

2 The government misconstrues the test regarding undue burden, narrowing the inquiry to
3 whether the regulation poses a “*significant threat* to the . . . health of a woman.” However, as
4 the Supreme Court noted in *Stenberg*, “[a]n ‘undue burden is . . . shorthand for the conclusion
5 that a state regulation has the purpose or effect of placing a substantial obstacle in the path of
6 a woman seeking an abortion of a nonviable fetus.’” 530 U.S. at 921 (quoting *Casey*, 505
7 U.S. at 877).

8 The Nebraska statute at issue in *Stenberg* proscribed:

9 deliberately and intentionally delivering into the vagina a living unborn child, or a
10 substantial portion thereof, for the purpose of performing a procedure that the
11 person performing such procedure knows will kill the unborn child.

11 530 U.S. at 938 (quoting Neb. Rev. Stat. Ann. § 28-326(9) (Supp. 1999)).

12 The state of Nebraska agreed that the statute would impose an undue burden if it
13 applied to the more commonly used D&E procedure as well as to the intact D&E procedure.
14 *Id.* at 938. However, the state argued that the statute’s aim was to ban intact D&E and that the
15 statute differentiated between D&E and intact D&E.

16 The Supreme Court, however, rejected the state’s arguments. The Court held that
17 regardless of the statute’s “aim,” “its language makes clear that [in addition to intact D&E], it
18 also covers a much broader category of procedures.” *Id.* at 939. It noted that “[t]he language
19 [of the statute] does not track the medical differences between D&E and [intact D&E] – though
20 it would have been a simple matter . . . to provide an exception for the performance of D&E
21 and other abortion procedures.” *Id.*

22 Moreover, that the state of Nebraska “generally intended to bar intact D&E” could be
23 correct, but according to the Supreme Court was “irrelevant.” *Id.* at 939. Instead, the relevant
24 inquiry was “whether the law was intended to apply *only* to [intact D&E].” *Id.* The Court noted
25 that “even were we to grant the [Nebraska] Attorney General’s views [regarding the aim of the
26 statute] substantial weight, [the Court] would still have to reject his interpretation [because] it
27 conflicts with the statutory language.” *Id.* at 942.

28 In holding that the statute constituted an undue burden, the Court further concluded that:

1 [U]sing this law some . . . prosecutors. . . may choose to pursue physicians who
2 use D&E procedures, the most commonly used method for performing
3 previability second trimester abortions. All those who perform abortion
4 procedures using that method must fear prosecution, conviction, and
5 imprisonment. The result is an undue burden upon a woman’s right to make an
6 abortion decision.

7 *Id.* at 945-46.

8 **D. *Stenberg*: Comparison of Act’s Language to Nebraska Statute**

9 In contrast to the Nebraska statute in *Stenberg*, the Act here forbids:

10 deliberately and intentionally vaginally deliver[ing] a living fetus until, in the case
11 of a head-first presentation, the entire fetal head is outside the body of the
12 mother, or, in the case of breech presentation, any part of the fetal trunk past the
13 navel is outside the body of the mother, for the purpose of performing an overt
14 act that the person knows will kill the partially delivered living fetus.

15 18 U.S.C. § 1531(b)(1)(A).

16 The government correctly notes that the language of the Act differs from the statute in
17 *Stenberg* in three respects: 1) the Act requires delivery of the fetus outside of the mother; 2)
18 the Act specifies the required protruding fetal parts; and 3) the Act proscribes an overt act
19 distinct from the completion of the delivery itself.

20 i. *Location of Delivered Fetus*

21 While the Nebraska statute applied where the living fetus or a substantial portion
22 thereof was delivered “into the vagina,” the Act here specifies vaginal delivery “outside the
23 body of the mother.” Neb. Rev. Stat. § 28-326(9); 18 U.S.C. § 1531(b)(1)(A). The
24 government contends that the constitutional infirmities of the Nebraska statute are avoided
25 because D&Es by disarticulation, as compared to intact D&Es, are generally internal
26 dismemberment procedures, and, as the Act here does not apply to procedures performed
27 internally, it does not encompass D&Es by disarticulation.

28 ii. *Fetal Parts*

In *Stenberg*, the Nebraska statute required the delivery into the vagina of “a living
unborn child or *substantial portion thereof*.” Neb. Rev. Stat. § 28-326(9). The Supreme
Court took issue with this language, noting that it could

not understand how one could distinguish, using this language, between D&E
(where a foot or arm is drawn through the cervix) and [intact D&E] (where the

1 body up to the head is drawn through the cervix). Evidence before the trial court
2 makes clear that D&E will often involve a physician pulling a “substantial portion”
of a living fetus, say, an arm or leg, into the vagina prior to the death of the fetus.

3 *Stenberg*, 530 U.S. at 938-39.

4 The Act, on the other hand, specifies vaginal delivery of “a living fetus until, in the case
5 of a head-first presentation, *the entire fetal head* is outside the body of the mother *or* in the
6 case of a breech presentation, *any part of the fetal trunk past the navel* is outside the body of
7 the mother.” 18 U.S.C. § 1531(b)(1)(A). The government likewise argues that inclusion of this
8 language avoids the constitutional infirmities in *Stenberg* because the Act provides “a specific
9 anatomic landmark.”

10 iii. *Overt Act*

11 The language of the Act regarding completion of the abortion also varies somewhat
12 from the Nebraska statute in *Stenberg*. In addition to defining the prohibited procedure, the
13 Act provides that the physician “perform[] the overt act, other than completion of delivery, that
14 kills the partially delivered living fetus.” 18 U.S.C. § 1531(b)(1)(B). In comparison, the
15 Nebraska statute defined the prohibited abortion procedure, and with respect to completion of
16 the abortion, provided that the procedure “does kill the unborn child.” Neb. Rev. Stat. § 28-
17 326(9).

18 The government argues that this further distinguishes the Act from the statute in
19 *Stenberg*. It argues that the language distinguishes intact D&Es from other procedures
20 because the specific act to kill the fetus must happen at a particular point and place in time.
21 According to the government, “the fact that during the course of a D&E [by disarticulation] or
22 induction, some ‘overt act’ is taken to kill a living fetus . . . does not render D&E or induction
23 unlawful” because the overt acts characteristic of the other procedures do not occur under the
24 other requirements specified by the Act.

25 **E. Findings of Fact**

26 This court concludes, however, based on the findings set forth below, that despite
27 linguistic differences between the Nebraska statute in *Stenberg* and the Act, the Act
28 nevertheless poses an undue burden on a woman’s right to choose an abortion because the

1 Act encompasses not only intact D&E procedures, but other previability D&E procedures and
2 possibly inductions as well, in violation of the Supreme Court's holding.

3 Specifically, this court finds, based on the evidence before it, that:¹³

4 1. Like the Nebraska statute in *Stenberg*, the Act bans abortions performed
5 at any time during a pregnancy, regardless of gestational age or fetal viability. In fact,
6 Congress rejected alternatives and amendments to the Act that would have limited its
7 applicability to viable fetuses. See 149 Cong. Rec. S3600 (daily ed. March 12, 2003)
8 (statement of Sen. Feinstein); 149 Cong. Rec. H4939 (daily ed. June 4, 2003) (statement of
9 Rep. Greenwood); 149 Cong. Rec. H4948 (daily ed. June 4, 2003) (statement of Rep.
10 Baldwin).

11 2. In performing all D&Es, including D&Es by disarticulation, and inductions,
12 physicians "deliberately and intentionally" extract the fetus from the woman's uterus and
13 through her vagina. Tr. Vol. 1 at 76:19-21 (Paul); Tr. Vol. 2 at 200:23-201:4 (Sheehan); Tr.
14 Vol. 3 at 422:3-12 (Doe); Tr. Vol. 5 at 822:0-823:12 (Westhoff). Extraction of the fetus from
15 the uterus, if brought through the cervix and vagina (as opposed to through an incision in the
16 woman's abdomen), is called a "vaginal delivery." Tr. Vol. 1 at 75:20-76:5 (Paul); Tr. Vol. 3 at
17 421:6-11 (Doe); Tr. Vol. 5 at 822:20-823:12 (Westhoff).

18 3. The fetus may still have a detectable heartbeat or pulsating umbilical cord when the
19 uterine evacuation begins in any D&E or induction, and may be considered a "living fetus." Tr.
20 Vol.1 at 67:3-11; 76:6-18 (Paul); Tr. Vol. 2 at 201:5-8 (Sheehan); Tr. Vol. 3 at 421:12-18
21 (Doe); Tr. Vol 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

22 4. Plaintiffs' and the government's experts agree that in any D&E or induction, a living
23 fetus may be extracted in a breech presentation until some "part of the fetal trunk past the
24 navel is outside the body of the mother." Tr. Vol. 6 at 945:17-21 (Bowes); Tr. Vol. 8 at
25 1283:17-20 (Shadigian); Lockwood Depo 235:16-24; Tr. Vol. 1 at 77:9-78:13 (Paul); Tr. Vol.
26

27 ¹³As noted previously, the background and qualifications of the experts relied on by the
28 court for the findings that follow are set forth in this court's findings of fact regarding the necessity
of health exception.

1 1 at 99:16-2; 201:9-16 (Sheehan); Tr. Vol. 2 at 281:22-282:3 (Drey); Tr. Vol. 3 at 405:4-12;
2 422:3-19 (Doe); Tr. Vol 4 at 521:2-15; 551:19-552:4 (Broekhuizen); Tr. Vols. 4 & 5 at 678:23-
3 679:14; 784:3-786:18 (Creinin); Tr. Vol. 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11 at
4 1783:15-1786:3 (Chasen).

5 5. In a D&E, this may occur under a variety of scenarios, including when:

6 (A) on an initial pass into the uterus with forceps, the physician disarticulates a
7 small fetal part, which does not cause immediate demise, and then on a
8 subsequent pass, the fetus is brought out of the cervix past the fetal navel;

9 (B) on an initial pass into the uterus with forceps, the physician brings out a fetal
10 part – either attached to the rest of the fetus, or not – that is “part of the fetal
11 trunk past the navel,” but the extraction does not cause immediate demise;

12 (C) the physician extracts the fetus intact until the calvarium lodges at the internal
13 cervical opening; or

14 (D) the physician extracts the fetus intact until “part of the fetal trunk past the
15 navel is outside the woman’s body,” but it is not extracted so far that the
16 calvarium lodges at the cervical opening.

17 Tr. Vol. 1 at 77:9-78:13 (Paul); Tr. Vol. 2 at 201:9-202:1; 272:18-22 (Sheehan); Tr. Vol. 4 at
18 521:2-15; 551:1-18 (Broekhuizen); Tr. Vols. 4 & 5 at 681:8-16; 784:3-786:18 (Creinin); Tr.
19 Vol. 5 at 822:20-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1784:20 (Chasen).

20 6. In an induction, this may occur because fetal demise may not have occurred by the
21 time the fetus passes through the woman’s cervix and vagina, and is outside the body of the
22 woman past the fetal navel. Tr. Vol. 4 at 530:15-533:6 (Broekhuizen); Tr. Vol. 11 at 1784:21-
23 1786:3 (Chasen).

24 7. In any D&E or induction, if the fetus has been brought to the point “where any part of
25 the fetal trunk past the navel is outside the body of the mother” or “the entire fetal head is
26 outside the body of the mother,” a physician may then, in order to complete the abortion in the
27 safest manner, need to perform an “overt act,” short of completing delivery, that the physician
28 knows the fetus cannot survive, if it is still living, and that “kills” the fetus. Lockwood Depo.

1 235:17-236:2; Tr. Vol. 1 at 79:8-16; 60:13-61:6; 69:22-25 (Paul); Tr. Vol. 3 at 422:3-19 (Doe);
2 Tr. Vol. 4 at 551:19-552:9 (Broekhuizen); Tr. Vol. 4 at 638:10-684:10 (Creinin); Tr. Vol. 11 at
3 1783:15-1786:3 (Chasen). This “overt act” may include disarticulation, cutting the umbilical
4 cord, or compressing or decompressing the skull or abdomen or other fetal part that is
5 obstructing completion of the uterine evacuation. Tr. Vol. 1 at 61:7-15; 70:1-6; 78:25-79:5
6 (Paul); Tr. Vol. 2 at 193:5-24; 205:8-15 (Sheehan); Tr. Vol. 3 at 405:13-22 (Doe); Tr. Vol. 4 at
7 523:1-524:1 (Broekhuizen); Tr. Vol. 5 at 783:15 (Creinin).

8 8. The procedures described above are performed by the testifying physicians only on
9 previable fetuses. Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at
10 420:9-22 (Doe); Tr. Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr.
11 Vol. 5 at 822:9-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

12 9. For these reasons, any abortion performed using the D&E or induction method
13 could proceed so as to violate the Act when performed in the safest manner. Tr. Vol. 1 at
14 92:2-93:4 (Paul); Tr. Vol. 1 at 165:11-21 (Sheehan); Tr. Vol. 2 at 282:20-283:3 (Drey); Tr. Vol.
15 11 at 1784:15-1786:3 (Chasen).

16 10. For the same reasons, the Act could also ban the steps that a physician takes
17 when treating a woman who presents in the midst of a spontaneous second trimester
18 miscarriage. Tr. Vol. 4 at 555:7-556:11 (Broekhuizen); Tr. Vol. 4 at 684:11-685:5 (Creinin);
19 Tr. Vol. 5 at 824:4-24 (Westhoff); Tr. Vol. 11 at 1786:4-1787:9 (Chasen).

20 11. As part of their routine practice, eleven of the experts who testified before this
21 court, including Drs. Paul, Sheehan, Doe, Drey, Broekhuizen, Creinin, Westhoff, Chasen,
22 Hammond, Grunebaum, and Fredriksen, sometimes perform previability abortions, as
23 described above, which would violate the act. Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 1 at
24 165:7-21 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr. Vol. 4 at
25 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2
26 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen); Exh. 36, Exh. 37, Exh. 38.

27 12. When beginning a D&E or induction procedure, a physician cannot predict if the
28 procedure will proceed in such a manner that it violates the Act, but the physician knows that is

1 a possibility. Tr. Vol. 1 at 71:17-24 (Paul); Tr. Vol. 2 at 206:1-13 (Sheehan); Tr. Vol. 3 at
2 420:18-22; 426:5-7 (Doe); Tr. Vol. 4 at 522:4-17 (Broekhuizen); Tr. Vol. 5 at 786:11-23
3 (Creinin).

4 13. Accordingly, because physicians may face criminal prosecution under the Act for
5 violative procedures, the nature of which they cannot always predict, the Act would have a
6 significantly negative impact on their practice and their relationships with their patients, and in
7 some circumstances, already has. See, e.g., Tr. Vol. 1 at 74:21-23 (Paul) (“my overriding
8 concern is that if I continue to practice . . . second trimester abortions in the way I believe is the
9 safest for women, that I could be in prison”); *id.* at 92:8-13 (“I think [the Act] would have a
10 tremendous impact on my practice. I would be forced with a decision I would have never
11 faced before in medicine and that is as to whether to continue to do procedures in a way that I
12 think are safest for women because if I did so, I would risk imprisonment”); *id.* at 93:5-12 (Act
13 would undermine fundamental trust that physician has with patient because it would prevent
14 them from giving best possible care); Tr. Vol. 4 at 563:3-16 (Broekhuizen) (the Act would
15 “make it significantly more difficult to provide . . . medically necessary services” and would
16 force him to utilize fetocidal injections more frequently which “may not really be in the best
17 interests of the patients”); Tr. Vol. 11 at 1787:10-23 (Chasen) (fear of committing a criminal
18 act may prevent physicians from giving their full attention while providing care); Tr. Vol. 5 at
19 820:6-20 (Westhoff) (describing complication that occurred as a result of a D&E performed
20 utilizing fetocidal injection in attempt to avoid Act’s coverage); Tr. Vol. 2 at 204:14-205:3
21 (Sheehan) (the Act “would really cause a significant disruption between [me and] the patient”);
22 Lockwood Depo. 68:2-68:16 (criminal penalties included in Act “further unravel physicians’
23 social contract with patients”).

24 **F. Conclusions of Law**

25 Accordingly, the court concludes that the definition of “partial-birth abortion” contained
26 in the Act encompasses several second trimester abortion procedures *in addition* to intact
27 D&E. Physicians may perform each element contained in the Act’s definition in any D&E
28 procedure, and in the course of certain induction abortions and treatment of spontaneous

1 miscarriages as well. And, because D&E procedures comprise nearly 85-95% of all second
2 trimester abortions, the Act creates a risk of criminal liability during virtually all abortions
3 performed after the first trimester, and “has the effect of placing a substantial obstacle in the
4 path of a woman seeking an abortion of a nonviable fetus.” *Stenberg*, 530 U.S. at 921
5 (quoting *Casey*, 505 U.S. at 877). A majority of the physicians who testified noted that
6 because they “fear prosecution, conviction, and imprisonment,” the wide net cast by the Act
7 could have and has already had the effect of impacting all previability second trimester
8 abortion services that they provide to their patients. See *id.* at 945-46.

9 The government’s argument that Congress intended to ban only the intact D&E
10 procedure is not convincing. First, as the Supreme Court noted in *Stenberg* in rejecting a
11 nearly identical argument by the state of Nebraska, if Congress did not intend to prohibit
12 procedures other than intact D&Es, it would have been simple for it to exclude other
13 procedures. See *Stenberg*, 530 U.S. at 939 (“it would have been a simple matter, for
14 example, to provide an exception for the performance of D&E and other abortion
15 procedures”); see also *Planned Parenthood of Central New Jersey v. Farmer*, 220 F.3d 127,
16 140 (3rd Cir. 2000) (holding New Jersey partial-birth abortion ban unconstitutional, and noting
17 that “[i]f the Legislature intended to ban only the [intact D&E] procedure, it could easily have
18 manifested that intent either by specifically naming that procedure or by setting forth the
19 medical definition of [intact D&E] utilized by ACOG”); cf. *Women’s Medical Prof’l Corp. v.*
20 *Taft*, 353 F.3d 436, 452-53 (6th Cir. 2003) (holding that Ohio partial-birth abortion ban did not
21 pose an undue burden because it “avoided the flaws identified in [*Stenberg*] by precisely
22 describing the restricted procedure and explicitly permitting D&E procedures”).

23 Moreover, it does not appear to this court that Congress simply overlooked the
24 *Stenberg* Court’s language to this effect. Instead, it appears that Congress intentionally chose
25 *not* to explicitly exclude D&Es. The government presented no evidence to this court that
26 supported its arguments regarding congressional intent, and the Congressional Record
27 suggests the contrary. Within Congress, opponents of the Act pointed out the potential
28 overbreadth of the Act and proposed remedies regarding the scope. They noted that:

1 Medical experts testified just yesterday before the Constitution Subcommittee
2 that the definition in the bill could easily be construed to ban the most commonly
used second trimester procedure.

3 H.R. Report No. 108-58, at 80 (2003) (“Record Exh. A”). Congress, however, rejected the
4 related amendments to narrow the scope of the Act.

5 However, even if it was Congress’ intent to limit the ban to intact D&Es, this court, like
6 the Supreme Court in *Stenberg*, is “without power to adopt a narrowing construction of [the
7 statute] unless such a construction is reasonable and readily apparent.” 530 U.S. at 944
8 (citing *Boos v. Berry*, 485 U.S. 312, 330 (1972)). Even if this court were to accept the
9 government’s argument that the phrase “partial-birth abortion,” as used by Congress, is
10 commonly associated with the intact D&E procedure, the use of that phrase does not limit the
11 scope of the Act to intact D&Es. Instead, the phrase “partial-birth abortion” is “subject to the
12 statute’s *explicit statutory definition*,” which this court is required to follow even if that definition
13 “varies from the term’s ordinary meaning.” *Id.* at 942-43 (citing *Meese v. Keene*, 481 U.S.
14 465, 484-85 (1987)); *see also Richmond Medical Center v. Hicks*, 301 F.Supp.2d 499, 515
15 (E.D. Va. 2004) (Virginia law posed an undue burden despite fact that it explicitly excepted
16 from coverage “the dilation and evacuation abortion procedure involving dismemberment of
17 the fetus prior to removal from the body of the mother where plain language of the Act
18 [nevertheless] ban[ned] pre-viability D&Es and would cause those who perform such D&Es to
19 fear prosecution, conviction, and imprisonment”). Here, for the reasons discussed above, the
20 Act’s statutory definition casts a net wider than intact D&Es, and may include other previability
21 abortion procedures, including D&Es by disarticulation, inductions, and treatment of
22 spontaneous miscarriages.

23 However, even if this court were to find that linguistic differences in the Act make it less
24 likely that the Act encompasses D&E by disarticulation procedures as did the Nebraska
25 statute in *Stenberg*, this court nevertheless concludes that the Act is unduly burdensome
26 because, even assuming that the Act covers only the intact D&E procedure, the Act does not
27 distinguish between previability and postviability in violation of *Roe* and *Casey*. *See*
28 *Stenberg*, 530 U.S. at 930 (the government’s “interest in regulating abortion previability is

1 considerably weaker than postviability”). To the extent that a woman seeks or requires an
2 intact D&E abortion prior to viability, this Act would undoubtedly place a substantial obstacle in
3 her path and decision.¹⁴

4 For the reasons stated above, the court finds that the Act is unconstitutional.

5 **III. CONSTITUTIONAL VAGUENESS**

6 **A. Parties’ Positions**

7 Plaintiffs next challenge the Act on the ground that it is void for vagueness, in violation
8 of the Due Process Clause, because the Act fails to clearly define the prohibited medical
9 procedures and does not use terminology that is recognized in the medical community.
10 Therefore, according to plaintiffs, it deprives physicians of fair notice and encourages arbitrary
11 enforcement.¹⁵

12 The government, however, contends that the inclusion of scienter requirements in the
13 Act mitigates any possible vagueness. *See, e.g., Village of Hoffman Estates*, 455 U.S. 489,
14 499 (1982); *Colauitti v. Franklin*, 439 U.S. 379, 395 n. 13 (1979). It cites to three statutory
15 phrases in the Act that it contends constitute scienter requirements. These phrases appear in
16 § 1531(a), and in § 1531(b)(1)(A) (defining partial-birth abortion), and provide in pertinent
17 part:

18 (a) Any physician who, in or affecting interstate or foreign commerce, *knowingly*
19 *performs* a partial-birth abortion and thereby kills a human fetus shall be fined
under this title or imprisoned not more than 2 years, or both....

20 (b) As used in this section —

21 (1) the term “partial-birth abortion” means an abortion in which the person
22 performing the abortion—

23 _____
24 ¹⁴The *Stenberg* court did not have to reach this issue because it concluded that the statute
25 in that case sufficiently encompassed other D&E procedures in addition to intact D&E
26 procedures. However, as the *Stenberg* court noted, “the fact that Nebraska’s law applies both
27 previability and postviability aggravates the constitutional problem presented.” *Id.*

28 ¹⁵Plaintiffs also argue that the Act is impermissibly vague regarding what conduct is “in or
affecting interstate or foreign commerce.” They contend that physicians, therefore, have no notice
regarding when the Act applies, thus subjecting them to arbitrary and discriminatory prosecution.
However, because the court concludes that the Act is unconstitutionally vague for the reasons set
forth above, it is unnecessary for the court to reach this specific argument.

1 (A) *deliberately and intentionally* vaginally delivers a living fetus until, in
2 the case of a head-first presentation, the entire fetal head is outside the body of
3 the mother, or, in the case of a breech presentation, any part of the fetal trunk
past the navel is outside the body of the mother, *for the purpose of* performing
an overt act that the person knows will kill the partially delivered fetus. . . .

4 (Emphasis added.)

5 The government contends that the inclusion of these scienter requirements as
6 emphasized above remedies any vagueness. It claims that because of the scienter
7 requirements, “the Act does not criminalize situations, during a D&E [by disarticulation], in
8 which a living fetus may be delivered, by happenstance, intact or even [in] cases where the
9 partial delivery of the intact fetus is intentional or foreseeable, but only procedures where the
10 provider deliberately delivers the fetus both in the manner described by the Act and *with* a
11 specific intent from the outset to perform an overt act that the provider knows will kill the fetus.”

12 **B. Legal Standard**

13 The Supreme Court has unambiguously stated that vague laws are unconstitutional:

14 It is a basic principle of due process that an enactment is void for vagueness if
15 its prohibitions are not clearly defined. Vague laws offend several important
16 values. First, because we assume that man is free to steer between lawful and
unlawful conduct, we insist that laws give the person of ordinary intelligence a
17 reasonable opportunity to know what is prohibited, so that he may act
accordingly. Vague laws may trap the innocent by not providing fair warning.
Second, if arbitrary and discriminatory enforcement is to be prevented, laws
must provide explicit standards for those who apply them.

18 *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). Accordingly, to avoid unconstitutional
19 vagueness, the Act must (1) define the offense with sufficient definiteness that ordinary people
20 can understand what conduct is prohibited; and (2) establish standards such that enforcement
21 may be conducted in a non-arbitrary, non-discriminatory manner. *Nunez v. City of San Diego*,
22 114 F.3d 935, 940 (9th Cir. 1997).

23 “The need for definiteness is greater when the ordinance imposes criminal penalties
24 on individual behavior or implicates constitutionally protected rights than when it regulates the
25 economic behavior of businesses.” *Id.* (quoting *Village of Hoffman Estates*, 455 U.S. at 494).
26 Moreover, if the Act does not provide sufficient “standards to prevent arbitrary enforcement,” it
27 “would be impermissibly vague even if it did not reach a substantial amount of constitutionally
28

1 protected conduct, because it would subject people to the risk of arbitrary deprivation of their
2 liberty.” *Forbes v. Napolitano*, 236 F.3d 1009, 1011-1012 (9th Cir. 2000) (citing *City of*
3 *Chicago v. Morales*, 527 U.S. 41, 42 (1999)). “Regardless of what type of conduct the
4 criminal statute targets, the arbitrary deprivation of liberty is itself offensive to the
5 Constitution’s due process guarantee.” *Id.* at 1012 (citing *Smith v. Goguen*, 415 U.S. 566,
6 575 (1972)).

7 **C. Findings of Fact and Conclusions of Law**

8 As plaintiffs note, several of the terms in the Act are ambiguous, including “partial-birth
9 abortion,” “overt act,” “deliberately and intentionally,” and “living fetus.” The trial testimony of
10 numerous physicians confirmed that, as physicians and practitioners providing abortion
11 services, they do not understand exactly what the Act prohibits. See, e.g., Tr. Vol. 1 at 76:7-
12 82:12 (Paul); Tr. Vol. 4 at 557:4-13 (Broekhuizen); Tr. Vol. 11 at 1787:10-23 (Chasen); Tr.
13 Vol. 5 at 820:6-20 (Westhoff); Tr. Vol. 2 at 200:23-202:3 (Sheehan).

14 As many of the physicians testified before this court, the term “partial-birth abortion”
15 has little if any medical significance in and of itself. See, e.g., Tr. Vol. 3 at 420:23-421:2
16 (Doe); Grunebaum Depo. at 214:1-7. Dissenting legislators within Congress made the same
17 observation, arguing that:

18 This legislation is overly vague. It is unclear exactly, which procedures we would
19 ban. The term ‘partial-birth abortion’ has no legal or medical meaning. It is a
20 term invented for political purposes. The findings and actual operative clauses
21 of the bill are inconsistent in their definitions, and in both cases are overly vague.

22 Record Exh. A, at 80.

23 Additionally, the Act’s use of the term “living fetus” adds to the vagueness of the statute,
24 since, the term “living fetus” is not pertinent to the framework set forth by the Supreme Court in
25 *Roe* and *Casey*, and does not pertain to viability. As set forth above in the court’s findings
26 regarding undue burden, a previable fetus may nonetheless be “living” if it has a detectable
27 heartbeat or pulsating umbilical cord. Tr. Vol. 1 at 67:3-11; 76:6-18 (Paul); Tr. Vol. 2 at 201:5-
28 8 (Sheehan); Tr. Vol. 3 at 421:12-18 (Doe); Tr. Vol. 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11
at 1783:15-1786:3 (Chasen). Moreover, as noted by the Third Circuit, “because a fetus may

1 be 'living' as early as seven weeks Imp, use of the term 'living' instead of 'viable' indicates
2 that, contrary to the understanding of the public and the concomitant rhetoric, the Act is in no
3 way limited to late-term, or even mid-term, abortions." *Farmer*, 220 F.3d at 137 (holding state
4 partial-birth abortion ban unconstitutionally vague, asserting that "the term 'living human fetus'
5 adds little to the Act's constitutional certainty because it does not draw the line at viability, as
6 the Supreme Court has done").

7 Nor does the requirement of an "overt act" sufficiently narrow the scope of the Act to
8 give notice of the type of abortion procedure prohibited. Again, as set forth above in the
9 court's findings regarding undue burden, the "overt act" may be interpreted to comprise many
10 acts, performed not only in the process of an intact D&E, but in the course of a D&E by
11 disarticulation or induction as well, including disarticulation of the calvarium, cutting the
12 umbilical cord, or compressing or decompressing the skull or abdomen or other fetal part that
13 is obstructing completion of the uterine evacuation. Tr. Vol. 1 at 61:7-15; 70:1-6; 78:25-79:5
14 (Paul); Tr. Vol. 2 at 193:5-24; 205:8-15 (Sheehan); Tr. Vol. 3 at 405:13-22 (Doe); Tr. Vol. 4 at
15 523:1-524:1 (Broekhuizen); Tr. Vol. 11 at 1783:15-1786:3 (Chasen). Accordingly, the term
16 "overt act" cuts such a wide swath that it cannot possibly be considered sufficient to put
17 physicians on notice of what type of "overt" act violates the Act.

18 This court further concludes that the Act's vagueness and unconstitutional breadth
19 cannot be cured by the alleged scienter requirements. First, the requirement that the
20 physician "knowingly perform" a "partial-birth abortion," as defined by the Act, is of no help to
21 the government. As plaintiffs have argued and the trial evidence has demonstrated, as part of
22 their routine medical practice, a physician performing a D&E, by disarticulation or intact, or an
23 induction abortion in the safest, most medically appropriate manner, "knows" that the
24 procedure may proceed in such a manner that the physician may have to engage in
25 procedures proscribed by the Act. See Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 1 at 165:7-21
26 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr. Vol. 4 at 550:18-
27 552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2 (Westhoff); Tr.
28 Vol. 11 at 1783:15-1786:3 (Chasen).

1 Nor can the fact that the Act requires that a physician “deliberately and intentionally
2 vaginally deliver a living fetus” cure the unconstitutional vagueness. The parties dispute
3 whether the phrase modifies only the vaginal delivery or the additional steps contained in the
4 Act’s definition of “partial-birth abortion.” However, this court need not resolve that dispute,
5 because, as the Third Circuit held in *Farmer*, this scienter requirement does nothing to
6 ameliorate the vagueness of Act. See *Farmer*, 220 F.3d at 138 (rejecting state’s argument
7 that scienter requirement specifying “deliberate[] and intentional[] deliver[y] into the vagina of a
8 living fetus” cured unconstitutional vagueness).

9 At a minimum, to limit the scope of a statute to ‘deliberately and intentionally’
10 performing a certain procedure, the procedure itself must be identified or readily
susceptible of identification. Here it is not.

11 *Id.* (citations omitted); see also *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d
12 386, 389 (8th Cir. 1999) (Iowa partial-birth abortion ban’s inclusion of scienter requirement did
13 not save Act because Act still “encompasse[d] more than just the [intact D&E] procedure”).

14 This same analysis applies to the Act’s requirement that the procedure be “for the
15 purpose” of performing “an overt act that the [physician] knows will kill the partially delivered
16 fetus.” Insofar as the court has already concluded that the Act’s definition may encompass
17 many second trimester abortions and that the terms “partial-birth abortion” and “overt act” are
18 ambiguous, the inclusion of a scienter requirement cannot cure the vagueness and save the
19 Act.

20 As noted previously, the government also argues that this court should narrow the
21 construction of the statute to eliminate any doubts about the Act’s unconstitutionality. This
22 court rejects that argument for the reasons set forth above in the court’s conclusions of law
23 regarding the undue burden posed by the Act.

24 Accordingly, the court finds that the Act is unconstitutional on this ground as well.

25 **IV. HEALTH EXCEPTION**

26 Separate and apart from the undue burden and vagueness analyses, *Stenberg* also
27 holds that “where substantial medical authority supports the proposition that banning a
28 particular abortion procedure could endanger women’s health, *Casey* requires the statute to

1 include a health exception where the procedure is ‘necessary, in appropriate medical
2 judgment, for the preservation of the life or health of the mother.’” *Stenberg*, 530 U.S. at 938
3 (citing *Casey*, 505 U.S. at 879). The Act, by contrast, excepts only “a partial-birth abortion that
4 is necessary to save the *life* of a mother,” and omits the health exception and the “appropriate
5 medical judgment” requirements of *Casey* and *Stenberg*.

6 Although the court has already found that the Act is unconstitutional because it poses
7 an undue burden and because it is vague, given the time and resources expended by the
8 parties and this court, and the extensive evidence presented on the issue, the court is
9 compelled to reach the issue regarding a health exception.

10 **A. Parties’ Arguments**

11 Plaintiffs contend that *Stenberg* requires a health – not just life – exception under the
12 circumstances, and that the congressional findings on the issue are not entitled to any
13 deference. In support, plaintiffs assert that the intact D&E procedure, is a safe, if not a safer,
14 option for pregnancy termination than other abortion procedures, and is necessary to preserve
15 the health of certain women under certain circumstances. Additionally, plaintiffs also argue
16 that the Act’s life exception is constitutionally inadequate because it does not allow a
17 physician to determine, in his or her best medical judgment, whether the intact D&E procedure
18 is necessary to preserve a woman’s life.

19 The government, however, argues that the Act’s life exception is constitutionally
20 adequate because Congress has concluded that the procedure is never medically necessary,
21 and that this court must defer to Congress’ finding. The government, therefore, contends that
22 the evidence before this court is relevant *only* in determining the degree of deference afforded
23 Congress’ finding regarding the necessity of a health exception.

24 **B. Trial Evidence**

25 At the outset, this court recognizes that Congress has made a finding pertinent to the
26 trial evidence before this court, and that in affording the appropriate level of deference to
27 Congress’ finding, the evidence before this court may play a limited role in resolution of this
28 issue. Nevertheless, the court, prior to determining the degree of deference to be accorded

1 the congressional findings, summarizes in significant detail and finds as follows regarding the
2 extensive evidence presented by both parties before this court.

3 1. Witnesses' Background and Qualifications

4 a. Plaintiffs' Witnesses

5 Plaintiffs presented trial testimony from eight expert witnesses in opposition to the Act,
6 several of whom also provided testimony in the New York case. Plaintiffs' testifying experts
7 included: Drs. Maureen Paul, Katharine Sheehan, Carolyn Westhoff, Fredrik Broekhuizen,
8 John Doe, Mitchell Creinin, Eleanor Drey, and Stephen Chasen.¹⁶

9 _____
10 ¹⁶The court briefly sets forth the qualifications of each of plaintiffs' testifying experts.
11 Dr. Maureen Paul is a board-certified obstetrician and gynecologist ("obgyn") who also holds a
12 masters' degree in public health and epidemiology (the study of research methods in determining
13 what groups are affected by what diseases). Dr. Paul serves as the chief medical officer for
14 plaintiff Planned Parenthood Golden Gate and is an associate clinical professor at the University
15 of California San Francisco ("UCSF"). She is also the editor-in-chief of the leading textbook on
16 abortion procedure. Dr. Paul has never previously testified as an expert witness in any abortion-
17 related case. See Exh. 60 (Paul CV); Tr. Vol. 1 at 6:13-13:-23.

14 Likewise, Dr. Katharine Sheehan is a board-certified obgyn who serves as the full-time
15 medical director of the Planned Parenthood affiliate for San Diego and Riverside Counties, which
16 is the only provider of second trimester abortions beyond 18 weeks for the entire area of
17 California south of Los Angeles. She also has a private practice and teaches as a clinical faculty
18 member of the University of California San Diego ("UCSD") medical school. She has never
19 testified in any court cases previously. Exh. 66 (Sheehan CV); Tr. Vol. 1 at 151:6-164:5:3, Tr. Vol.
20 2 at 178:8-179:8 (Sheehan).

18 Dr. Doe testified in this case under a pseudonym. He is a board-certified obgyn who is
19 board eligible in maternal-fetal medicine. He practices in the San Francisco Bay Area. He has
20 never given testimony in court before. Tr. Vol. 3 at 377:8-387:23 (Doe).

21 Dr. Fredrik Broekhuizen is a board-certified obgyn who serves as a part-time medical
22 director for Planned Parenthood of Wisconsin, a full professor of obstetrics at the Medical
23 College of Wisconsin, and who also has a private practice. He has previously testified in other
24 abortion litigation. Exh. 6 (Broekhuizen CV), Tr. Vol. 4 at 481:12-494:11 (Broekhuizen).

23 Dr. Mitchell Creinin is a board-certified obgyn. He is a full professor of obstetrics and
24 epidemiology at the University of Pittsburgh, and the part-time medical director of that area's
25 Planned Parenthood affiliate. He is also the co-author of a chapter in a leading obstetrics
26 textbook on induction abortions. Exh. 28 (Creinin CV), Tr. Vol. 4 at 645:13-656:20 (Creinin).

25 Dr. Carolyn Westhoff is a board-certified obgyn who is affiliated with the New York
26 Presbyterian Hospital and is a professor at the Columbia University Medical School in both obgyn
27 and epidemiology. She is a member of the board of Planned Parenthood, is a member of the
28 National Abortion Federation ("NAF") and has provided testimony in a number of cases involving
Planned Parenthood. Exh. 67 (Westhoff CV), Tr. Vol. 5 at 790:24-798:10, 834:1-835:21
(Westhoff).

1 Plaintiffs' expert witnesses all currently practice and/or teach in the area of obstetrics
2 and gynecology ("obgyn"), and all were qualified as experts in that area and in abortion
3 practice. Additionally, three of the eight were also qualified as experts in maternal-fetal
4 medicine; two were qualified as experts in epidemiology; and one taught epidemiology jointly
5 with his medical practice. All eight have performed intact D&Es during the course of their
6 practices, with varying frequencies, and all of those experts who teach in the area of abortion
7 practice teach the intact D&E variant. Of plaintiffs' witnesses asked to quantify the number of
8 abortions they had performed, all answered in the thousands. See, e.g., Tr. Vol. 1 at 160:5-14
9 (Sheehan, estimating 30,000); Tr. Vol. 5 at 732:10-12 (Creinin, estimating 5,000). Moreover,
10 all eight opine that enforcement of the Act would significantly affect their patients and
11 practices, and could subject them to prosecution under the Act. Six of plaintiffs' experts have
12 never previously testified in any case involving a ban on abortion. None of plaintiffs' experts
13 testified before or was consulted by Congress with respect to the drafting of the Act or the
14 findings supporting the Act.¹⁷

15 Plaintiffs also submitted the deposition testimony of five experts: one who is an expert
16 in perinatal and gynecological pathology, and four of whom are experts in obgyn and abortion
17 practice, including intact D&E. Three of the four are also experts in maternal-fetal medicine.

18 **b. Government Witnesses**

19 The government presented trial testimony from five expert witnesses. Several of these
20 witnesses practice and teach in obgyn; and four of the five were, therefore qualified as experts
21 in that area. Two of those four were also qualified as experts in maternal-fetal medicine, and

22 _____
23 Dr. Eleanor Drey is a board-certified obgyn, the medical director of the Women's Option
24 Center at San Francisco General Hospital, and an assistant clinical professor teaching abortion
25 methods at UCSF. She has never offered expert testimony before. Tr. Vol. 2 at 274:9-278:2,
26 286:15-291:3 (Drey), Exh. 33 (Drey C.V.).

27 Dr. Stephen Chasen is board-certified in both obgyn and maternal-fetal medicine. He is
28 an associate professor at the Cornell University Medical College and directs the high-risk
29 obstetrics program, the obgyn residency program, and the maternal-fetal medicine fellowship
30 program. Exh. 24 (Chasen CV), Tr. Vol. 11 at 1705:12-1717:19 (Chasen).

¹⁷One of plaintiffs' witnesses, Dr. Creinin, wrote a letter to Congress in opposition to the
Act.

1 one was qualified as an expert in medical literature. Three of the four were qualified as
2 experts in pregnancy termination. However, none had performed the intact D&E procedure at
3 issue in this case. Moreover, none had been instructed regarding the procedure or had
4 personally observed the procedure being performed.

5 All four witnesses had testified previously in support of state law restrictions on
6 abortion, or had offered testimony before Congress in support of the Act, or both. The
7 government's fifth testifying expert, Dr. Anand, was qualified as an expert in the areas of
8 pharmacology of anesthetic drugs, fetal neurobiology, and fetal pain.

9 The government also introduced deposition testimony from one expert witness, an
10 expert in obgyn, maternal-fetal medicine, and abortion practice, with the caveat that he has
11 never performed an intact D&E procedure.

12 The four government witnesses qualified as experts in obgyn included Drs. Leroy
13 Sprang, Curtis Cook, Watson Bowes, and Elizabeth Shadigian.

14 Dr. Sprang, an associate clinical professor at Northwestern University and a practicing
15 obgyn for approximately twenty eight years, testified that he had never performed any abortion
16 procedure on a fetus post-17 weeks Imp, that he had performed fewer than twenty D&Es by
17 disarticulation in his twenty eight years of practice, all of which were on demised fetuses, and
18 that he had never been instructed regarding, had never taught, performed, or even observed
19 an intact D&E procedure. Tr. Vol. 7 at 1033:17-18; 1034:1-1038:4 (Sprang). He further
20 testified that his knowledge regarding intact D&E was based exclusively on his conversations
21 with other physicians,¹⁸ his review of medical literature, and his involvement in this litigation

22
23 ¹⁸Dr. Sprang testified that his knowledge regarding the intact D&E procedure was derived
24 from conversations with other physicians. *Id.* at 1041:1-1046:6. He claimed that there were two
25 "significant" or "memorable" physicians with whom he had discussions after a meeting, and had
26 received more information than usual regarding the intact D&E procedure. *Id.* at 1042:20-22.
27 However, he could not recall the names, dates, or locations associated with those conversations.
28 *Id.* at 1044:4-14.

26 Moreover, this basis for Dr. Sprang's knowledge is somewhat questionable since two of
27 plaintiffs' witnesses in this case, Drs. Hammond and Frederiksen, teach at Northwestern as well.
28 While he was aware that Dr. Hammond teaches intact D&E at Northwestern, Dr. Sprang testified
that he was aware of the practices and teachings of Drs. Hammond and Frederiksen only from
the residents at Northwestern because he had never spoken with either of them in person. *Id.* at

1 and other litigation in which he was required to read other expert reports and related
2 documents. *Id.* at 1045:2-1052:4. The court also notes that Dr. Sprang has never conducted
3 clinical research in the area of abortion. *Id.* at 1029:3-7.

4 Like Dr. Sprang, while Dr. Cook possesses expertise generally in obgyn and maternal-
5 fetal medicine, he also lacks expertise regarding the intact D&E procedure in particular. Dr.
6 Cook has never performed, personally observed, supervised, received instruction in, or taught
7 the intact D&E procedure.¹⁹ Tr. Vol. 9 at 1380:7-1381:7 (Cook). Dr. Cook also lacks
8 expertise in post-20 week D&Es generally. *Id.* at 1365:15-22. He has performed only three to
9 five D&Es by disarticulation in his career, limited to cases where fetal demise had already
10 occurred. *Id.* at 1364:14-25. Moreover, in terms of his observation of D&Es by disarticulation,
11 Dr. Cook testified that he generally observes the procedure prior to 18 weeks gestation. *Id.*

12 The same is true of Dr. Bowes, an emeritus professor of obgyn at the University of
13 North Carolina/ Chapel Hill, retired from his clinical practice. He is board-certified in obgyn
14 and maternal-fetal medicine. Tr. Vol. 6 at 875:1-879:7 (Bowes). Dr. Bowes has never
15 performed an intact D&E; and he has only performed 2-3 D&Es by disarticulation on fetuses
16 that had not already died at the time of the procedure. *Id.* at 978:8-983:23. Those D&Es were
17 performed to save the mother's life, as Dr. Bowes believes that abortion generally is
18 warranted only when there are severe medical complications that threaten a mother's life. *Id.*
19 at 977:1-4.

20 Likewise, Dr. Elizabeth Shadigian, an obgyn and a clinical associate professor of
21 obgyn at the University of Michigan, testified that she has never performed an intact D&E, and
22 has never supervised, observed, been instructed in, or taught the procedure. Tr. Vol. 8 at
23
24

25 _____
26 1046:3-6. Moreover, although she is on the faculty at his university, he knows Dr. Frederiksen
27 "very minimally" and "if [he] saw her in the room, [he] wouldn't be sure that [he] would recognize
28 her." *Id.* at 1166:1-21.

¹⁹Dr. Cook did testify that he once observed a videotape of the evacuation process of an
intact D&E; however, the quality of the videotape was extremely poor.

1 1214:3-1215:3 (Shadigian).²⁰ Of the abortions that she has performed on fetuses prior to
2 demise, all have been induction abortions under circumstances of severe maternal
3 complications. In her career, all of the D&Es by disarticulation that she has performed have
4 been on demised fetuses.

5 c. Expert Qualifications

6 Accordingly, this court found that the government's experts lacked the background,
7 experience, and instruction to qualify as experts regarding the technique of the intact D&E
8 procedure. Instead, the court allowed the government's experts to testify only regarding their
9 opinions on the safety of the procedure, based upon their review of the literature. The court
10 noted that if it were to qualify the government's witnesses, who did not "appear to have any
11 personal experience with late-term abortion procedures at issue here," it would mean that any
12 obgyn would be considered an expert on late-term abortions. See Tr. Vol. 7 at 1052:22-25.

13 Overall, while the government's witnesses are eminently qualified as obgyn
14 practitioners, the court finds that the government's witnesses lack the qualifications,
15 experience, and knowledge possessed by plaintiffs' witnesses with respect to late-term
16 abortion procedures generally, and intact D&E in particular.

17 2. Overview of Plaintiffs' Evidence

18 Plaintiffs presented evidence that intact D&E is at least as safe as D&E by
19 disarticulation, and under some circumstances safer, because the procedure is quicker and
20 requires fewer passes with the forceps. Plaintiffs also presented evidence that common
21 sense and sound medical judgment indicate that fewer passes reduce the risk of uterine
22 perforation and cervical lacerations from instruments and/or fetal bone fragments. Tr. Vol. 1 at

23
24 ²⁰She further attested that she probably did not even personally know any physicians who
25 performed the procedure, and had never done any research regarding the procedure other than
26 in connection with the instant litigation. *Id.* at 1214:22-1215:6. Dr. Shadigian testified that she
27 was not aware of the intact D&E procedure being taught at the University of Michigan, where she
28 works. *Id.* at 1231:12-1232:7. However, she did testify that she was aware that the chair of the
Maternal-Fetal Medicine Department at the University of Michigan, Dr. Timothy Johnson, whom
she testified she respected as a physician, was of the opinion that intact D&E was the safest and
most appropriate procedure under certain circumstances and that she had no reason to doubt
Dr. Johnson's testimony in the New York case that such procedures are conducted up to 22 wks
Imp at the University of Michigan. *Id.* at 1294:20-1297:4; 1316:19-25.

1 70:10-17 (Paul); Tr. Vol. 1 at 166:13-167:2, 169:7-13, Tr. Vol. 2 at 186:14-187:16 (Sheehan);
2 Tr. Vol. 3 at 399:18-400:217, 407:12-20 (Doe); Tr. Vol. 5 at 798:12-804:5 (Westhoff); Tr. Vol.
3 11 at 1755:5-1756:19 (Chasen). Certain of defendants' witnesses agreed. Tr. Vol. 6 at
4 944:20-945:21 (Bowes); Tr. Vol. 8 at 1285:4-14 (Shadigian); Tr. Vol. 9 at 1486:11-1487:5
5 (Cook). *But see* Tr. Vol. 7 at 1127:8-1128:12 (Sprang, opining that no risk in additional
6 passes if ultrasound is used).

7 In addition, since the fetus undergoes less disarticulation, the risk of leaving fetal parts
8 in the uterus is diminished, and the procedure is likely to take less time. Tr. Vol. 1 at 72:7-73:8
9 (Paul); Tr. Vol. 5 at 799:1-4, 800:13-4, 801:8-21 (Westhoff). The quicker the procedure, the
10 less time the woman must spend under sedation, which further reduces the potential for
11 complications caused by anesthesia. Tr. Vol. 1 at 168:19-169:6 (Sheehan). Plaintiffs also
12 argue that a shorter surgical procedure will decrease the amount of blood loss and the risk of
13 infection. Tr. Vol. 5 at 799:4 (Westhoff); Tr. Vol. 11 at 1756:15-19 (Chasen).

14 Because the intact D&E procedure results in a fetus that remains relatively intact after
15 surgery, an autopsy of the fetus for diagnostic purposes is possible, particularly if the reason
16 for the abortion was due to fetal anomalies. Such further diagnosis may be helpful for the
17 woman in planning for future pregnancies. Tr. Vol. 2 at 189:3-20 (Sheehan); Tr. Vol. 11 at
18 1757:14-1758:19 (Chasen). Some women also prefer a surgical procedure that yields a
19 relatively intact fetus for psychological reasons, so that the mother can hold the fetus and, if
20 desired, have the fetus receive religious rites. *See, e.g.*, Tr. Vol. 4 at 503:18-504:3; 562:10-
21 22 (Broekhuizen). However, if the intact D&E procedure destroys the contents of the brain,
22 analysis of the brain tissue would be impossible. Tr. Vol. 2 at 254:17-25 (Sheehan); Tr. Vol. 3
23 at 433:9-434:6 (Doe, also noting that brain tissue is not always needed in autopsies and
24 cannot always be successfully obtained even in inductions).

25 The AMA task force, on which government witness Dr. Sprang served, concluded that
26 intact D&E "may minimize trauma to the woman's uterus, cervix, and other vital organs, [and]
27 may be preferred by some physicians, particularly when the fetus has been diagnosed with
28 hydrocephaly or other anomalies incompatible with life outside the womb." Tr. Vol. 7 at

1 1133:12-1134:8 (Sprang).

2 3. Overview of Government's Evidence

3 In contrast, the government took the position that intact D&E is a dangerous procedure
4 that is less safe than any other second trimester abortion method, is never medically
5 necessary, and could potentially pose grave risks to women's health. The government argues
6 that not only is there no scientific evidence showing that the procedure is safe as a whole, but
7 the individual elements of the procedure have been shown to be unsafe as well. See, e.g., Tr.
8 Vol. 7 at 1079:1-1081:5 (Sprang); Tr. Vol. 8 at 1233:12-1234:3 (Shadigian); Tr. Vol. 9 at
9 1411:22-1416:1 (Cook).

10 The government also introduced evidence that in no situation is an intact D&E
11 medically necessary, since a woman could always undergo another method of second
12 trimester abortion in any given situation, including D&E by disarticulation, induction, or
13 hysterotomy or hysterectomy. See, e.g., Tr. Vol. 7 at 1110:14-1111:9 (Sprang); Tr. Vol. 8 at
14 1220:16-21 (Shadigian); Tr. Vol. 9 at 1390:3-22 (Cook).

15 4. Medical Organizations

16 Numerous medical organizations are divided on their positions regarding the Act.
17 Among the largest organizations that oppose the Act are ACOG, a professional membership
18 organization organized in 1951, concerned with professional practice and education in the
19 health care of women. ACOG has more than 44,000 members in the United States, Canada,
20 and Mexico. Each member of ACOG is a board-certified obgyn, and more than 90% of all
21 board-certified obgyns are members of ACOG. See *generally* Deposition of Joanna Cain,
22 M.D. ("Cain Depo").

23 The California Medical Association ("CMA") also opposes the Act. The CMA, which
24 advocates for the interests of physicians and their patients, is California's largest medical
25 association, with more than 30,000 members, comprised of licensed physicians. See
26 *generally* Deposition of John Whitelaw, M.D. ("Whitelaw Depo"). Two other associations, the
27 American Medical Women's Association ("AMWA"), an organization of 10,000 medical
28 professionals, including women physicians, residents, and medical students, dedicated to

1 advancing women in medicine and improving women’s health, and the American Public
2 Health Association (“APHA”), an organization with approximately 50,000 members from all
3 public health occupations, including obstetricians and gynecologists, devoted to advancing
4 and promoting public health, also oppose the Act. See *generally* Deposition of Meghan
5 Kissell (“Kissell Depo”); Deposition of Alan Baker (“Baker Depo”).

6 Among those organizations that supported the Act were the Association of American
7 Physicians & Surgeons (“AAPS”), which submitted an amicus brief in support of Nebraska in
8 the *Stenberg* case. AAPS is a nonprofit organization dedicated to defending the practice of
9 private medicine. It submitted the amicus brief on behalf of several other medical
10 organizations, including ISMS, the Illinois State Medical Society. An organization co-founded
11 by government witness Dr. Cook to advocate for the banning of partial-birth abortion, the
12 Physicians’ Ad Hoc Coalition for Truth (“PHACT”), with approximately 400 physician
13 members, also opposed the Act. See Tr. Vol. 9 at 1361:11-62:14 (Cook).²¹

14 The American Medical Association (“AMA”), a national association with approximately
15 250,000 physician and medical student members, created to advocate on behalf of
16 physicians and patient rights, supported the Act initially, but subsequently withdrew its support
17 because of the criminal penalties included in the Act.

18 5. Scientific Studies on Intact D&E

19 The parties agree that no definitive large-scale studies have been completed that
20 conclusively show that intact D&E is safe, or that it is unsafe. Tr. Vol. 1 at 102:9-14 (Paul); Tr.
21 Vol. 3 at 438:5-11, 443:3-9 (Doe); Tr. Vol. 5 at 849:9-12 (Westhoff); Tr. Vol. 6 at 905:19-
22 909:20, 971:14-972:19 (Bowes); Tr. Vol. 8 at 1297:25-1298:12 (Shadigian).

23 It is the government’s position that in the absence of definitive studies concluding that
24 intact D&E is safe, physicians should not be permitted to use the technique. See, e.g., Tr. Vol.
25 8 at 1221:5-12, 1229:2-6, 1232:8-13 (Shadigian). Plaintiffs, on the other hand, take the
26 position that in the absence of studies concluding that intact D&E is unsafe, physicians should

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28 ²¹PHACT, however, is no longer in existence.

1 be able to exercise their own medical judgment to determine if the procedure is appropriate
2 under the circumstances presented. See, e.g., Tr. Vol. 1 at 90:13-17 (Paul); Tr. Vol. 11 at
3 1828:3-21 (Chasen).

4 **a. Research Methodology**

5 The medical community follows certain epidemiological principles when evaluating the
6 weight and significance of research results, and all parties recognized these principles in
7 presenting trial evidence.

8 In general, “evidence-based medicine is a way of doing medicine that takes into
9 consideration the scientific information that is available. . . [I]f there is good evidence that one
10 particular method should be used, then it is [the physician’s] responsibility to use that method,
11 but where that evidence is lacking or inadequate, then we use our best clinical judgment to
12 render the safest care possible for our patients.” Tr. Vol 1, 91:5-13 (Paul).

13 Research methodology is evaluated on a hierarchy. Prospective randomized trials,
14 where patients are selected before any treatment begins and randomly placed into treatment
15 groups, yield the most significant results, since this type of study is considered to be subject to
16 the least amount of bias. The next most reliable study is a retrospective cohort study, where
17 records are reviewed after patients have undergone different types of treatment and the
18 results are compared. Somewhat less reliable is a retrospective case study series, where
19 records are reviewed after patients have undergone one specific type of treatment and the
20 results are reported. Finally, if there is no study possible or available, doctors should rely on
21 their clinical judgment and experience in determining what medical methods to use. Tr. Vol. 1
22 at 95:17-97:21 (Paul); Tr. Vol. 2 at 253:3-254:2 (Sheehan); Tr. Vol. 2 at 346:13-348:15 (Drey);
23 Tr. Vol. 6 at 890:15-894:7, 895:25-896:8 (Bowes); cf. Tr. Vol. 8 at 1298:13-1299:3
24 (Shadigian, stating that intuitive judgment is of no value in assessing short- and long-term
25 risks). When studies have been conducted, doctors are encouraged to incorporate the results
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1 into their practice.²²

2 Certain published studies are also subjected to peer review, where other doctors
3 practicing in the same area will review results and provide criticism and commentary
4 designed to ensure the accuracy of the results reported. Tr. Vol. 1 at 97:22-98:6 (Paul); Tr.
5 Vol. 6 at 894:8-895:4 (Bowes).

6 **b. Studies on Abortion Safety**

7 The parties agree that abortion in general is a safe procedure, and that it is in fact safer
8 than carrying a pregnancy to term. Tr. Vol. 1 at 22:11-38:5 (Paul, noting that risk of death from
9 childbirth is 10 times greater than risk of death in abortion). The parties also agree that while
10 no published studies comparing the safety of intact D&E to other methods of abortion exist,
11 various studies have examined individual aspects of the intact D&E procedure, and others
12 have compared the safety of D&Es generally with other methods of abortion.

13 The first large-scale studies on abortion safety took place in the 1970s, through the
14 Joint Program for the Study of Abortion (“JPSA”), administered through the Centers for
15 Disease Control (“CDC”). The JPSA study ran from 1971-1979, and included over 250,000
16 women.²³ It concluded that D&E abortions led to significantly fewer major medical
17 complications than inductions, which at that time were performed using saline injections.²⁴ Tr.
18 Vol. 1 at 25:18-31:13 (Paul).

19 The parties agree that the methods of performing both D&E and induction abortions
20 have changed since the time the JPSA studies were conducted, and both procedures have
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22 ²²While the government argues that studies have shown that other clinical procedures
23 previously believed to be safe as a matter of clinical judgment, such as episiotomies (surgical
24 incisions in the vagina during childbirth) or fetal heart monitoring, are in fact detrimental to either
25 the woman or the fetus, see, e.g., Tr. Vol. 1 at 103:23-105:7, 109:20 (Paul); Tr. Vol. 3 at 439:22-
441:2 (Doe); Tr. Vol. 6 at 896:9-897:24 (Bowes), the government also concedes that those
26 studies would not support a ban on these procedures if used in a physician’s best judgment. Tr.
27 Vol. 6 at 972:20-974:15 (Bowes); Tr. Vol. 8 at 1301:12-21 (Shadigian).

28 ²³The JPSA program no longer exists. Tr. Vol. 1 at 31:20-32:1.

²⁴While data regarding intact D&E was not broken out separately, plaintiffs argue that at
least some of the safety data included in the JPSA study would have included intact D&Es, since
intact D&Es are merely a variant of D&Es in general. Tr. Vol. 1 at 48:18-23 (Paul).

1 become even more safe. Tr. Vol. 1 at 31:14-19 (Paul). Individual witnesses, though, disagree
2 as to which method between the two is better. *Compare, e.g.*, Tr. Vol. 5 at 717:24-719:3
3 (Creinin, noting that while inductions are safe, they have not improved in safety over the last 20
4 years); Tr. Vol. 3 at 414:8-14 (Doe, noting anecdotally that inductions have more
5 complications than D&Es); Tr. Vol. 11 at 1771:22-1772:19 (Chasen, stating that D&Es are still
6 significantly safer than current induction methods); Tr. Vol. 6 at 946:5-13 (Bowes, agreeing
7 D&E safer than induction) *with* Tr. Vol. 7 at 1092:17-1093:7, 1122:14-1123:5 (Sprang,
8 claiming inductions as safe or safer than D&E); Tr. Vol. 8 at 1229:2-6, 1269:15-1274:25
9 (Shadigian, claiming inductions unambiguously safer than D&E).

10 In terms of abortion mortality, the primary study relied upon is based on data collected
11 by the CDC between 1972-1987, and includes information about abortion-related deaths
12 throughout the United States. Exh. 63 (Lawson report). That study concluded that while the
13 risk of death increases with fetal gestational age, the risks of mortality from D&E are very low,
14 and comparable to those for induction. Most of the witnesses agreed that both of those
15 procedures are also significantly safer than a hysterectomy or hysterotomy. Exh. 63 (table III;
16 listing D&E as “evacuation,” and induction as “instillation”). *See also* Tr. Vol. 1 at 32:7-37:7,
17 82:13-85:11 (Paul); Tr. Vol. 3 at 414:15-415:23 (Doe) (noting risks of hysterotomy and
18 hysterectomy). *But see* Tr. Vol. 9 at 1517:2-11 (Cook, recommending hysterotomy over
19 D&E).

20 c. Lack of Published Studies on Intact D&E

21 The JPSA and CDC studies provide the latest available statistics from long-term and
22 large-scale studies on abortion safety comparing D&E to induction. The parties agree that
23 relatively few studies have been conducted on second trimester abortions generally, and none
24 have been published on the subject of intact D&E. *See, e.g.*, Tr. Vol. 5 at 719:19-720:3
25 (Creinin); Tr. Vol. 6 at 905:19-908:20 (Bowes). Furthermore, the few studies that have been
26 published have not been on the same scale or held the same authoritative value as the JPSA
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1 and CDC results.²⁵

2 Because there is no significant authoritative data about intact D&E, while extensive
3 authoritative data about the safety of other methods of second trimester abortion exists, the
4 government presented evidence that physicians have a responsibility to use those other
5 methods until such time that intact D&E is proven to be safe. See, e.g., Tr. Vol. 6 at 922:20-
6 924:6 (Bowes); Tr. Vol. 8 at 1237:3-1239:18, 1257:9-1258:12 (Shadigian).

7 Plaintiffs, on the other hand, presented evidence that the study of abortion poses
8 various methodological difficulties. As an initial matter, since abortion is so safe in general, a
9 large number of women would need to be included in any study to make any meaningful
10 findings on safety. Furthermore, since so few women have second trimester abortions, a
11 large number of institutions would be required to participate in any study to ensure that
12 sufficient numbers of women could be included. See Tr. Vol. 1 at 89:4-90:11 (Paul); Tr. Vol. 5
13 at 705:4-707:19 (Creinin, noting that any study would require over 5000 women in each group
14 to be statistically significant). Plaintiffs note that it is also very difficult to secure sufficient
15 funding or cooperation for studies relating to abortion funding, given the controversial nature of
16 the subject.²⁶ Tr. Vol. 5 at 780:8-13 (Creinin).

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18 ²⁵One study, by Dr. Amy Autry, published in 2001 in the American Journal of Obstetrics and
19 Gynecology, concluded that modern methods of induction had a higher rate of complication than
20 modern methods of D&E. Tr. Vol. 1 at 85:16-86:7 (Paul); Tr. Vol. 5 at 719:19-722:2 (Creinin).
21 However, the study was relatively small, had some methodological problems, and the parties
22 dispute whether the main complication seen (retained placenta) should properly be considered
23 a “complication” of induction. Compare Tr. Vol. 1 at 114:3-115:13 (Paul); Tr. Vol. 5 at 776:16-
24 777:19 (Creinin) with Tr. Vol. 7 at 1094:9-1099:9 (Sprang); Tr. Vol. 8 at 1278:13-1281:15
(Shadigian); Tr. Vol. 9 at 1394:13-1395:19 (Cook). Another study on modern methods of second
trimester abortion, by Dr. David Grimes, was attempted but could not be completed because
researchers could not obtain sufficiently high numbers of women consenting to an induction to
make the numbers statistically significant. Tr. Vol. 5 at 707:24-709:24 (Creinin); Tr. Vol. 6 at
932:20-938:18, 951:8-954:9 (Bowes, concluding that study would be difficult but not impossible
to perform).

25 ²⁶Because of this distinction, the government’s use of the studies published in the *Lancet*
26 journal on breech deliveries as a comparator is unpersuasive. See, e.g., Tr. Vol. 6 at 924:9-
27 925:10 (Bowes). While breech deliveries are rare, they are not as rare as second trimester
28 abortions, they occur worldwide, and they are not associated with political controversy. To obtain
a statistically significant sample size, the studies done of breech deliveries involved 121 different
hospital centers located in 26 different countries. Additionally, breech deliveries are performed
in standard ways. Tr. Vol. 5 at 778:22-779:22 (Creinin); Tr. Vol. 6 at 955:10-956:21 (Bowes); Tr.
Vol. 8 at 1299:14-1301:21 (Shadigian). Given the nature of abortion practice and policy, it would

1 Even if women who are willing to participate in studies can be located, there are further
2 problems related to obtaining their consent. Many women have strong preferences as to
3 which abortion procedures they wish to undergo, and thus it is difficult to achieve consent for
4 true randomization of abortion methods, as would be required to conduct a full prospective
5 study. Tr. Vol. 5 at 703:19-709:24 (Creinin). More significantly, because doctors cannot tell
6 whether an intact D&E is feasible until the procedure has begun, it is difficult to control the
7 number of procedures included in the studies. Tr. Vol. 3 at 441:22-442:9 (Doe). Under these
8 circumstances, plaintiffs conclude that the principles of evidence-based medicine permit
9 doctors to continue performing intact D&Es in their best medical judgment, even in the
10 absence of studies on the topic. Tr. Vol. 1 at 90:13-17 (Paul).

11 **d. Chasen Study**

12 While there are no published studies on the safety of intact D&E, one study by Dr.
13 Stephen Chasen comparing modern methods of intact D&E with D&E by disarticulation is
14 currently in press. Exh. 19.²⁷ The parties strongly dispute the interpretation of Dr. Chasen's
15 findings.

16 **i. Methodology and Results of Study**

17 Dr. Chasen conducted a retrospective cohort study examining the medical records of
18 383 women who had second trimester abortions after 20 weeks of pregnancy at the Cornell
19 Weill Medical Center from 1996 to June 2003. Of those women, 120 underwent an intact
20 D&E, and 282 underwent a D&E by disarticulation.²⁸ Exh. 29. See *generally* Exh. 29, Tr. Vol.
21 11 at 1735:1-1754:17 (Chasen); see *also* Vol. 5 at 805:16-811:17, 850:22-864:17 (Westhoff).

22 The fetuses of the women who underwent an intact D&E were at a median of 23 weeks

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24 be extremely difficult to obtain a similar level of support for studies of the intact D&E procedure.

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26 ²⁷The article is scheduled for publication in May 2004 in the American Journal of Obstetrics
and Gynecology, by Elsevier.

27 ²⁸The article refers to intact D&E as "intact D&X," and D&E by disarticulation as "D&E."
28 Intact D&E in the article is defined as any extraction where forceps were not needed to
disarticulate the fetus.

1 gestation, which was two weeks more advanced than the median gestational age of the
2 fetuses of the women who underwent a D&E by disarticulation (21 weeks). The median blood
3 loss suffered by each group was identical (100 mL), and the median procedure time was
4 identical as well (22 minutes). The blood loss for the D&E by disarticulation group ranged
5 from 40 mL to 1500 mL, and the procedure time ranged from 6-60 minutes. The blood loss
6 for the intact D&E group ranged from 20 mL to 1200 mL, and the procedure time ranged from
7 6-45 minutes. Exh. 29.

8 Of the 383 women, 19 suffered complications, with equal frequency in both groups.
9 However, the six complications observed in the intact D&E group were considered relatively
10 minor (4 superficial lacerations and 2 follow-up curettages), and none were major (defined as
11 requiring admission to an intensive care unit). In the group undergoing D&E by disarticulation,
12 most injuries were minor, but three major complications occurred: one amniotic fluid embolus,
13 where amniotic fluid is introduced into the woman's bloodstream; one case of sepsis, or
14 generalized infection throughout the woman's system; and one perforated uterus. Exh. 29.
15 Both parties concede that these complications are generally very rare, and that these results
16 thus cannot be given much weight. Tr. Vol. 11 at 1746:9-1747:10 (Chasen); Tr. Vol. 7 at
17 1104:7-1105:18 (Sprang).

18 The study also followed 62 of these women into subsequent pregnancies, when they
19 obtained their prenatal care at the Cornell Medical Center. Of these 62 women, only 4
20 experienced preterm birth, 2 who had undergone a D&E by disarticulation and 2 who had
21 undergone an intact D&E. The two women who had undergone intact D&E and subsequently
22 experienced early labor were both previously considered at high risk for premature labor, and
23 were able to continue their subsequent pregnancies significantly longer than their previous
24 ones. Tr. Vol. 5 at 810:21-24 (Westhoff); Tr. Vol. 11 at 1749:16-1751:17 (Chasen).

25 The article concludes that intact D&E and D&E by disarticulation are equally safe
26 procedures, and that the decision of which technique to use should be left to the performing
27 physician's medical judgment. The article also concludes that intact D&E does not appear to
28 have adverse effects on maternal health. Exh. 29.

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ii. The Parties’ Interpretations of the Chasen Study

Plaintiffs interpret this study as indicating not only that intact D&E is safe, but that it is in fact safer than D&E by disarticulation. For instance, the women undergoing intact D&E had more advanced pregnancies, which normally would indicate a higher likelihood of complications, since abortions become more difficult to perform as gestational age increases. However, the complication rates were identical for intact D&Es at 23 weeks gestational age and D&Es by disarticulation at 21 weeks gestational age, which plaintiffs argue permits the inference that the intact D&E is in fact safer than D&E by disarticulation. Tr. Vol. 5 at 808:11-810:9 (Westhoff); Tr. Vol. 11 at 1747:11-1748:18 (Chasen); see also Tr. Vol. 6 at 945:22-946:4 (government witness Bowes, agreeing).

The government, in contrast, notes that any arguments concerning the increased safety of the intact D&E due to the shorter time of the procedure and smaller amounts of blood loss are contradicted by the findings which show that on average, an intact D&E takes exactly as much time as a D&E by disarticulation. Tr. Vol. 11 at 1807:2-1811:18 (Chasen, agreeing with these findings).

Plaintiffs emphasized that while the median blood loss and procedure times were identical for intact D&E and D&E by disarticulation, the maximum values for these factors were significantly lower for the intact D&E group. This indicated to certain of plaintiffs’ experts that the most difficult intact D&Es take less time and result in less blood loss than the most difficult D&E by disarticulation, and therefore they believed this indicated the greater safety of the intact D&E procedure. Tr. Vol. 5 at 860:20-862:13 (Westhoff).

The government presented evidence in response that the Chasen study, while useful as an initial study of intact D&E, was too small in scale to support any conclusions.²⁹ Tr. Vol. 6 at

²⁹The government also argued that Dr. Chasen, as a plaintiff in the New York litigation, was biased in favor of intact D&E, as seen by his failure to disclose to the journal publishers his plaintiff status or his previous participation in Planned Parenthood litigation. See, e.g., Tr. Vol. 6 at 921:1-922:4 (Bowes). Dr. Chasen convincingly testified that he had fully complied with the publisher’s ethical policy, and noted that the research for the article was completed before these lawsuits were filed. Tr. Vol. 11 at 1802:13-1806:11, 1825:3-1826:19 (Chasen). While Dr. Chasen’s support of Planned Parenthood in previous litigation is noted, the court is not persuaded that Dr. Chasen acted unethically or that his research results are biased as a result

1 915:20-920:25 (Bowes), Tr. Vol. 7 at 1101:8-1108:13 (Sprang). The government noted, for
2 example, that after peer review of the article, Dr. Chasen agreed to add language noting that
3 the study's retrospective nature and the relatively small sample size made it difficult to draw
4 more generalized conclusions about the safety of the procedure. Tr. Vol. 11 at 1810:12-
5 1814:18 (Chasen). This difficulty applies both to the findings as to safety, as well as to the
6 findings on subsequent preterm labor, which the government notes is further flawed in that
7 follow-up care could be reviewed only for patients who returned to the Cornell Medical Center.
8 Tr. Vol. 11 at 1793:23-1794:22 (Chasen, on cross); Tr. Vol. 6 at 919:12-25 (Bowes).

9 **e. Risks of Intact D&E**

10 The government argues that intact D&E is a dangerous procedure that is less safe than
11 any other second trimester abortion method and that it poses grave risks to women's health.
12 See, e.g., Tr. Vol. 7 at 1079:1-1081:5 (Sprang). *But see* Tr. Vol. 6 at 974:21-976:7 (Bowes,
13 stating that intact D&E does not appear to pose any long-term risks to women's health).
14 Plaintiffs take a contrary position and refute the risks asserted by the government. These risks
15 primarily include the following.

16 **i. Cervical Incompetence**

17 The government presented evidence that the use of 25-30 osmotic dilators could
18 potentially overstretch the cervix and lead to a condition called "cervical incompetence," a
19 condition where the cervix painlessly dilates during a subsequent pregnancy and causes
20 either miscarriage or preterm delivery. Tr. Vol. 7 at 1081:14-1082:8 (Sprang); Tr. Vol. 9 at
21 1413:4-1415:5 (Cook). In support of this position, the government relies on an October 2001
22 study by Dr. Laurence Henriet published in the British Journal of Obstetrics and Gynaecology,
23 which studied 12,000 women in France and concluded that abortion increased the risk of
24 preterm delivery.

25 Plaintiffs dispute the methodology of the Henriet study as "awful," Tr. Vol. 5 at 755:25
26 (Creinin), noting that the study was purely retrospective and based on subjective self-reporting,

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28 of his outside activities.

1 which could have notably skewed the results, since women who experienced preterm delivery
2 would be predisposed to recall previous abortions at a higher rate than those who did not (a
3 phenomenon known as “recall bias”).³⁰ The study also was designed to compare women who
4 had had abortions to women who had not had abortions. Plaintiffs presented evidence that
5 these two groups are irrelevant to a study whose aim is to compare women who have
6 undergone one method of abortion (intact D&E) with women who have undergone another
7 method of abortion. Tr. Vol. 5 at 780:15-784:2 (Creinin); Tr. Vol. 9 at 1493:22-1496:25
8 (Cook).

9 Plaintiffs also question the relevance of the results to the issues at hand. For instance,
10 96% of the abortions reported in the study were performed in the first trimester. Data
11 regarding those abortions does not relate to the question whether intact D&E abortions in the
12 second trimester cause cervical incompetence, especially since most first trimester abortions
13 do not involve the use of osmotic dilators or prostaglandin drugs but rather mechanical
14 dilators, which are known to cause more trauma to the cervix. Plaintiffs also note that “preterm
15 delivery” is different from “cervical incompetence,” in that cervical incompetence can cause
16 preterm delivery, but not all preterm deliveries are caused by cervical incompetence. Tr. Vol.
17 5 at 780:15-784:2 (Creinin); Tr. Vol. 7 at 1144:22-1147:7 (Sprang, on cross).

18 Plaintiffs cite instead a 2002 article by Dr. Robin Kalish from the American Journal of
19 Obstetrics and Gynecology, which concluded that second trimester D&Es did not cause an
20 increased risk of miscarriage or preterm birth. Exh. 17 (study co-authored by Chasen). This
21 paper was a retrospective case series, which followed 96 women who subsequently became
22 pregnant after a second trimester D&E. The paper also noted that increased cervical dilation
23 in the D&E actually decreased the likelihood of miscarriage or preterm birth in the second
24 trimester, theorizing that increased dilation reduced the risk of cervical trauma when removing
25 the fetus. Tr. Vol. 11 at 1726:13-1735:2 (Chasen); see *also* Tr. Vol. 4 at 692:3-691:17
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27 ³⁰Plaintiffs also note that the government’s position makes no physiological sense, since
28 the cervix is dilated much wider and in a much shorter period of time in both induction abortions
and in childbirth at term. Tr. Vol. 4 at 691:15-692:2 (Creinin).

1 (Creinin testimony on study); Exh. 29 (Chasen study discussed above, similarly concluding no
2 increased risk of preterm birth after intact D&E). *See also* Tr. Vol. 8 at 1282:5-1283:17
3 (Shadigian, admitting use of serial laminara was “not unsafe”).

4 The government notes in response that the fact that these studies involved a relatively
5 small number of participants, and followed only a limited number of women who returned to the
6 same hospital where the abortion was performed for care in their subsequent pregnancies,
7 might have skewed the results. *See, e.g.*, Tr. Vol. 6 at 919:8-25 (Bowes); Tr. Vol. 7 at
8 1105:20-1106:23 (Sprang).

9 Plaintiffs also cite the AMA task force’s report on second trimester abortion, which
10 concluded that there was insufficient medical research or evidence to conclude that dilation
11 increases the risk of cervical incompetence, and noted that the government’s witness Dr.
12 Sprang was a member of that task force. Tr. Vol. 7 at 1147:8-1148:6 (Sprang). Also,
13 practitioners report that they have not seen in their practices any increased incidence of
14 cervical incompetence for subsequent pregnancies after intact D&E. Tr. Vol. 11 at 1734:2-25
15 (Chasen).

16 ii. Infection

17 The government also claimed, and plaintiffs acknowledged, that the insertion of the
18 laminaria could potentially rupture the amniotic sac, introduce bacteria from the vagina into the
19 uterus, and increase the risk of a woman’s chance of infection. Tr. Vol. 7 at 1082:19-1085:17
20 (Sprang); *see also* Tr. Vol. 4 at 626:3-7 (Broekhuizen). Plaintiffs’ experts, testified, however,
21 they have never encountered this actual situation except in cases where the amniotic sac had
22 already ruptured, which predisposes the uterus to infection. *See, e.g.*, Tr. Vol. 11 at 1719:23-
23 1720:10 (Chasen).

24 iii. Injuries from Podalic Version

25 Not all doctors perform a podalic version before commencing D&Es of any kind, but
26 the doctors who do stated that rotation of the fetus is naturally effected as part of the
27 procedure when the doctor takes hold of a fetal extremity and begins the extraction process,
28 for any D&E. Furthermore, any placental separation that might occur does not pose a

1 problem because the placenta will be removed in the extraction process in any event, and the
2 risk of amniotic fluid embolus is nonexistent, because all amniotic fluid is removed from the
3 uterus before a D&E begins. No doctors who perform podalic version preliminary to an intact
4 D&E reported any of the complications discussed by the government's witness, Dr. Sprang.
5 See, e.g., Tr. Vol. 4 at 516:8-518:6 (Broekhuizen); Tr. Vol. 4 at 668:18-678:4 (Creinin,
6 discussing and discounting all purported risks); Tr. Vol. 5 at 827:19-829:1 (Westhoff).
7 Moreover, plaintiffs note that Dr. Sprang's citation for these complications comes directly from
8 a textbook on full-term delivery, where the fetus is significantly larger than it is in the second
9 trimester, and furthermore, that the references to the complications were removed in
10 subsequent editions of the textbook. Tr. Vol. 7 at 1087:24-1089:1 (Sprang, speculating that
11 section of the text was removed for space considerations).

12 **iv. Injury from Instrumentation**

13 The government also claims that the use of the trocar or scissors to reduce the size of
14 the fetal head could cause injury to the woman if the instrument slips, especially when the
15 instruments are used blindly, without the doctor's being able to see where the instruments are
16 being inserted. This appears to be based on Dr. Haskell's 1992 description of the intact D&E
17 procedure. The government also argues that if the fetal head is crushed with forceps before
18 removal, the sharp ends of the skull fragments may pose a risk of laceration to the woman. Tr.
19 Vol. 7 at 1089:25-1091:14 (Sprang). *But see* Tr. Vol. 7 at 1127:8-1128:12 (Sprang, arguing
20 no risk of laceration or injury if ultrasound is used).

21 While the plaintiffs concede that laceration by instruments used to crush the skull or by
22 fragments of fetal bones can pose a risk to women's health, plaintiffs argue that intact D&E
23 reduces the amount of risk from such laceration. Tr. Vol. 1 at 110:25-111:17 (Paul); Tr. Vol. 2
24 at 271:3-16, 273:3-14 (Sheehan), Tr. Vol. 3 at 445:4-446:23 (Doe); Tr. Vol. 4 at 631:18-634:2
25 (Broekhuizen).

26 Of the testifying doctors who perform intact D&E by puncturing the calvarium, none
27 insert the trocar or scissors blindly; rather, they all visualize the insertion point either directly or
28 through ultrasound. Tr. Vol. 4 at 632:2-8, 638:18-640:7 (Broekhuizen); Tr. Vol. 4 at 682:14-19

1 (Creinin); Tr. Vol. 5 at 801:25-802:5, 818:8-11 (Westhoff). Cf. Tr. Vol. 7 at 1136:7-14
2 (Sprang, agreeing that visualization would reduce risk). Similarly, when fetal bones are
3 crushed, the doctor takes special care to ensure that the bone fragments are covered with the
4 forceps when removing them through the cervix.³¹

5 Of plaintiffs' experts, only a few testified that they had ever perforated a uterus while
6 performing a D&E, and the ones who had, had done so only when performing a D&E by
7 disarticulation. No expert had perforated a uterus while performing an intact D&E. See Tr.
8 Vol. 1 at 73:13-18, 123:12-125:25 (Paul); Tr. Vol. 2 at 195:3-12 (Sheehan); Tr. Vol. 5 at
9 800:5-12 (Westhoff); Tr. Vol. 11 at 1755:24-1756:6 (Chasen).

10 **f. Maternal and Fetal Health Concerns**

11 Finally, plaintiffs presented evidence that for certain women or certain fetuses, an intact
12 D&E may be the best option for their particular health situation. See, e.g., Tr. Vol. 11 at
13 1762:8-25 (Chasen, noting that intact D&E is the quickest and therefore the safest procedure
14 for these women); see *also* Tr. Vol. 6 at 943:4-944:19 (government witness Bowes, testifying
15 that doctors should be allowed to use their judgment in determining whether any particular
16 procedure is in a patient's best interest, including intact D&E).

17 The government presented evidence that even in those circumstances, an intact D&E
18 is never a physician's only option for terminating the pregnancy, and thus the procedure is
19 never medically necessary. The government's position appears to be that induction is almost
20 always a viable option for terminating a second trimester pregnancy, and in those rare
21 circumstances when it is not, hysterotomy or hysterectomy would be. Furthermore, D&E by
22 disarticulation also remains an option for women who would otherwise seek an intact D&E.
23 See, e.g., Tr. Vol. 7 at 1109:19-1114:9 (Sprang); Tr. Vol. 8 at 1220:16-21 (Shadigian); Tr. Vol.
24 9 at 1390:3-22, 1411:22-1416:2 (Cook).

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³¹Furthermore, to the extent that blindly used instruments or skull fragments pose a risk of laceration, the risk would be identical in an intact D&E and a D&E by disarticulation.

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i. Maternal Health

Uterine Scarring

Women with uterine scars, from previous caesarean operations or other uterine surgery, cannot be treated with prostaglandins such as misoprostyl, because the contractions caused by these medications can cause uterine rupture along the scar. Uterine rupture has serious implications for a woman’s future reproductive health, and can endanger a woman’s life. Accordingly, ACOG strongly discourages the use of prostaglandins for women with uterine scars, and thus doctors ordinarily recommend that women with uterine scars undergoing a second trimester abortion proceed with a D&E. See, e.g., Tr. Vol. 2 at 190:14-20 (Sheehan); Tr. Vol. 3 at 410:20-413:2 (Doe); Tr. Vol. 4 at 506:2-10, 506:25-507:20 (Broekhuizen); Tr. Vol. 5 at 712:9-714:4 (Creinin); Tr. Vol. 6 at 947:4-13 (Bowes).

The government presented evidence that an induction is still possible for such women, as long as milder prostaglandins or different labor inducing drugs are administered and she is well-monitored, but concedes that a risk of uterine rupture still exists. Tr. Vol. 9 at 1413:9-1436:5 (Cook). *But see* Tr. Vol. 3 at 434:13-435:10 (Doe, noting that other drugs are less likely to induce labor successfully); Tr. Vol. 8 at 1285:17-1286:13 (Shadigian, admitting that other drugs may cause uterine rupture).

Blood Loss

Some pregnant women suffer from bleeding-related disorders that render the blood loss inherent in a two-day induction procedure risky to their health. For instance, women with bleeding disorders, on blood-thinning medications, or suffering from renal disease have a propensity to bleed excessively, which makes any extended procedure causing blood loss dangerous. Analogously, pregnant women diagnosed with preeclampsia, a rare and potentially fatal condition caused by the pregnancy itself, often lose blood volume as their blood thickens and begins to clot, so even a slight loss of blood can have drastic effects on their health. Women with cardiac or pulmonary disease, including asthma, also cannot tolerate excessive blood loss, because it causes excessive strain on their systems. See, e.g., Tr. Vol. 1 15:14-17:18 (Paul); Tr. Vol. 3 at 383:17-22, 388:3-390:6 (Doe); Tr. Vol. 8 at

1 1286:14-1287:11 (Shadigian). Thus, plaintiffs presented evidence that women with these
2 health considerations who are undergoing second trimester abortions are better served by the
3 quicker D&E procedure, and particularly by intact D&E. See, e.g., Tr. Vol. 11 at 1763:1-20
4 (Chasen).

5 In response, the government presented evidence that with any surgery, there is the risk
6 of traumatic injury, which could cause extreme blood loss as well, and that on balance, it is
7 safer to treat such a woman in the hospital, where her blood loss can be monitored and
8 transfusions can be given if necessary, than in an outpatient setting where there is not likely to
9 be emergency care immediately available. Tr. Vol. 9 at 1391:10-20, 1420:22-1428:2 (Cook);
10 see also Tr. Vol. 8 at 1223:8-1224:2 (Shadigian, recommending induction or hysterotomy for
11 preeclampsia). But see Tr. Vol. 9 at 1477:12-1478:16 (Cook, conceding that intact D&E
12 could be performed in a hospital setting).

13 *Placenta Previa*

14 Certain women develop the condition of placenta previa in pregnancy, where the
15 placenta grows over the cervix and thus blocks the cervical opening. The parties agree that an
16 induction cannot be performed in this circumstance because the fetus cannot pass through the
17 blocked opening. Tr. Vol. 3 at 410:12-19 (Doe); Tr. Vol. 4 at 506:14-24 (Broekhuizen).
18 Plaintiffs presented evidence that in this circumstance, the placenta should be removed or
19 pierced in a D&E. Tr. Vol. 11 at 1768:5-21 (Chasen).

20 The government, however, takes the position that a D&E is not indicated in this
21 circumstance. The government witnesses would instead recommend that a hysterotomy be
22 performed, even though the hysterotomy is significantly riskier than a D&E and has serious
23 implications for the woman's future reproductive health. Tr. Vol. 9 at 1428:3-1429:10 (Cook,
24 stating that in later gestational ages, hysterotomy or caesarean delivery is the way to deliver a
25 baby with placenta previa).

26 *Uterine Infections*

27 Women sometimes develop uterine or amniotic infections during pregnancy, and if
28 these infections are not treated, they can lead to sepsis, or a generalized blood infection,

1 which can spread throughout the body. If that happens, the uterus must be emptied
2 immediately. Plaintiffs presented evidence that an induction would not be appropriate in that
3 circumstance because the procedure takes too long and the woman's health could be
4 compromised while waiting for the fetus to deliver. Tr. Vol. 11 at 1766:19-1767:5 (Chasen).

5 In response, the government presented evidence that if an infection is present, the D&E
6 surgery could potentially spread the infection if the uterus were perforated, and that induction
7 would be acceptable as long as the woman was closely monitored over the two-day period.
8 Tr. Vol. 9 at 1400:12-1401:1, 1429:14-1430:16 (Cook); see also Tr. Vol. 8 at 1224:3-22,
9 1266:23-1268:10 (Shadigian).

10 *Emergency Situations*

11 The government witnesses testified that if time was of the essence and a
12 pregnancy needed to be terminated immediately, an intact D&E would take too long as well,
13 since the cervix must be prepared over a two day period, and that a hysterotomy or
14 hysterectomy would be the quickest way to proceed. Tr. Vol. 8 at 1227:6-12 (Shadigian); Tr.
15 Vol. 9 at 1436:12-1437:12 (Cook). Plaintiffs agreed that D&Es in general require several
16 hours of cervical preparation, though in certain situations, when misoprostyl and osmotic
17 dilators are used, the cervix can be dilated in as little as 90 minutes. See, e.g., Tr. Vol. 1 at
18 59:9-11 (Paul).

19 *Psychological Reasons*

20 Finally, many women do not wish to undergo inductions, primarily for psychological and
21 emotional reasons. Some women do not wish to go through the physical and psychological
22 pain of labor if the pregnancy is to be terminated, especially if the termination is for medical
23 reasons, and some women also prefer having a quicker outpatient procedure, rather than
24 checking into a hospital as is required for an induction. See, e.g., Tr. Vol. 1 at 91:17-92:1
25 (Paul), Tr. Vol. 3 at 457:1-458:10 (Doe); Tr. Vol. 4 at 503:22-504:3 (Broekhuizen); Tr. Vol. 5 at
26 802:11-803:19 (Westhoff), Tr. Vol. 11 at 1773:23-1776:10 (Chasen). *But see* Tr. Vol. 8 at
27 1277:22-1278:3 (Shadigian, stating that labor pains from induction should not be
28 characterized as "traumatic").

ii. Fetal Anomalies

Fetuses sometimes have anomalies that can create contraindications for induction. Examples of this include hydrocephaly, ascites, or non-immune hydrops, where fluid collects in the fetal head, abdomen, or extremities and grossly distends those portions of the fetal body. In those circumstances, the fetal body may be so distended that it cannot be removed from the uterus unless reduced in size. Tr. Vol. 4 at 499:9-22 (Broekhuizen); Tr. Vol. 9 at 1446:16-1447:7 (Cook). These conditions can be, but are not always, fatal to the fetus. Tr. Vol. 7 at 1114:5-9 (Sprang); Tr. Vol. 9 at 1447:8-1448:5 (Cook).

If a D&E is performed, many doctors will remove all portions of the fetus from the uterus except for the oversized portion, and then take a deliberate action to reduce the size of the distended body part so that it too can be removed. All parties agree that this action could violate the Act if it caused fetal demise. Plaintiffs argue that this type of intact D&E is the best way to terminate a pregnancy where these conditions are present. Tr. Vol. 11 at 1759:8-1760:22 (Chasen).

The government argues that doctors could instead use a hypodermic needle to aspirate the fluid from the distended body part before the abortion is performed and proceed with either an induction or D&E by disarticulation. Tr. Vol. 7 at 1113:21-1114:9 (Sprang); Tr. Vol. 9 at 1446:16-1447:7 (Cook). Plaintiffs rebut this argument by stating that in some circumstances, fluid would refill the body part before the abortion could be completed, which would render aspiration futile, and furthermore, that there is no reason to subject the woman to an additional injection and the concomitant risks associated with it when an intact D&E procedure achieves the same end more efficiently. Tr. Vol. 11 at 1759:23-1762:7 (Chasen).

The government responds by arguing that if an injection is contraindicated, a hysterotomy or hysterectomy could be performed instead to terminate the pregnancy. The government also argues that the induction could be completed to the point at which the fetal body part lodges in the cervical os, and then “Duhrssen’s incisions” of approximately 1-2 cm in length could be made in the cervix to widen the os sufficiently for the fetus to pass. Plaintiffs contend that Duhrssen’s incisions are extremely risky to the woman’s future fertility, while the

1 government argues that when properly performed, they do not represent any serious risk.
2 *Compare* Tr. Vol. 4 at 533:18-534:24 (Broekhuizen, stating that Duhrrsen's incisions not
3 appropriate to use in an induction); Tr. Vol. 11 at 1787:3-4 (Chasen) *with* Tr. Vol. 9 at 1509:20-
4 1513:25 (Cook).

5 6. Fetal Demise

6 The Act does not proscribe intact D&Es performed after the death of the fetus. Thus,
7 the government contends that if an intact D&E were ever necessary, the doctor could simply
8 effect fetal demise before performing the procedure to escape liability under the Act. See,
9 *e.g.*, Tr. Vol. 7 at 1114:10-13 (Sprang).

10 Plaintiffs argue that effecting fetal demise before a D&E is unnecessary, and doctors
11 should not be required to subject their patients to an additional medical procedure that poses
12 some risk and no benefit to the patient solely to protect themselves from liability. Tr. Vol. 2 at
13 291:5-20 (Drey); Tr. Vol. 5 at 727:22-728:4 (Creinin); Tr. Vol. 5 at 819:20-820:5 (Westhoff).
14 See *also* Tr. Vol. 2 at 334:19-335:14 (Drey) (stating that it would be “a very painful decision”
15 for her to begin using digoxin to avoid liability under the Act because “I wouldn’t even have any
16 idea how to consent a patient if I am giving digoxin for my benefit as a provider . . . I wouldn’t
17 be saying that this is for her clinical benefit . . . It is for me. I would feel very much forced to do
18 something to a patient that wasn’t for her. That would just really be awful for me.”).

19 a. Injection Techniques

20 Fetal demise can be effected in a number of ways, but the methods primarily
21 discussed at trial were the injection of either digoxin or potassium chloride (“KCl”) through the
22 woman’s abdomen and either into the amniotic fluid (“intra-amniotically”) or directly into the
23 fetus’ heart (“intra-cardiac” or “intra-fetal injection”), both of which are toxic to the fetus.

24 Digoxin can be administered either intra-amniotically or through an intra-cardiac
25 injection, while KCl can only be administered intra-fetally. Tr. Vol. 2 at 295:9-25 (Drey). It is
26 relatively simple to inject digoxin intra-amniotically, but intra-amniotic injection is not always
27 effective in causing fetal demise. An intra-cardiac injection of either KCl or digoxin is virtually
28 100% effective, but requires more skill to perform, and thus is typically performed only by

1 maternal-fetal medicine obgyn specialists. Tr. Vol. 2 at 197:15-198:7, 243:25-245:1
2 (Sheehan); Tr. Vol. 2 at 312:7-24 (Drey); Tr. Vol. 6 at 964:18-968:17 (Bowes); Tr. Vol. 11 at
3 1780:20-1782:24 (Chasen).

4 After fetal demise, the fetal tissue rapidly undergoes a number of physiological
5 changes, so by the time the D&E begins, the tissue is much softer and will disarticulate more
6 easily (known as tissue “friability”). Tr. Vol. 2 at 243:16-24 (Sheehan); Tr. Vol. 2 at 341:12-25
7 (Drey); Tr. Vol. 8 at 1284:19-1285:3 (Shadigian). This process, known as “maceration,” also
8 renders the fetal tissue unusable for autopsy or diagnostic testing. Tr. Vol. 11 at 1758:7-19,
9 1781:25-1782:5 (Chasen).

10 Some doctors effect fetal demise routinely as part of their D&E practice, while others
11 have only done so upon direct request by the patient. Some doctors report that some of their
12 patients are strongly opposed to causing fetal demise before the procedure begins, while
13 other doctors indicate that their patients strongly prefer that an injection be given. *Compare*
14 Tr. Vol. 2 at 196:5-20, 242:12-243:2 (Sheehan, stating that all patients accept digoxin
15 injection) *with* Tr. Vol. 2 at 342:9-15 (Drey, stating that some patients find digoxin upsetting);
16 Tr. Vol. 3 at 418:2-15 (Doe, stating that patients generally do not want fetal demise effected
17 upon discussion); Tr. Vol. 4 at 561:15-562:22 (Broekhuizen, saying that opinions on this issue
18 differ sharply among his patients).

19 **b. Risks of Procedure**

20 As with any medical procedure, there are risks associated with these injections, which
21 include bleeding and infection. While these risks are minimal, they can have significant
22 ramifications for women with certain medical conditions, such as HIV or hepatitis. The
23 injection itself is also uncomfortable, and some women experience nausea or vomiting
24 afterwards. Tr. Vol. 2 at 197:2-14 (Sheehan); Tr. Vol. 2 at 314:14-329:20 (Drey); Tr. Vol. 3 at
25 417:6-419:19 (Doe); Tr. Vol. 5 at 728:5-19 (Creinin); Tr. Vol. 6 at 968:25-969:6 (Bowes).

26 After fetal demise is effected, some women will also spontaneously miscarry the fetus
27 before surgical extraction begins, which can be distressing, particularly if the woman is not in
28 the hospital at the time. Tr. Vol. 2 at 198:12-13 (Sheehan); Tr. Vol. 2 at 296:7-22 (Drey).

1 Finally, during the procedure, if the fetus has already died, the increased friability of the
2 tissue can increase the risk of leaving fetal parts in the uterus and subsequent infection. Tr.
3 Vol. 2 at 341:23-25 (Drey); Tr. Vol. 5 at 820:6-822:4 (Westhoff, noting that she encountered
4 this situation shortly after the Act was passed and she was using KCl for the first time, and
5 believes she may have caused a uterine perforation as a result of the softened tissue).

6 c. Scientific Studies

7 Dr. Drey has conducted two prospective randomized studies on the safety and efficacy
8 of intra-amniotic injections of digoxin, and has concluded that while digoxin is generally safe to
9 use, it did not improve the performance of D&E abortions in any significant way. See
10 *generally* Tr. Vol. 2 at 291:5-20 (Drey).

11 For the safety aspect of the study, Drey followed eight women who received intra-
12 amniotic digoxin injections before their second trimester abortions and monitored their
13 reactions to the drug. The study concluded that digoxin was generally safe for use in women
14 for whom digoxin was not contraindicated. Exh. 34 (article); Tr. Vol. 2 at 305:4-314:14 (Drey).

15 Drey and her colleagues then studied the efficacy of the drug in facilitating D&E
16 abortions. In that study, the doctors followed 126 women, 62 of whom received digoxin
17 injections before their abortions and 64 of whom did not. The doctors performing the
18 abortions could not tell the differences between the groups, and the study found no benefit to
19 either the doctors or the women from having the injection. Women who received digoxin
20 injections reported significantly higher incidents of vomiting. The report also demonstrated
21 that intra-amniotic injections failed to cause fetal demise in 8% of the women. Exh. 30
22 (article); Tr. Vol. 2 at 314:14-329:20 (Drey).

23 The article on the efficacy of digoxin concluded that “[digoxin] did not decrease
24 procedure time, difficulty, or pain compared to placebo,” and thus recommended its use only
25 when a patient specifically requests fetal death before the procedure begins. Exh. 30.
26 Accordingly, UCSF discontinued the routine use of digoxin in second trimester abortions. Tr.
27 Vol. 2 at 328:24-329:11 (Drey).

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d. Contraindications

Some women have contraindications for these injections. For example, women with heart conditions should not receive digoxin injections because if the digoxin inadvertently enters the woman’s bloodstream, it could cause major heart damage. Women who have low amniotic fluid levels or who have had a rupture of the amniotic sac cannot be monitored with ultrasound or receive intra-amniotic injections. Injections are also contraindicated for morbidly obese women, if the hospital is unable to provide needles long enough to inject into the woman’s uterus. Tr. Vol. 2 at 308:10-3:10:18 (Drey); Tr. Vol. 6 at 964:10-17, 968:21-24 (Bowes); Tr. Vol. 11 at 1781:10-24 (Chasen).

e. Cutting of Umbilical Cord

The other method of causing fetal demise discussed at trial was the cutting of the fetal umbilical cord at the beginning of the D&E extraction procedure, which cuts off the fetal blood and oxygen supply. The cord is not always accessible to the doctor, though, and once the cord is cut, it can take up to five to ten minutes for fetal demise to occur. Tr. Vol. 7 at 1119:12-20 (Sprang); Tr. Vol. 11 at 1782:6-21 (Chasen).

7. Fetal Pain

Finally, the government presented testimony on the issue of fetal pain, in support of the congressional finding that fetuses do feel pain. There is no consensus of medical opinion on the issue.

a. Physiology

The fetus develops the basic elements and connections of a nervous system by approximately 20 weeks after conception.³² Fetuses at this age have been observed to respond to outside sensory stimuli such as sound, light, and smell, and when fetuses undergo stressful stimuli, such as fetal surgery or fetal blood transfusions, the fetus releases stress hormones and blood flow to the brain increases, just as it does for newborn infants and adults. See generally Tr. Vol. 10 at 1570:1-1614:11 (Anand).

³²This is at 22 weeks Imp.

1 However, the fact that the fetus responds to stimuli does not necessarily mean that it
2 feels pain. For the fetus to interpret stimuli as pain requires not only that the fetus respond to
3 stimuli, but also that when the stimulus reaches the brain, the brain interprets it as unpleasant
4 or painful.³³ In other words, the fetus must have developed some form of consciousness to be
5 said to “feel pain.” Tr. Vol. 10 at 1626:10-1627:16 (Anand).

6 The only way that an outside observer can determine whether any entity feels pain is if
7 the entity communicates distress to the observer. The parties agree that fetuses are unable to
8 communicate, so it is impossible to determine conclusively if the stress responses seen in
9 fetuses in fact translate into an actual pain response, and thus no studies on fetal pain suffered
10 during abortions have been conducted. Both parties agreed that as a result, much of the
11 debate on this issue is based on speculation and inference. Tr. Vol. 10 at 1629:24-1630:24
12 (Anand).

13 **b. Scientific Debate**

14 **i. Early Development of Pain**

15 One group of physicians believe that fetuses feel intense pain starting as early as 22
16 weeks Imp. These physicians argue that at this point, since the entire nervous system has
17 developed and has connected to the brain, the fetus can be considered to have developed
18 consciousness, and is thus fully able to feel pain. These physicians argue further that since the
19 last part of the nervous system to develop is the nervous system’s inhibitory mechanisms,
20 which permit the modulation or blocking of pain impulses, fetuses at this age feel intense pain,
21 even more so than infants or adults. Tr. Vol. 10 at 1570:1-1614:11 (Anand); Tr. Vol. 7 at
22 1120:4-10 (Sprang).

23 These physicians admit that they have no way of conclusively determining whether this
24 hypothesis is true, but note that fetuses in this age range often demonstrate shifting patterns of
25 brain wave activity in response to stimuli, much like sentient infants and adults do. They also
26 argue that empirically, fetuses at this age are observed to recoil from outside stimuli, such as

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28 ³³For instance, the body produces a pain response during surgery, but anesthetics block
the brain from interpreting those responses as pain. Tr. Vol. 5 at 725:22-726:2 (Creinin).

1 needles, that are introduced into the womb. Tr. Vol. 7 at 1046:23-25 (Sprang); Tr. Vol. 10 at
2 1583:14-1586:5, 1618:1627:7 (Anand); Tr. Vol. 11 at 1823:16-1824:20 (Chasen).

3 Physicians who ascribe to this school of thought argue that the process of intact D&E,
4 where the skull is collapsed, causes the fetus extreme pain. These doctors also believe that a
5 D&E by dismemberment would be excruciatingly painful for the fetus, and that even a needle
6 injection of digoxin or KCl would cause the fetus pain as well. Tr. Vol. 10 at 1605:16-1608:15,
7 1666:16-1668:7 (Anand).

8 **ii. Later Development of Pain**

9 Other physicians believe that the fetus does not develop full consciousness until
10 approximately 26 weeks Imp at the earliest, citing a study conducted by the British Royal
11 College of Obstetricians and Gynecologists, which indicated that the nervous system was not
12 fully integrated until that time. These physicians argue that consciousness cannot be said to
13 be based on an on/off model and instead, should be seen as existing in gradations, so that
14 fetuses before 26 weeks have rudimentary consciousness but not the full consciousness which
15 would enable them to process stimuli as pain. Tr. Vol. 5 at 722:8-727:21 (Creinin).

16 These physicians also believe that fetuses cannot be compared to infants or even
17 premature infants, since the birth process and the lack of dependency on the mother makes
18 infants physiologically different from fetuses in utero. While certain physiological markers may
19 look similar, it is possible that the fetal brain interprets these markers differently than it would if
20 the fetus was entirely delivered. Furthermore, these physicians note that physiological
21 markers such as a rise in stress hormones may not necessarily be correlated with the
22 sensation of pain even in adults, so it is impossible to determine what, if anything, the fetus
23 feels in response to these physiological events. Tr. Vol. 10 at 1614:13-1668:8 (Anand,
24 explaining opposing position).

25 **C. Findings of Fact**

26 Having reviewed the trial evidence, the court finds as follows.

27 **1. Credibility of Witnesses**

28 The court found all of the plaintiffs' experts not only qualified to testify as experts, but

1 credible witnesses based largely on their vast experience in abortion practice.

2 However, of the four government witnesses who were qualified as experts in obgyn, all
3 revealed a strong objection either to abortion in general or, at a minimum, to the D&E method
4 of abortion. The court finds that their objections to entirely legal and acceptable abortion
5 procedures color, to some extent, their opinions on the contested intact D&E procedure.

6 Dr. Sprang testified that he “wouldn’t be comfortable actually taking the life of the
7 fetus.” In his “practice, if patients want to have an abortion, they are referred to abortion
8 providers.” Tr. Vol. 7 at 1060:6-7 (Sprang). Dr. Sprang also testified that he felt so strongly
9 regarding the benefits of induction because it is a more “physiologic” process with less
10 “instrumentation” to D&E post-20 weeks that he would not even discuss D&E as an option
11 with his patients. *Id.* at 1122:20-1123:1. This is in spite of the fact that he admits that post-20
12 weeks, D&E and induction are comparably safe. *Id.* at 1124:9-10.

13 Dr. Shadigian is a member of AAPLOG, the American Association of Pro-Life
14 Obstetricians and Gynecologists, and likewise, will not personally perform an abortion on a
15 preivable fetus that has not already died unless “the woman is so sick that the only way she is
16 going to survive is to have the pregnancy ended.” Tr. Vol. 8 at 1210:6-21 (Shadigian). Dr.
17 Bowes similarly testified that he would not personally perform an abortion even to save the life
18 of one of his patients unless he believed that there was at least a 50% likelihood that she
19 would die absent the abortion – even if the pregnancy was the result of rape or incest. Tr. Vol.
20 6 at 977:1-12 (Bowes).

21 Additionally, Dr. Cook testified that because of his beliefs, he will not perform abortions
22 for “elective” reasons. Tr. Vol. 9 at 1353:25 - 1354:2 (Cook). Like the other government
23 witnesses, Dr. Cook testified that he strongly prefers inductions because he believes that they
24 are “more physiologic.” *Id.* at 1513:5-1514:25. However, the strength of Dr. Cook’s
25 preference for induction is not supported by the medical evidence, and there appear to be
26 several circumstances under which Dr. Cook would utilize induction, or an even less safe
27 alternative, hysterotomy, when the medical evidence and literature suggest that the safest
28

1 procedure is D&E.³⁴ The court also has some misgivings regarding Dr. Cook's credibility
2 based on his extremely equivocal and elusive testimony regarding the medical necessity of
3 D&E under certain circumstances.³⁵

4 Finally, the court notes that Dr. Anand, the government's expert witness on the issue of
5 fetal pain, is not an anesthesiologist, neurologist, obstetrician, or maternal-fetal medicine
6 specialist. Anand is a pediatrician who has conducted research on pain in general, focusing
7 primarily on infants. Tr. Vol. 10 at 1540:6-1568:14 (Anand). Thus, Anand's opinions on fetal
8 pain as they relate to fetal development have been given no more weight than the testimony of
9 other obstetricians and maternal-fetal medicine experts, who reviewed the same material and
10 concluded that fetal consciousness and pain do not exist until at least 26 weeks. See, e.g., Tr.
11 Vol. 3 at 419:20-420:4 (Doe); Tr. Vol. 5 at 722:8-727:21 (Creinin).

12 2. Findings of Fact Regarding Relevant Abortion Procedures

13 Both D&E and Induction are Safe Procedures

14 Both D&E and induction are safe procedures, with extremely low rates of morbidity
15 (medical complications) and mortality. Between the two, however, the studies consistently
16 show that D&E is as safe or even significantly safer than induction, and both procedures are
17 greatly safer than either hysterotomy or hysterectomy.

18 *Intact D&E is a Variant of the D&E Procedure*

19 Intact D&E is not a separate procedure, but rather, simply a variant of the established

21 ³⁴Dr. Cook asserted that he so strongly preferred induction, that he would prefer to allow
22 a woman who was suffering from an infection of the amniotic membranes called
23 chorioamnionitis to continue to labor for several hours as opposed to performing a D&E. *Id.*
24 at 1475. Moreover, Dr. Cook also testified that in the case of an induction complication, in which
25 the fetal head became trapped in the woman's cervical opening, he would prefer to utilize
26 Duhrssens' incisions, a series of up to three cervical incisions up to two centimeters long and the
full-depth of the cervix, as opposed to performing a D&E. *Id.* at 1512:5-1513:9. He compared
the incisions to "cervical lacerations that occur during the normal labor process," and referred to
them as "a variation on a normal process," and still "more physiologic" than dilation with laminaria,
associated with a D&E. *Id.* at 1512:20. Finally, Dr. Cook stated that he does not consider D&E
an option post-20 weeks, and would utilize hysterotomy as opposed to D&E. *Id.* at 1517:2-7.

27 ³⁵Dr. Cook contradicted himself several times regarding whether he had ever found D&E
28 to be "medically necessary" in his practice, before agreeing that he found it to be not only
medically necessary on occasion, but under certain circumstances, superior to induction. *Id.* at
1459:3-1461:25; 1472:21-24.

1 D&E technique. While doctors cannot always predict beforehand whether a D&E abortion will
2 proceed by disarticulation or through an intact extraction, the record is clear that some doctors
3 may prefer to perform an intact extraction if at all possible.

4 ***Intact D&E v. Induction and Other Abortion Procedures***

5 D&E, including intact D&E, presents significant medical benefits over an induction,
6 hysterotomy, or hysterectomy. A D&E, including an intact D&E, takes significantly less time
7 than an induction, and to the extent that up to 10% of inductions require a subsequent D&E to
8 remove unexpelled fetal parts, surgical procedures are not necessarily avoided in an
9 induction. Moreover, other benefits to D&E, including intact D&E, include a reduced exposure
10 to risks and maternal complications associated with induction abortions, including uterine
11 rupture and infection, and a decreased risk of blood loss and infection and complications
12 arising from unexpelled fetal parts.

13 A D&E, including an intact D&E, also does not require a woman to undergo labor. For
14 this reason, most women strongly prefer a D&E abortion. Moreover, the record is clear that
15 some individual women, for health reasons, cannot undergo an induction abortion. The court
16 finds that it would be unreasonable to expect women for whom inductions are contraindicated
17 to put their health at risk by undergoing induction, hysterotomy, or hysterectomy. While an
18 induction has the benefit that an intact fetus can be obtained for autopsy or psychological
19 grieving purposes, an intact D&E can have the same result without requiring women to
20 undergo induced labor.

21 ***Intact D&E v. D&E by Disarticulation***

22 The existing studies show that intact D&Es are at least as safe as D&Es by
23 disarticulation. Exh. 27 (Chasen report). While the Chasen study indicates neither that intact
24 D&E is in every circumstance safer than D&E by disarticulation, nor that intact D&E is in every
25 circumstance less safe than D&E by disarticulation, and cannot be considered conclusive on
26 the issue, even the government's expert Dr. Bowes agrees that such small-scale studies are
27 an important first step in designing further studies on the issue. Tr. Vol. 6 at 960:23-961:8
28 (Bowes, discussing Chasen report). Thus, these preliminary results indicate the relative safety

1 of intact D&E, and provide valuable information for doctors in exercising their clinical
2 judgment.

3 Furthermore, the court finds that it is wholly appropriate for doctors, in their best
4 medical judgment, to rely on their clinical judgment and these relatively small-scale
5 retrospective studies in determining, with their patients, whether they wish to perform intact
6 D&E abortions – just as the government’s experts rely on their clinical judgment (or “intuition”)
7 in recommending induction abortions over D&E abortions, despite the lack of studies
8 indicating that modern induction abortions are superior to D&Es and despite the fact that D&E
9 remains overwhelmingly the procedure of choice for women undergoing second trimester
10 abortions. *Cf.* Vol. 8 at 1302:15-1303:24 (Shadigian, defending her position that induction is
11 safest method of late second trimester abortion).

12 Moreover, all of the doctors who actually perform intact D&Es concluded that in their
13 opinion and clinical judgment, intact D&Es remain the safest option for certain individual
14 women under certain individual health circumstances, and are significantly safer for these
15 women than other abortion techniques, and are thus medically necessary. *See also, e.g.,*
16 Cain Depo. at 205:14-210:16 (ACOG policy reflecting same finding). These doctors are all
17 well-respected in their practices, and their expertise in recommending and performing D&E
18 and intact D&Es is unassailable. As noted, the court accepts their testimony over that of the
19 government witnesses, who, while also well-respected and qualified to provide testimony in
20 general on obgyn practice and safety, do not perform intact D&Es and who were not qualified
21 to testify as experts on the practice.

22 The evidence also demonstrates that intact D&E presents significant safety benefits
23 over D&E by disarticulation under certain circumstances for the following reasons, including:
24 (1) fewer passes are made with the forceps and/or other instruments, resulting in a reduced
25 risk of lacerations to the cervix and/or uterus; (2) since the fetus is removed either intact or
26 largely intact, there is a reduced risk of inadvertently leaving fetal parts in the uterus and thus a
27 reduced risk of infection; (3) because the fetus is removed intact or partially intact, there is a
28 reduced risk of injury to the woman caused by the removal of bony fetal fragments; and (4)

1 there may be a reduced operating time, which likewise decreases the risks associated with
2 blood loss and infection.

3 ***Alleged Risks of Intact D&E***

4 There also appears to be little risk from the various elements of an intact D&E
5 procedure. As an initial matter, not all doctors perform all four ACOG elements of an intact
6 D&E, so to the extent that certain doctors do not perform certain elements, the attendant risks
7 are nonexistent for their patients. In addition, no doctors who actually perform intact D&Es
8 have reported any of the claimed risks from podalic version or infection caused by laminaria.
9 Dr. Sprang, who has never performed an intact D&E, provided testimony that may be more
10 appropriate in the context of a full-term birth, but it is of limited relevance to an inquiry into the
11 safety of intact D&E.

12 The government also has not shown that intact D&E increases a woman's likelihood of
13 cervical incompetence. While the Kalish and Chasen studies are not conclusive, they provide
14 strong preliminary evidence that no correlation between the two exists. The methodological
15 problems with the Henriot study, as well as the fact that it primarily addresses first trimester
16 abortions, renders it of limited relevance to this inquiry.

17 On the question of uterine laceration, plaintiffs admit there is a risk of injury caused by
18 misplaced instruments or fetal bone fragments from the collapsed fetal skull. However, it
19 appears that this risk is minimal, and it does not appear to be any greater than the risk of
20 laceration from D&Es by disarticulation in general. Furthermore, the physicians who perform
21 this procedure state that this risk is greatly minimized by the use of ultrasound guidance and
22 direct visualization.

23 ***Fetal Demise***

24 The evidence shows that there is no medical benefit to causing fetal demise before
25 beginning a D&E procedure, including intact D&Es, except potentially as psychological
26 comfort to some, but not all, women. It does not make the abortion procedure safer, easier, or
27 quicker, and the injection procedure itself is not without risk.

28 Furthermore, each method of causing fetal demise has serious drawbacks. While

1 most doctors can inject digoxin intra-amniotically, this method is not always effective in
2 causing fetal demise, which would defeat the purpose for its use and place doctors using this
3 method at risk of prosecution. While intra-cardiac injection is almost always effective, not all
4 hospitals and virtually no clinics have access to maternal-fetal medicine specialists to perform
5 the injection. In addition, a number of women will be unable to tolerate the injection process.

6 While cutting the umbilical cord will guarantee fetal demise, it is not always possible to
7 reach the cord in utero. Also, the doctor performing the abortion would have to wait five to ten
8 minutes before death occurred with the woman under sedation and prepared for surgery,
9 which would almost double the time of the extraction procedure.

10 ***Fetal Pain***

11 The issue of whether fetuses feel pain is unsettled in the scientific community.
12 However, it appears to be irrelevant to the question of whether intact D&E should be banned,
13 because it is undisputed that if a fetus feels pain, the amount is no less and in fact might be
14 greater in D&E by disarticulation than with the intact D&E method. Tr. Vol. 10 at 1605:16-
15 1608:15, 1666:16-1668:7 (Anand).

16 ***Intact D&E May Be Significantly Safer For Some Women*** 17 ***Under Certain Circumstances***

18 In conclusion, the court finds that intact D&E is in fact the safest medical option for
19 some women in some circumstances and is significantly safer than induction, hysterotomy, or
20 hysterectomy for terminating a second trimester pregnancy, and under certain circumstances,
21 also significantly safer than D&E by disarticulation.

22 However, plaintiffs have not demonstrated the existence of any particular situation for
23 these women for whom induction is contraindicated in which an intact D&E would be a
24 doctor's only option to preserve the life or health of a woman. The government is correct that
25 for most women, a D&E by disarticulation could be utilized instead of induction when
26 contraindications for induction exist. Furthermore, plaintiffs concede that an intact D&E
27 abortion cannot be guaranteed before the extraction procedure begins. A woman can request
28 that an intact D&E be attempted, but the doctor cannot guarantee that it will occur. _See, e.g.,

1 Tr. Vol. 2 at 190:5-7 (Sheehan), Tr. Vol. 11 at 1758:2-6 (Chasen).

2 **D. Congressional Findings**

3 In support of the Act, the 108th Congress made numerous findings, which are
4 discussed in detail below. The first fourteen findings, (1) through (14), include Congress'
5 interpretation of the United States Supreme Court's decision in *Stenberg*, and Congress'
6 analysis regarding (1) why it believes that it is entitled to make factual findings contrary to
7 those in *Stenberg*; (2) the degree of deference that Congress asserts the courts should
8 accord its factual findings subsequently set forth in section (14) at (A) through (O); and (3) its
9 ultimate findings regarding the necessity of a health exception. Sections 14(A) through (O)
10 subsequently detail Congress' more specific or particular factual findings pertinent to the issue
11 of a health exception. See Act, § 2(1)-(14); (14)(A)-(O).

12 **1. Congressional Legal "Findings" and Interpretations**

13 As noted, some of the "findings" made by Congress include legal interpretations
14 of *Stenberg* and other Supreme Court jurisprudence. There is no dispute that this court
15 reviews issues of constitutional law *de novo*. Accordingly, Congress' legal conclusions and its
16 characterization of the Supreme Court's holding in *Stenberg*, and any additional legal
17 analysis, is not entitled to deference by this court. Nor are any of Congress' legal conclusions,
18 which may be disguised as factual findings, entitled to deference by this court. However, to
19 the extent that such interpretations provided Congress with a framework for its factual findings,
20 the Court discusses those findings below and notes that many of Congress' legal
21 interpretations are inaccurate and mischaracterize Supreme Court precedent.

22 **a. The Congressional Findings Mischaracterize**
23 **the *Stenberg* Case in Many Respects**

24 Specifically, regarding the *Stenberg* case, Congress, in its findings, mischaracterizes:
25 (1) the Supreme Court's holding regarding "undue burden;" (2) the quantity and quality of the
26 evidence supporting the district court's factual findings; (3) and the Supreme Court's treatment
27 of the district court's factual findings. See *id.* at § 2(3), (5)-(8).

28

1 **i. Supreme Court’s Holding regarding *Undue Burden***

2 First, Congress incorrectly combined the two bases for the Supreme Court’s holding in
3 *Stenberg*, asserting that the Court concluded that the Nebraska law in *Stenberg* posed an
4 undue burden “because it failed to include an exception for partial-birth abortions deemed
5 necessary to preserve the ‘health’ of the mother.” However, as discussed above, this was not
6 the basis for the Supreme Court’s holding regarding the law’s undue burden on a woman’s
7 right to seek an abortion.

8 Contrary to Congress’ assertions, *Stenberg’s* conclusion regarding the necessity of a
9 health exception was distinct from its undue burden analysis, and concerned the ban’s impact
10 not on abortion procedures as a whole, but on a smaller group of women: those patients for
11 whom the banned procedure “may bring with it greater safety.” *Stenberg*, 530 U.S. at 937,
12 934 (“the State cannot prohibit a person from obtaining [‘a rarely used’] treatment simply by
13 pointing out that most people do not need it”); *see also Planned Parenthood v. Brady*, 2003
14 WL 21383721, at *2 (D.Del. June 9, 2003) (“whether [partial-birth abortion] ban poses an
15 obstacle to one . . . woman or thousands does not change the constitutional analysis” of the
16 ban’s failure to contain a health exception).

17 **ii. District Court Record and Findings and**
18 **Supreme Court Review of Record**

19 Preliminary to Congress’ ultimate finding that a health exception is never medically
20 necessary, Congress also criticized the district court’s findings in *Stenberg* and the Supreme
21 Court’s alleged reliance on those findings. *See* Act, § 2(5)-(8). First, Congress second
22 guessed the *Stenberg* district court’s findings, based *not* on the evidence compiled
23 independently by Congress, but instead based on the evidence heard by the district court.
24 Congress asserted that there was a “dearth of evidence in the *Stenberg* trial court record
25 supporting the district court’s findings;” and that none of the witnesses in the *Stenberg* case
26 “identified a single circumstance during which a partial-birth abortion was necessary to
27 preserve the health of a woman.” Act, § 2(6); (14)(D).

28 While this court will not attempt to second guess the findings made by the district court

1 in *Stenberg*, which was in a much better position to evaluate the evidence and the credibility of
2 the evidence before it *at the time of the trial*, this court nevertheless notes that the pertinent
3 congressional findings grossly mischaracterize the state of the trial evidence in *Stenberg*, as
4 reflected in the trial court's reported decisions.

5 Following an evidentiary hearing, the district court in *Stenberg* held, based on the
6 evidence before it, that Nebraska's partial-birth abortion law was likely to be found
7 unconstitutional after a trial on the merits, and should be preliminarily enjoined. See *Carhart v.*
8 *Stenberg* ("*Carhart I*"), 972 F.Supp. 507 (D. Neb. 1997).³⁶ Subsequently, after a trial on the
9 merits, the district court held that the law, as applied to plaintiff Dr. Carhart and his patients,
10 was unconstitutional because it posed an undue burden and was unconstitutionally vague.
11 See *Carhart v. Stenberg* ("*Carhart II*"), 11 F.Supp.2d 1099 (D. Neb. 1998).³⁷ In support, it
12 found that "[intact D&E] significantly obviates health risks in certain circumstances," a finding
13 that the Supreme Court, in contrast to Congress, subsequently characterized as supported by
14 "a highly plausible *record-based* explanation of why that might be so. . . ." *Stenberg*, 530 U.S.
15 at 936-37.

16 The record that the *Stenberg* district court had before it included the Congressional
17 Record that existed to date, an AMA report regarding late-term abortions, CDC data and
18 reports, a January 1997 ACOG policy statement regarding intact D&Es, and the testimony of
19 six expert witnesses, including plaintiffs' witnesses Dr. Carhart, Dr. Jane Hodgson, the
20 founding fellow of ACOG and an obgyn who had supervised and/or performed at least 30,000
21

22 ³⁶At that stage, as opposed to a trial on the merits, the district court was required to
23 evaluate:

24 (1) the threat of irreparable harm to the movant; (2) the state of the balance of the
25 harm and injury that granting the injunction will inflict on other parties; (3) the
26 probability that the movant will succeed on the merits; and (4) the public interest.

26 *Id.* at 523 (citing *Dataphase Systems, Inc. v. CL Systems, Inc.*, 640 F.2d 109, 113 (8th Cir.
1981)).

27 ³⁷The *Stenberg* district court limited its review to the constitutionality of the Nebraska law
28 as it applied to Dr. Carhart and his patients only, declining to decide generally the facial validity
of the state law. See *id.* at 1119-1120.

1 abortions at that time, Dr. Phillip Stubblefield, chief obgyn at the Boston Medical Center who
2 regularly performed abortions, Dr. Stanley Henshaw, a director of research at the Alan
3 Guttmacher Institute, who held a Ph.D. in sociology and specialized in non-profit research and
4 writing regarding abortion data; and defense witnesses Dr. Riegel, an obgyn and infertility
5 expert, and Dr. Frank Boehm, the director of obstetrics at Vanderbilt Medical Center. *Carhart*
6 *II*, 11 F.Supp. at 1116.³⁸ Accordingly, the evidence before the district court in *Stenberg*
7 cannot credibly be characterized as a “dearth of evidence.”

8 Additionally, Congress asserted that the *Stenberg* district court failed to “identif[y] a
9 single circumstance *during which a partial-birth abortion was necessary to preserve the*
10 *health of a woman.*” Act, § 2(14)(D). This assertion is somewhat misleading because at the
11 time of the trial before the district court in 1998, the Supreme Court had not enunciated the
12 requirement of a health exception with respect to partial-birth abortion bans. Therefore, to the
13 extent that Congress intended to imply that the evidence before the district court was deficient
14 on this basis, it ignored both the chronology of the *Stenberg* case and prior Supreme Court
15 precedent on the issue.

16 Nevertheless, an examination of the district court record and findings reflects that
17 Congress’ assertion is also factually erroneous. First, there was record evidence in support of
18 the district court’s findings regarding the safety of intact D&E generally. The district court cited
19 to substantial record evidence in support of its conclusion that intact D&E, as applied to Dr.
20 Carhart and his patients, was “the safest procedure in certain circumstances.” *Carhart II*, 11
21 F.Supp. at 1122. Specifically, the district court relied on Dr. Hodgson’s “credible” testimony
22 that the “[intact D&E] procedure [was] ‘an advance in technology’ because by removing the
23 fetus intact there is ‘less instrument manipulation’ and greater safety;” the corroborating
24 testimony of Drs. Carhart and Stubblefield, whose testimony the district court found
25 “particularly persuasive” given that “[Stubblefield] possessed the most extensive training,
26

27 ³⁸The district court, however, found that Dr. Riegel’s testimony regarding abortion
28 procedures lacked credibility due to the fact that he lacked experience and was poorly informed
regarding the intact D&E procedure, having not performed any abortions due to moral objections,
and having never even observed, let alone performed, a D&E or intact D&E. *Id.* at 1116.

1 experience, and knowledge about the use and teaching of abortion procedures;” the testimony
2 received by district courts in two other cases involving state partial-birth abortion bans, which
3 included the testimony of at least two experts in the case at hand, Drs. Westhoff and Cook;
4 and Dr. Haskell’s testimony before Congress. See *id.* at 1107-08, 1116, 1123 (incorporating
5 prior decision).

6 Moreover, and most importantly, the district court specifically found based on the trial
7 evidence, and contrary to Congress’ assertion otherwise, that as a result of Nebraska’s
8 partial-birth abortion ban, approximately “10 to 20 women a year. . . could not receive the best
9 care from Dr. Carhart . . . [and] would be forced against their will to endure appreciably greater
10 risks to their health and lives than are necessary.” *Id.* at 1127. In support, the district court
11 found that:

12 “[a]mong other things, [these women] would suffer a larger than necessary risk
13 of: (1) longer operating time; (2) greater blood loss and infection; (3)
14 complications from bony fragments; (4) instrument-inflicted damage to the
15 uterus and cervix; (5) exposure to the most common causes of maternal
16 mortality (DIC and amniotic fluid embolus); [and] (6) ‘horrible complications’
17 arising from retained fetal parts.”

18 *Id.*

19 Congress also implies that the Supreme Court blindly deferred to the allegedly
20 erroneous factual findings by the district court, and that the law regarding judicial standards of
21 review required such blind deference. See Act, § 2 (6)-(8). Specifically, Congress found that:

22 Despite the dearth of evidence in the *Stenberg* trial court record supporting the
23 district court’s findings, the United States Court of Appeals for the Eighth Circuit
24 and the Supreme Court *refused to set aside* the district court’s factual findings
25 because, under the applicable standard of appellate review, they were not
26 ‘clearly erroneous.’

27

28 Thus, in *Stenberg*, the United States Supreme Court *was required to accept the
very questionable findings* issued by the district court judge.

Id. at § 2(6),(7).

Neither is the case. Putting aside Congress’ disparaging characterization of the
district court’s factual and evidentiary findings, this court notes that, as a matter of law, the
Supreme Court will not blindly defer to factual findings that are as questionable as Congress
portrays the *Stenberg* district court’s factual findings to have been. See, e.g., *Easley v.*

1 *Cromartie*, 532 U.S. 234 (2001) (reversing district court’s determination that North Carolina’s
2 Legislature used race as the “predominant factor” in drawing Congressional district
3 boundaries). In reviewing a trial court’s findings for “clear error,” the Supreme Court “will not
4 reverse a lower court’s finding[s] of fact simply because [it] ‘would have decided the case
5 differently.’” *Id.* at 242 (quoting *Anderson v. Bessemer City*, 470 U.S. 564, 573 (1985)).
6 However, where a review of the trial court’s findings “leaves [the Court] ‘with the definite and
7 firm conviction’ that the District Court’s key findings are mistaken,” it will reverse those
8 findings. *Id.* at 242-43 (quoting *United States v. United States Gypsum Co.*, 333 U.S. 364,
9 395 (1948)) (noting that although the Court had “given weight to the fact that the District Court
10 was familiar with [the] litigation, heard the testimony of each witness, and considered all the
11 evidence with care,” the Court “[n]onetheless . . . cannot accept the District Court’s findings as
12 adequate”).

13 Nowhere in the Supreme Court’s decision in *Stenberg* does the Court imply that there
14 was an inadequacy or insufficiency of relevant evidence before the district court; nor does the
15 Court imply that it considered the district court’s findings to be “very questionable.” As noted,
16 to the contrary, the Supreme Court approved of the district court’s ultimate finding that intact
17 D&E “significantly obviates health risks in certain circumstances” as a “highly plausible record-
18 based explanation. . . .” *Stenberg*, 530 U.S. at 936-37. Moreover, the Supreme Court clearly
19 conducted its own review of the record evidence before the district court, and summarized the
20 evidence in its decision. See *id.* at 923-30 (noting that “[t]he evidence before the trial court, as
21 supported or supplemented in the literature, indicates the following”).³⁹

22 2. **Congressional Findings Regarding Necessity of a Health** 23 **Exception**

24 Congress also proffers its interpretation of the law regarding judicial review in an
25

26 ³⁹Congress also mischaracterized the effect of *Stenberg* on legislative determinations,
27 asserting that *Stenberg* “render[ed] null and void the reasoned factual findings and policy
28 determinations of the United States Congress. . . .” Act, § 2(7). However, that conclusion again
ignores the chronology of events. At the time that *Stenberg* was decided, prior Congresses may
have voted to ban “partial-birth abortions,” but none of those bans had been signed into law.

1 attempt to justify its ultimate “finding,” contrary to the Supreme Court’s decision in *Stenberg*,
2 that the Act is “not required to contain a ‘health’ exception . . . because a partial-birth abortion
3 is *never* necessary to preserve the health of a woman.” Act, § 2(13) (emphasis added).

4 Congress interprets the *Stenberg* Court’s requirement that partial-birth abortion bans
5 contain a health exception “where it is necessary, in appropriate medical judgment for the
6 preservation of the life of the mother,” as a finding of fact unique to the facts in *Stenberg*, and,
7 therefore, susceptible to contrary congressional fact-finding. See *id.* at § 2(4)-(13).

8 Accordingly, Congress “finds” that it is “entitled to reach its own factual findings [on the issue]
9 – findings that the Supreme Court [is required to] accord[] great deference – and to enact
10 legislation based upon these findings so long as [Congress] seeks to pursue a legitimate
11 interest that is within the scope of the Constitution, and draws reasonable inferences based on
12 substantial evidence.” *Id.* at § 2(8). In support, Congress cites to and discusses several
13 Supreme Court cases for its assertion that the courts “owe Congress’ findings an additional
14 measure of deference out of respect for its authority to exercise the legislative power.” *Id.* at §
15 2(12). Congress’ “findings” then conclude for the courts that its ultimate finding reflects the
16 “very informed judgment of . . . Congress” and is supported by “substantial record evidence.”
17 *Id.* at § 2(13).

18 However, Congress’ assertion that the courts are required to defer to its “factual”
19 findings raises questions regarding: (1) the nature of the Supreme Court’s holding that a
20 health exception was required in the *Stenberg* case; and (2) Congress’ ability to make factual
21 findings contrary to the Court’s holding.

22 **a. *Stenberg* Court’s Ruling Regarding Necessity of Health**
23 **Exception**

24 Accordingly, this court examines the *Stenberg* Court’s determination that the Nebraska
25 statute was unconstitutional because it “lack[ed] any exception ‘for the preservation of the . . .
26 health of the mother.’” 530 U.S. at 930 (citing *Casey*, 505 U.S. at 879).

27 The *Stenberg* Court reiterated its prior holdings in *Roe* and *Casey* that “subsequent to
28 viability, the State in promoting its interest in the potentiality of human life may, if it chooses,

1 regulate, and even proscribe abortion *except where it is necessary, in appropriate medical*
2 *judgment, for the preservation of the life or health of the mother.*” *Id.* at 921 (quoting *Casey*,
3 505 U.S. at 879). Noting that the Nebraska statute, like the Act at issue in this case, applied
4 both pre- and postviability, and that “the State’s interest in regulating abortion previability is
5 considerably weaker than postviability,” the *Stenberg* Court concluded, that since “a health
6 exception [is required] to validate even a postviability abortion regulation, it at a minimum
7 requires the same in respect to previability regulation.” *Id.* at 930.

8 The Court was clear that a health exception is required regardless of whether it is the
9 pregnancy itself, an unrelated health condition, or a “state regulation forc[ing] women to use
10 riskier methods of abortion.” 530 U.S. at 931. The court noted:

11 Our cases have repeatedly invalidated statutes that in the process of regulating
12 the *methods* of abortion, imposed significant health risks. They make clear that
13 a risk to . . . women’s health is the same whether it happens to arise from
14 regulating a particular method of abortion, or from barring abortion entirely.

13 *Id.*

14 The state of Nebraska, however, asserted that the law did not require a health
15 exception “unless there is a need for such exception,” and that there was no need for it in the
16 *Stenberg* case because safe alternatives were available to women and the ban created no
17 risk to the health of women, arguments strikingly similar to the congressional findings in this
18 case.

19 The Court rejected Nebraska’s argument, concluding that, given the “medically related
20 evidentiary circumstances,” the Nebraska statute required a health exception. *Id.* at 937. The
21 “medically related evidentiary circumstances” supporting the Court’s determination included:
22 (1) the district court’s findings that were supported by the record; (2) “a division of opinion
23 among some medical experts over whether [intact D&E] is generally safer;” and (3) “an
24 absence of controlled medical studies that would help answer these medical questions.” *Id.* at
25 936-37. Accordingly, the district court findings and record was just one of the three bases
26 upon which the Supreme Court based its conclusion that a health exception was required.

27 i. District Court Findings and Record

28 The Supreme Court found that the district court record “show[ed] that significant

1 medical authority supports the proposition that in some circumstances, [intact D&E] would be
2 the safest procedure.” *Id.* at 932. Moreover, the state of Nebraska failed to rebut the
3 substantial record evidence to this effect. *See id.* (noting that “[t]he State fails to demonstrate
4 that banning [intact D&E] without a health exception may not create significant health risks for
5 women”).

6 The Court then noted the record findings and evidence supporting a health exception,
7 and rejected arguments made by Nebraska in support of its position that no exception was
8 necessary. *See id.* at 934 (“We find these eight arguments insufficient to demonstrate that
9 Nebraska’s law needs no health exception.”). The specific eight arguments made by the State
10 that the *Stenberg* Court rejected almost entirely were:

11 (1) that the intact D&E procedure is “little-used;”

12 (2) that the intact D&E procedure is used by only a “handful of doctors;”

13 (3) that D&E [by disarticulation] and labor induction are at all times ‘safe and
14 alternative procedures;’

15 (4) that the ban does not increase a woman’s risk of several rare abortion
16 complications;

17 (5) Amici Association of American Physicians and Surgeon’s (“AAPS”) argument that the intact D&E procedure creates its own special risks;

18 (6) that there are no medical studies establishing the safety of the intact D&E
19 procedure or comparing it to other abortion procedures;

20 (7) an AMA policy statement that intact D&E is not “the only appropriate
21 procedure to induce abortion;” and

22 (8) ACOG’s qualification of its statement that intact D&E “may be the best or
23 most appropriate procedure” with the fact that ACOG “could identify no
24 circumstances under which [the intact D&E] procedure . . . would be the only
25 option to save the life or preserve the health of the woman.”

26 *Id.* at 933-937.

27 The Court found that several of the above arguments advanced by the State were
28 “beside the point.” *Id.* at 934. First, it held that “[t]he [intact D&E] procedure’s relative rarity is
not highly relevant.” *Id.* The court noted that the health exception was concerned instead with

whether protecting women’s health requires an exception for those infrequent occasions. A rarely used treatment might be necessary to treat a rarely occurring disease that could strike anyone – the State cannot prohibit a person

1 from obtaining treatment simply by pointing out that most people do not need it.
2 *Id.* The Court further found that the number of physicians who performed the procedure was
3 not relevant as there was no way of discerning the reason behind those numbers. *Id.*

4 As for alternative methods, the Supreme Court noted the trial court's agreement that
5 there were "safe alternatives," but rejected Nebraska's argument based on the related district
6 court finding that under certain circumstances, "the [intact D&E] method was significantly
7 safer." *Id.* Moreover, regarding complications associated with intact D&E, the Supreme
8 Court implied that there was a split of opinion, and that the trial court had relied on testimony
9 contrary to that relied on by the State, which suggested that intact D&E may eliminate the risk
10 of certain complications. *Id.* at 935.

11 The Court also rejected Amici AAPS's arguments regarding special risks associated
12 with intact D&E. The Court noted that another Amici, ACOG, pointed out that the risks
13 highlighted by AAPS are risks generally associated with all abortion procedures, including the
14 alternatives advanced by the State, and were not specifically associated with intact D&E. *Id.*
15 at 935. Additionally, the court rejected the State's characterization of ACOG's position,
16 especially in light of ACOG's contrary position in its amicus brief. *Id.* at 935-36 (noting that
17 ACOG asserted that "[intact D&E] presents a variety of potential safety advantages over other
18 abortion procedures used during the same gestational period").

19 Of the eight arguments, the only ones that the Supreme Court did not reject were
20 Nebraska's assertions regarding the absence of medical studies and the AMA policy
21 statement. However, it did note that Nebraska had cited only to the most favorable language
22 in the AMA statement, and had omitted a portion of the statement. *Id.* As for the absence of
23 studies, the Court noted that Nebraska was correct that "[t]here are no general medical
24 studies documenting [the] comparative safety of the intact D&E procedure with other abortion
25 procedures." *Id.* at 935.

26 **ii. Significance of Division of Medical Opinion and**
27 **Absence of Medical Studies**

28 Expounding on its holding in *Casey*, that "the governing standard requires an exception

1 'where it is *necessary, in appropriate medical judgment* for the preservation of the life or
2 health of the mother,'" the *Stenberg* Court explained that "necessity" contained in the above
3 phrase "cannot refer to an absolute necessity or to absolute proof;" nor to "unanimity of
4 medical opinion." *Id.* at 937. It found that the necessity or propriety of a certain procedure
5 depended on the particular circumstances of a particular case, and its relative health risks
6 and/or benefits. *Id.*

7 The court further noted that "[d]octors often differ in their estimation of comparative
8 health risks and appropriate treatment." *Id.* It, therefore, held that *Casey* requires "the judicial
9 need to tolerate differences of medical opinion." *Id.* The Court noted that the division of
10 medical opinion regarding the safety and propriety of the intact D&E procedure "involve[d]
11 highly qualified knowledgeable experts on both sides of the issue" – division "of a sort that [the
12 AMA] and [ACOG]'s statements together indicate are present here." *Id.*

13 Accordingly, the Court held that the existence of a division of medical opinion
14 supported the need for an exception, as opposed to the contrary. *Id.*

15 Where a significant body of medical opinion believes a procedure may bring
16 with it greater safety for some patients and explains the medical reasons
17 supporting that view, we cannot say that the presence of a different view by itself
18 proves the contrary.

19 *Id.* The Supreme Court reasoned that such a division of medical opinion meant that there was
20 a "significant likelihood that those [physicians] who believe that [intact D&E] is a safer abortion
21 method in certain circumstances may turn out to be right." *Id.* Accordingly, this likelihood
22 justifies a health exception, because to hold otherwise would "place women at an unnecessary
23 risk of tragic health consequences." *Id.*

24 In conclusion, the *Stenberg* Court held that:

25 [w]here substantial medical authority supports the proposition that banning a
26 particular abortion procedure could endanger women's health, *Casey* requires
27 the statute to include a health exception when the procedure is 'necessary, in
28 appropriate medical judgment, for the preservation of the life or health of the mother.'

Id. at 938.

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b. Relationship of *Stenberg* Health Exception and Related Congressional Findings

The dispute as to congressional factfinding regarding the necessity of a health exception is two-fold: (1) whether the issue is one of fact susceptible to contrary fact-finding by Congress; and (2) assuming that the issue is one of fact, the degree of deference that this court is required to afford congressional findings on the issue.

At this court’s request, the parties briefed those issues pertinent to the deference that this court was required to afford the congressional findings. The parties disagreed as to the characterization of *Stenberg*’s health exception and the appropriate standard of deference, as did law professors in an amicus brief submitted to this court.

i. Plaintiff’s Position Regarding Deference to Congressional Findings

Plaintiffs contend that the congressional findings are not really “findings,” but an attempt to evade the constitutional standards set forth by the Supreme Court in *Stenberg*. Accordingly, plaintiffs contend that the “findings” should be reviewed *de novo*. See, e.g., *Dickerson v. United States*, 530 U.S. 428, 432, 437 (2000) (*Miranda* warnings were a “constitutional decision of [the Supreme] Court” and may not be “legislatively supersede[d]” by an Act of Congress); see also *United States v. Morrison*, 529 U.S. 598, 615-617 (2000) (striking down Violence Against Women Act (“VAWA”), concluding that Congress lacked constitutional power under Commerce Clause and that “the existence of congressional findings is not sufficient, by itself, to sustain the constitutionality of Commerce Clause legislation”); *City of Boerne v. Flores*, 521 U.S. 507, 532 (1997) (striking down Religious Freedom Restoration Act (“RFRA”), enacted by Congress under Section 5 of the 14th Amendment, “regardless of the state of the legislative record,” where Act was in direct response to a prior Supreme Court decision and sought to legislatively supersede the legal standards set by the Court in that prior case).

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ii. Government’s Position Regarding Deference to Congressional Findings

The government, on the other hand, argues that this case is distinguishable from the cases cited by the plaintiffs because *Stenberg’s* determination regarding the necessity of a health exception does not rise to the level of a “constitutional rule,” like the *Miranda* requirements that Congress sought to overrule in *Dickerson*, or the Supreme Court’s constitutional interpretation of the RFRA, which Congress sought to overrule in *City of Boerne*. Instead, the government contends that whether a health exception is required is a “factual” issue, “decided on review of the particular record . . . in the [*Stenberg*] district court.”

The government contends that the *Stenberg* Court’s conclusion regarding the necessity of a health exception was “inextricably tied to the record evidence compiled in that specific case” and “did [n]ot suggest that Congress could not make an independent assessment of the medical evidence.” Accordingly, the government asserts that Congress did not attempt to overrule a constitutional standard, but instead that its findings fell within the constitutional parameters articulated by the Supreme Court in *Stenberg* and *Casey*.

Because it asserts that Congress was entitled to make the contrary factual findings, the government urges this court to apply the standard of review set forth by the Supreme Court in *Turner Broadcasting Sys., Inc. v. FCC (“Turner II”)*. 520 U.S. 180 (1997). In *Turner II*, the Supreme Court decided the second of a pair of cases involving the appropriate standard of judicial deference due congressional findings of fact in First Amendment free expression cases.

The Supreme Court held in *Turner II* that the “must-carry” provisions of the Cable Television Consumer Protection and Competition Act of 1992, requiring cable television providers to dedicate a portion of their channels to local broadcast television stations, as challenged by cable operators and programmers, did not run afoul of the First Amendment. *Id.* at 224-25. In so holding, the Court gave substantial deference to congressional findings in support of the regulation. Those findings included Congress’ ultimate conclusion that the confluence of undue market influence possessed by cable operators, cable operators’

1 economic interests not to carry broadcast signals, and local broadcasters' reliance on cable
2 operators for access to viewers, together, significantly threatened the future viability of local
3 broadcast television.

4 In according substantial deference to the legislative findings, the *Turner II* Court noted
5 that its:

6 sole obligation is to assure that in formulating its judgment, Congress has drawn
7 reasonable inferences based on substantial evidence. As noted in [*Turner I*],
8 substantiality is to be measured in this context by a standard more deferential
9 than we accord to the judgments of an administrative agency.

10 *Id.* at 195.

11 Accordingly, the government argues that this court should consider the trial evidence
12 "only to supplement the Congressional record [such] that the Court may determine whether
13 Congress' judgment was reasonable and based on substantial evidence." See *id.* at 196
14 (examining "first the evidence before Congress and then the further evidence presented to the
15 district court on remand to supplement the congressional determination").

16 **iii. Amici's Position Regarding Deference to** 17 **Congressional Findings**

18 A third and distinct approach regarding the deference to be accorded the
19 congressional findings was advanced by Amici, a group of law professors who teach and
20 write in the area of constitutional law. Amici argue that the necessity of a health exception
21 under *Stenberg* is not a pure fact as the government would characterize it, but instead a
22 constitutional or "legislative" fact. See, e.g., *A Woman's Choice v. Newman*, 305 F.3d 684,
23 688 (7th Cir. 2002) (discussing difference between legislative and adjudicative facts, and
24 noting that Supreme Court had suggested "constitutionality must be assessed at the level of
25 legislative fact, rather than adjudicative fact. . . . [because] only treating the matter as one of
26 legislative fact produces the nationally uniform approach that *Stenberg* demands"); see also
27 *Casey*, 505 U.S. at 888-893 (ruling that spousal notification requirement placed a substantial
28 obstacle in the path of women seeking to terminate their pregnancies as a matter of law).

While the government would like to characterize *Stenberg's* health exception as an

1 “adjudicative fact,” tried by courts and concerning only the immediate parties to the dispute,”
2 Amici note, in contrast, that legislative facts “transcend particular cases and must be decided
3 by courts as a matter of law.” March 1, 2004 Amicus brief at 4. According to Amici, the issue
4 here must be treated as one of legislative fact, because otherwise,

5 the [government’s] proposed standard would create the prospect that different
6 legislatures could find different facts predicated on essentially the same record.
7 . . . Such a result would leave different jurisdictions with disparate constitutional
practices notwithstanding the fact that the empirical issue is identical in each of
them.

8 *Id.* Accordingly, “the necessity of a medical exception must be found at the level of
9 constitutional fact – not amenable to alteration by the fact-finding of individual legislatures.” *Id.*
10 at 5.

11 Amici do not agree with plaintiffs that this court should review the findings *de novo*
12 simply because they constitute legislative or constitutional facts. Nor do Amici agree with the
13 standard advocated by the government.

14 Amici contend that although the *Turner* standard of deference may apply to legislative
15 facts under some circumstances, that is not true of a case in which a fundamental right, as
16 opposed to economic regulation, is implicated.⁴⁰ In cases such as this, involving fundamental
17 rights or liberties, Amici argue that the standard of deference to be applied is a “hard-look”
18 standard.⁴¹ Amici acknowledge that the Supreme Court “has not specifically articulated the
19 standard it employs,” but contend that “case law makes it clear that the Court stringently
20 reviews proffered findings of fact when basic liberties are infringed, and the Court does not
21 hesitate to go well beyond the legislative record in finding facts regarding the relevant inquiry.”
22 March 1, 2004 amicus brief, at 2. According to Amici, this approach requires “that courts

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24 ⁴⁰Amici also appropriately note that the government’s suggestion that the Act at issue here
25 is “economic” simply because it was passed pursuant to Congress’ Commerce Clause power
26 mischaracterizes the Act. According to such analysis, all legislation enacted pursuant to
Congress’ power under the Commerce Clause could be deemed “economic” regardless of its
impact on fundamental rights.

27 ⁴¹This “hard-look” standard of review is applied only to congressional findings regarding
28 the issue of the necessity of a health exception under *Stenberg*. As for the inquiry regarding
undue burden, Amici note that this court is required to make an independent legal judgment
regarding whether the Act unduly burdens a woman’s right to terminate a pregnancy.

1 conduct a stringent and broadly-based review of the methods and principles underlying factual
2 claims that affect the existence of protection of basic liberties.” *Id.*

3 **iv. Analysis Re: Level of Deference**

4 This court is inclined to agree with Amici regarding both the characterization of the
5 Supreme Court’s requirement of a health exception in *Stenberg* as one of “constitutional fact,”
6 and the applicable standard of deference.

7 This court’s discussion of *Stenberg* above dispels Congress’ and the government’s
8 characterization of the issue as one of pure fact, limited to the record in that particular case.
9 Instead, as noted, the record was only one of several “medically related evidentiary
10 circumstances” that the Supreme Court considered in concluding that a health exception was
11 required. The other two significant considerations included the state of medical studies and
12 the division of expert medical opinion on the issue -- general evidentiary considerations that
13 were not limited exclusively to the record in the *Stenberg* case. See 530 U.S. at 879.

14 Accordingly, this case appears to be factually closer to those cases relied on by
15 plaintiffs, including *City of Boerne*, *Dickinson*, and *Morrison*, in which the Supreme Court held
16 that, as a matter of law, congressional factfinding was not entitled to deference where
17 Congress intended to legislatively supersede constitutional standards. However, this case is,
18 at the same time, not identical to those cases. As the government has pointed out, those
19 cases involved constitutional “rules.” Here, *Stenberg*’s health exception requirement does not
20 appear to arise to the level of a constitutional “rule” like *Miranda* requirements. Instead,
21 because it is based on “medically related evidentiary circumstances,” the necessity of the
22 exception is, for the reasons explained by Amici, more appropriately considered an issue of
23 “legislative” or “constitutional” fact.

24 Assuming that the Supreme Court’s holding in *Stenberg* regarding the necessity of a
25 health exception is amenable to subsequent legislative factfinding, this court would be inclined
26 to agree with the “hard look” standard of deference advanced by Amici. That is, that while this
27 court does not review congressional findings regarding these types of facts *de novo*, as
28 plaintiffs have advocated, the court also does not believe the standard is one of substantial

1 deference, advocated by the government. *See also Newman*, 305 F.3d at 688 (noting that
2 with respect to abortion regulations, “constitutionality must be assessed at the level of
3 legislative fact, rather than adjudicative fact determined by more than 650 district judges”).
4 “Only treating the matter as one of legislative fact produces the nationally uniform approach
5 that *Stenberg* demands.” *Id.*

6 This court agrees that the issue of deference in this case is not clearly established by
7 Supreme Court precedent. Because this case involves a woman’s fundamental right to
8 choose an abortion, the court is not persuaded that it should afford congressional findings that
9 undermine that right the same substantial deference utilized by the Supreme Court in cases
10 involving economic regulation, like *Turner II*. In *Turner II*, regarding the applicability of the
11 standard of substantial deference, the Supreme Court explicitly noted that:

12 [The] principle has special significance in cases, like this one, involving
13 congressional judgments concerning *regulatory schemes of inherent*
14 *complexity and assessments about the likely interaction of industries*
15 *undergoing rapid economic and technological change*. Though different in
16 degree, the deference to Congress is in one respect akin to deference owed to
17 administrative agencies because of their expertise.

18 520 U.S. at 196 (citing *FCC v. National Citizens Comm. for Broadcasting*, 436 U.S. 775, 814
19 (1978)) (emphasis added).

20 Nevertheless, while recognizing the importance of the issue, this court need not
21 articulate the precise degree of deference to be accorded the congressional findings in this
22 case. That is because, even if this court were to assume that the findings are entitled to the
23 most stringent standard of deference advocated by the government and Congress: that of
24 substantial deference, the court concludes for the reasons set forth below, that Congress has
25 not drawn reasonable inferences based on substantial evidence, and its findings are therefore
26 not entitled to substantial deference.

27 **3. Congress’ Determination that the Partial-Birth Abortion Procedure**
28 **is Never Medically Necessary is not Reasonable and is not Based**
on Substantial Evidence

In *City of Boerne*, the Supreme Court recognized that “[o]ur national experience

1 teaches that the Constitution is preserved best when each part of the Government respects
2 both the Constitution and the proper actions and determinations of the other branches.” 521
3 U.S. at 535-36. In recognition of this principle and the pertinent congressional findings, this
4 court believes it necessary to set forth in detail the history of the congressional proceedings
5 and Congressional Record underlying Congress’ ultimate finding, and to discuss the specific
6 findings made by Congress, in support of this court’s conclusion that Congress’ finding
7 regarding the necessity of a health exception is not entitled to deference.

8 a. Overview of Congressional Record

9 In evaluating the congressional findings in this case, it is helpful first to briefly
10 summarize the record before Congress. The evidence presented before Congress was
11 qualitatively different than the evidence presented before this court. While some witnesses
12 testified both before Congress and the court, the court was presented with much more
13 extensive medical and scientific evidence on both sides of the issue concerning the safety and
14 necessity of intact D&Es. Congress, on the other hand, heard significantly more policy-based
15 arguments.

16 From 1995 to 2003, the 104th through the 108th Congresses held a total of six
17 hearings relating to “partial-birth abortion.” In addition, various individuals and organizations
18 submitted numerous policy statements and letters for inclusion in the Congressional Record.⁴²

19 i. 104th Congress (1995)

20 In 1995, Congress held three hearings on intact D&E.

21 *House Judiciary Committee Hearings*

22 The first hearing of the 104th Congress took place before the House Judiciary
23 Committee on June 15, 1995. Partial-Birth Abortion Hearing before the Subcomm. on the
24 Constitution of the House Comm. on the Judiciary, 104th Cong 1st Sess (1995) (“Record Exh.
25 G”). In those proceedings, various representatives debated the issue of intact D&E in the
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27 ⁴²As both parties have agreed, the court takes judicial notice of the fact that materials and
28 testimony are included in the Congressional Record but not necessarily for the truth of the matters
asserted therein. See Fed. R. Evid. 201.

1 context of Dr. Haskell's description of the procedure before the National Abortion Federation
2 in 1992.

3 Two physicians, Dr. Pamela Smith and Dr. Robert White, and one nurse, Mary Ellen
4 Morton, testified in favor of a ban. Dr. Smith, a gynecologist who does not perform abortions,
5 gave a general overview of the procedure, and stated that there was no medical need for the
6 procedure, while Dr. White, a neurosurgeon with no obstetrics training, testified that he
7 believed that the fetus would feel intense pain during an intact D&E procedure. Record Exh. G
8 at 38-44, 90 (Smith testimony), 67-71 (White testimony). Morton, a neonatal nurse, presented
9 photographs of premature infants and testified in a written statement that she believed that
10 premature infants were identical to fetuses in the second trimester of pregnancy and that they
11 would feel pain during an intact D&E procedure. *Id.* at 76-86.

12 One physician testified against the ban, Dr. J. Courtland Robinson, an obgyn with
13 training in public health. Dr. Robinson testified that intact D&E is a rare procedure, that the
14 ban seemed vague, and that Congress should not substitute its judgment for those of women
15 and their physicians. Dr. Robinson did not provide information about how an intact D&E is
16 performed, and stated that he was unfamiliar with this technique until a few weeks before
17 testifying. Record Exh. G at 63-67, 88.

18 One woman, Tammy Watts, who had undergone an intact D&E, also provided
19 testimony. Watts had discovered 7 months into her pregnancy that her fetus suffered from
20 trisomy 13, a fatal chromosomal anomaly, and decided to terminate the pregnancy. Because
21 she had an intact D&E, Watts was able to see and hold the fetus, and the fetus was autopsied
22 for future diagnostic purposes. Record Exh. G at 71-76.

23 The four testifying witnesses were then questioned by various members of Congress.
24 The witnesses did not provide extensive medical explanations of the procedure, as the
25 representatives focused mainly on policy issues in the debate. Record Exh. G at 86-97.

26 Various statements were also read into the Record, including newspaper articles on
27 intact D&E, statements from pro-life groups, letters from pro-life doctors, including Dr. Bowes,
28 letters from the National Abortion Federation (a pro-choice organization), a copy of Dr.

1 Haskell's article and a written response from Dr. Haskell generally objecting to
2 mischaracterizations of his article, and statements from attorneys on the constitutionality of a
3 ban. See, e.g., Exh. G at 4-28, 97-142.

4 *Senate Judiciary Hearings*

5 The second hearing on intact D&E took place before the Senate Judiciary Committee
6 on November 19, 1995. Partial Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 before
7 the Senate Comm. on the Judiciary, 104th Cong. 1st Sess. (1995) ("Record Exh. F").

8 The first witness to testify was Brenda Pratt Shafer, a nurse who claimed to have
9 worked in Dr. Haskell's office. Shafer testified that she observed an intact D&E procedure
10 where a 26-week fetus visibly struggled during the procedure. Dr. Haskell's office submitted a
11 letter in response stating that they do not perform intact D&E procedures after 24 weeks and
12 noting other inconsistencies in Shafer's testimony. Certain senators also noted that Shafer's
13 deposition testimony had previously been ruled inadmissible in Ohio's litigation concerning a
14 state ban on intact D&E. Record Exh. F at 17-21, 205-06.

15 Next, the Senate heard from the first panel of witnesses, which included: Dr. Smith and
16 Dr. Robinson, who had previously testified before the House; Dr. Mary Campbell, Dr. Nancy
17 Romer, Dr. Norig Ellison, and Helen Alvare. Dr. Smith and Dr. Romer, who supported a ban
18 on intact D&E, discussed generally the dangers of intact D&E and the lack of medical
19 necessity for the procedure. Dr. Romer indicated that she had never performed an intact
20 D&E.

21 Dr. Campbell, the medical director for the Washington DC Planned Parenthood
22 affiliate, discussed in general how second trimester abortions are performed, and Dr.
23 Robinson reiterated his belief that Congress should not legislate how doctors practice
24 medicine. Dr. Ellison, an anesthesiologist, offered testimony solely on the issue of whether
25 anesthetic given to the woman would cause fetal demise, and he testified that it would not.
26 Alvare offered testimony as a representative of the Catholic church that intact D&Es were
27 immoral. The witnesses did not explain matters in great scientific detail, though they were
28 questioned extensively on policy issues by the committee members and some medical

1 research issues were discussed in that context. Record Ex. F at 75-158.

2 The next panel of witnesses consisted of three women, two of whom had undergone
3 intact D&Es: Coreen Costello, Viki Wilson, and Jeannie French. Costello was carrying a
4 fetus diagnosed at seven months with a fatal neurological anomaly and needed to terminate
5 the pregnancy. She had requested a caesarean but her doctors advised against the risk, and
6 she could not undergo an induction because the fetus was suffering from hydrocephaly. She
7 underwent an intact D&E, believed that the fetus had died before birth, and was able to hold
8 the baby after the procedure. Wilson testified that her fetus was diagnosed at 36 weeks with
9 an encephalocoele, where the brain develops outside the fetal skull, and would not live outside
10 the uterus. Because of the size of the head, Wilson could not undergo an induction, and thus
11 underwent an intact D&E. French testified that she gave birth to twins, one of whom was
12 diagnosed with an encephalocoele and did not survive, and that intact D&E was not
13 necessary for her. Record Ex. F at 158-168.

14 The third panel consisted of two law professors who debated the constitutionality of a
15 ban, Record Ex. F at 169-207, and the remainder of the hearing materials consist of written
16 statements from various doctors, medical associations, and pro-life advocacy groups. *Id.* at
17 207-363.

18 *House Hearings on Anesthesia*

19 The third and final hearing of the 104th Congress, held on March 21, 1996, focused on
20 the issue of whether anesthesia given to the mother in an intact D&E would cause fetal
21 demise.⁴³ Effects of Anesthesia During a Partial-Birth Abortion: Hearing before the
22 Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong. 2nd Sess
23 (1996) ("Record Ex. E").

24 In previous hearings, some doctors, patients, and pro-choice advocacy groups had
25 indicated that they believed that the anesthetic given to a woman undergoing an intact D&E
26 would be sufficient to cause fetal demise before the extraction procedure began. Record Exh.

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28 ⁴³Plaintiffs in this matter agree with the government that the anesthetic given to women will not cause fetal demise, and thus this question is not an issue in this litigation.

1 E at 1-3. A congressman who is also a doctor, Tom Coburn, testified that it would not. *Id.* at
2 135-136.

3 Next, a panel of four anesthesiologists provided testimony: Dr. Ellison, who had
4 testified previously, Dr. David Birnbach, Dr. David Chestnut, and Dr. Jean Wright. All four
5 doctors testified that anesthetic given to the mother would not cause fetal demise, and Dr.
6 Wright testified that beginning around 26 weeks after gestation (28 weeks Imp) fetuses can
7 feel intense pain. Record Exh. E at 137-150. The panel was then questioned by various
8 members of Congress. *Id.* at 291-303.

9 The final panel consisted of Shafer, who had previously testified before the Senate;
10 Costello, who had previously testified before the Senate, Mary-Dorothy Line, who had
11 undergone an intact D&E, and Alvare, who had previously testified before the Senate. Shafer
12 reiterated her testimony from the first hearing, as did Costello and Alvare. Line, who had not
13 previously testified, stated that her fetus had been diagnosed as hydrocephalic at 22 weeks,
14 and she had undergone an intact D&E where a needle was used to aspirate the fluid from the
15 fetus' head. Record Exh. E at 310-335. Members of Congress then questioned the
16 witnesses. *Id.* at 335-352.

17 The remainder of the record of this hearing consists of letters from advocacy groups
18 and doctors, a letter from President Clinton opposing the ban, excerpts from previous portions
19 of the Congressional Record before the Senate Judiciary Committee, medical research
20 articles on fetal pain, a letter from Dr. Creinin, who testified before this court, stating that
21 fetuses do not feel pain, and a copy of the order from the Ohio district court finding the Ohio
22 ban on intact D&E unconstitutional. See, e.g., Record Exh. E at 4-134, 151-282, 352-56.

23 The proposed bill was then passed by both chambers of Congress, and President
24 Clinton vetoed it on April 10, 1996. 142 Cong. Rec. H3338 (daily ed. Apr. 15, 1996). The
25 Senate was unable to override the veto, and it was sustained. 142 Cong. Rec. S11389 (daily
26 ed. Sept. 26, 1996).

27 ii. 105th Congress

28 New legislation to ban intact D&E was then proposed in the 105th Congress. The

1 House and Senate Judiciary Committees held a joint hearing on March 11, 1997, on the
2 issue. Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 before the Senate
3 Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the
4 Judiciary, 105th Cong. 1st Sess (1997) (“Record Exh. D”).

5 The first panel to testify at this hearing consisted of members of various advocacy
6 groups: Renee Chelian, of the National Coalition of Abortion Providers; Kate Michelman, of
7 NARAL; Helen Alvare, of the Catholic Church; Gloria Feldt, of Planned Parenthood; Vicki
8 Saporta, of NAF; and Douglas Johnson, of the National Right to Life Committee. The
9 witnesses presented primarily policy-based reasons for their positions, and not medical ones;
10 some statistics on both sides were introduced into the record, but not discussed. Record Exh.
11 D at 17-66. Members of Congress then extensively questioned the panel. *Id.* at 67-119.

12 The second panel consisted of Dr. Cook, who testified before this court, and is one of
13 the co-founders of Physicians’ Ad-Hoc Coalition for Truth (“PHACT”), a group opposed to
14 intact D&E; Eileen Sullivan and Maureen Britell, who underwent intact D&Es; and Whitney
15 Goin, whose fetus was diagnosed with fetal anomalies but who declined an abortion. Dr.
16 Cook testified that there was no need for intact D&E but did not explain the medical reasons
17 for his conclusions. Sullivan’s fetus was diagnosed with a fatal heart anomaly at 26 weeks,
18 and Sullivan decided on an intact D&E so the fetus could be autopsied to help her in making
19 her future reproductive decisions. Britell, who was previously active in the pro-life movement,
20 was pregnant with a fetus diagnosed with anencephaly at the beginning of her third trimester.
21 When Britell’s induction abortion failed, she underwent an intact D&E so her priest could
22 deliver religious rites to the fetus. Goin’s fetus was diagnosed with abdominal defects which
23 were not fatal but would require extensive surgery after birth. Goin declined a second
24 trimester abortion and her child is alive today. Members of Congress questioned the women
25 and Dr. Cook whether intact D&E procedures were necessary in their circumstances. Record
26 Exh. D at 120-135.

27 The remainder of the record consists of prepared statements by attorneys on the issue
28 of the constitutionality of the bill, copies of medical research articles, copies of previous

1 testimony given before Congress on the issue, and letters from advocacy groups. See, e.g.,
2 Record Ex. D at 1-17, 135-142, Record Appendix.

3 The bill was passed, and President Clinton vetoed it. 143 Cong. Rec. H8891 (daily ed.
4 Oct. 21, 1997). The Senate was again unable to override the veto. 144 Cong. Rec. S10564
5 (daily ed. Sept. 18, 1998).

6 **iii. 106th Congress**

7 No hearings were held in the 106th Congress, but other written materials were
8 introduced into the Congressional Record, such as letters from doctors and policy groups.

9 The Supreme Court decided *Stenberg* on June 28, 2000, and relied in part on
10 evidence presented in the Congressional Record up to this point.

11 **iv. 107th Congress**

12 On July 9, 2002, Congress again held a hearing on the issue of intact D&E. Partial
13 Birth Abortion Ban Act of 2002: Hearing before the Subcomm. on the Constitution of the
14 House Comm. of the Judiciary, 107th Cong. 2nd Sess (2002) (“Record Ex. C”).

15 The only panel of witnesses that testified at this hearing consisted of Dr. Aultman and
16 Dr. Cook, both of whom supported the ban and had previously testified before Congress;
17 Simon Heller, an attorney on behalf of the Center for Reproductive Law and Policy who
18 believed the proposed law to be unconstitutional; and Robert Destro, an attorney who believed
19 the proposed law to be constitutional. Dr. Aultman testified that the bill was not vague and that
20 no health exception was needed, and Dr. Cook testified that intact D&E was not medically
21 necessary. Dr. Aultman also provided a position paper outlining the medical basis for her
22 opinion. Heller and Destro presented opposing views on the constitutionality of the ban.
23 Record Ex. C at 6-28. Members of Congress then questioned the witnesses. Id. at 28-46.

24 The record also includes an extensive appendix of materials, which includes letters
25 from doctors and advocacy groups, statements from senators, and medical papers on both
26 sides of the issue. Record Ex. C at 47-280.

27 **v. 108th Congress**

28 The House held its final hearing on this issue on March 25, 2003. Partial-Birth Abortion

1 Ban Act of 2003: Hearing before the Subcomm. on the Constitution of the House Comm. on
2 the Judiciary, 108th Cong. 1st Sess (2003) (“Record Exh. B”).

3 Only one panel of witnesses testified at this hearing, consisting of Dr. Mark Neerhof,
4 who supported a ban, and Simon Heller and Gerard Bradley, attorneys testifying regarding the
5 constitutionality of the act. Dr. Neerhof provided an overview of his medical opinion
6 concerning the lack of necessity for the procedure. The Congressional Findings of Fact
7 appear to have drawn in significant part from this overview. Record Exh. B at 6-10. Heller and
8 Bradley discussed the constitutionality of the act in light of *Stenberg*, and Bradley’s
9 conclusions appear to have been incorporated into the Congressional Findings of Fact as
10 well. *Id.* at 10-22. Members of Congress then questioned the witnesses. *Id.* at 22-35.

11 The record of this hearing also includes an extensive appendix, consisting of
12 statements from doctors and policy groups on both sides of the issue. Record Exh. B at 37-
13 279.

14 b. Analysis re: Congressional Record

15 i. Witnesses

16 The oral testimony before Congress was heavily weighted in favor of the Act. As was
17 the case with many of the government’s witnesses before this court, Congress heard
18 disproportionately from physicians opposed to abortion generally, unless the life of the mother
19 was absolutely compromised. This court’s review of the Congressional Record reflects that
20 over a period of approximately eight years, Congress entertained live testimony from a total of
21 eight physicians, six of whom supported the ban, and two of whom opposed the ban.⁴⁴ Of
22 those six physicians who supported the ban, two are related to the instant case: Drs. Cook
23 and Neerhof. Like the government’s witnesses in this case, none of the six physicians who
24 testified before Congress had ever performed an intact D&E. Several did not provide
25 abortion services at all; and one was not even an obgyn.

26 It is apparent to this court, having heard the testimony of the thirteen expert witnesses in
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28 ⁴⁴This does not include the four physicians who testified exclusively regarding the effect
of maternal anesthesia on the fetus, not at issue here.

1 this case, and having reviewed the deposition testimony of an additional six expert witnesses,
2 that the oral testimony before Congress was not only unbalanced, but intentionally polemic. In
3 contrast to the evidence before Congress, this court heard from eight physicians who have all
4 performed the banned procedure, and have been instructed in the procedure, many of whom
5 teach the procedure themselves.

6 This court cannot evaluate the credibility of those witnesses who appeared both before
7 this court and also testified or submitted materials to Congress *as they appeared before*
8 *Congress*. However, this court has made findings regarding those witnesses' credibility, set
9 forth above, *as they appeared before this court*. That group includes Drs. Cook, Sprang, and
10 Bowes.

11 While Dr. Sprang did not testify personally before Congress, he submitted letters in
12 favor of the ban, and along with Dr. Neerhof, who testified before Congress in support of a
13 ban, is the co-author of an article submitted to and cited by Congress in support of its findings.
14 See Exh. A-55, Sprang & Neerhof, *Rationales for Banning Abortions Late in Pregnancy*,
15 280 Journal of the American Medical Association ("JAMA") 8, at 744-47 (August 26, 1998).
16 Many of the congressional "findings" mirror substantially the conclusions reached in Dr.
17 Sprang's article. That article, upon which Congress very obviously relied, and which was
18 admitted into evidence at trial, was published in 1998, prior to the Supreme Court's decision
19 in *Stenberg*, and was considered and implicitly rejected by the Supreme Court in its decision.
20 See 530 U.S. at 933 (citing to article).

21 This court finds a number of the conclusions in that article, including those resembling
22 many of Congress' findings, troublesome and contrary to the medical evidence presented by
23 both sides to this court. The article itself constitutes an opinion piece, representing a generally
24 anti-late-term abortion view. The article was published in the "Controversies" section of the
25 journal, a section that includes "one article pro and one article con on an issue." Dr. Sprang
26 himself agreed that the article was one part of a two-part piece taking opposite viewpoints on
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1 restrictions on late-term abortions. Tr. Vol. 7 at 1020:19-23; 1032:17-19 (Sprang).⁴⁵

2 Unlike other studies that this court admitted into evidence, the article did not rely on any
3 clinical research or medical studies conducted by Dr. Sprang. Instead, it was based on his
4 review of the literature on the issue – literature which included non-medical sources like
5 newspaper articles and weekly periodicals. For that reason, this court indicated at trial that it
6 found the article itself to be lacking in trustworthiness. Tr. Vol. 8 at 1340:2-11 (Sprang).
7 Moreover, given Dr. Sprang’s lack of expertise in late-term abortion procedures, and intact
8 D&E procedures specifically, and the contradictory testimony that Dr. Sprang gave at trial, the
9 article and many of its conclusions become even more questionable.

10 This court shares similar qualification and credibility concerns regarding Dr. Cook,
11 another government witness, based on his testimony before this court. Dr. Cook testified
12 before Congress several times and also submitted written materials to Congress in
13 opposition to the ban from himself, and from an organization that he co-founded, PHACT.
14 Congress relied in part on Dr. Cook’s testimony for its findings, testimony which included his
15 opinion regarding two specific medical situations concerning the necessity of intact D&E.⁴⁶
16 Tr. Vol. 9 at 1437:13-20 (Cook).

17 Both Dr. Bowes, who testified for the government, and Dr. Creinin, plaintiffs’ witness,
18 submitted letters to Congress in support of, and in opposition to the Act, respectively.
19 However, this court does not have the same credibility concerns with respect to the

20 _____
21 ⁴⁵Dr. Sprang was asked to draft his article in response to an article by Dr. David Grimes,
opposing restrictions on late-term abortion methods. *Id.* at 1020:17-25.

22 ⁴⁶Dr. Cook testified, however, that he did not review the actual medical records associated
23 with the cases about which he testified. *Id.* at 1382:3-11. The two medical situations regarding
24 which Dr. Cook opined before Congress were in rebuttal to a letter written by a physician, Dr.
Phillip Darney, in opposition to the Act. In that letter, Dr. Darney detailed two specific situations
25 for Congress in which he believed that the intact D&E procedure had been necessary to the life
of the women. Dr. Cook responded, rebutting the necessity of the intact D&E procedure. *Id.* at
1437:13-20.

26 Government counsel posed the same two situations as hypotheticals to Dr. Cook before
27 this court, both of which included women with placenta previa and other disorders or emergency
circumstances requiring pregnancy termination. *Id.* at 1438:10-1441:14. Dr. Cook opined that
28 intact D&E was neither necessary nor recommended. However, Dr. Chasen, in subsequent
testimony, disagreed with Dr. Cook’s opinions. See Tr. Vol. 11 at 1768-1782 (Chasen).

1 government's witness, Dr. Bowes, or plaintiffs' witness, Dr. Creinin.

2 **ii. Medical Organizations**

3 Congress also had before it policy statements and materials from numerous medical
4 organizations, the majority of which opposed the Act. Among the medical organizations who
5 submitted materials in opposition to the Act were ACOG, CMA, AMWA, NAF, APHA, PRCH
6 ("Physicians for Reproductive Choice and Health"), and ANA ("American Nurses
7 Association"). Two organizations supporting the bill also submitted materials: PHACT, co-
8 founded by Dr. Cook, and AAPS. As noted, the AMA, which supported a ban initially,
9 subsequently withdrew its support.

10 In the materials submitted before Congress, the two largest medical organizations,
11 ACOG and AMA, while agreeing in their opposition to the Act, disagreed regarding their
12 positions on "partial-birth abortion." The AMA was ethically opposed to "partial-birth abortion,"
13 whereas ACOG believes that there are circumstances during which "partial-birth abortion"
14 "may be the most appropriate and safest procedure to save the life or health of a woman."
15 See Record Ex. B, at 146-152 (1997 AMA "Fact Sheet"); Record Ex. C, at 186 (AMA
16 Statement); *id.* at 260 (AMA Policyfinder); *id.* at 240 (4/00 ACOG "Fact Sheet"); Record Ex.
17 B, at 197 (7/02 ACOG Statement). In recognition of their differences, the AMA and ACOG
18 submitted to Congress a "Joint Statement," noting that "they were concerned regarding the
19 negative impact caused by different positions reached by [the organizations]," and provided
20 goals common to both organizations. See Record Ex. C, at 220 (AMA/ACOG Joint
21 Statement). One commonality shared by both ACOG and the AMA was that they opposed any
22 partial-birth abortion ban that included criminal sanctions. *Id.*

23 Congress in its findings, however, chose to disregard the statements by ACOG and
24 other medical organizations in opposition to the Act, and then exclusively utilized statements
25 derived directly from 1997 AMA policy statements in its findings – policy statements that the
26 Supreme Court had before it in *Stenberg*, but did not rely upon in reaching a contrary
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1 conclusion.⁴⁷ See *Stenberg*, 530 U.S. at 934-35 (noting 1997 AMA policy statement
 2 asserting that “there does not appear to be any identified situation in which intact [D&E] is the
 3 only appropriate procedure to induce abortion”). Among the statements that Congress
 4 disregarded was ACOG’s amicus brief submitted to the Supreme Court in *Stenberg*, and
 5 cited by the Supreme Court approvingly in that case,⁴⁸ and a July 2002 ACOG statement, one
 6 of the few new statements submitted by a medical organization post-*Stenberg*. See Record
 7 Exh. A, at 98 (ACOG amicus brief); Record Exh. B, at 197 (7/02 ACOG statement). That
 8 statement provides in pertinent part that:

9 ACOG has concluded that there are circumstances under which this type of
 10 procedure would be the most appropriate and the safest procedure to save the
 11 life or health of a woman. Only the doctor, in consultation with the patient, based
 12 upon the woman’s particular circumstances, can make this decision.

13 This bill violates a fundamental principle at the very heart of the doctor-patient
 14 relationship; that the doctor, in consultation with the patient, based on the
 15 patient’s individual circumstances, must choose the most appropriate method of
 16 care for the patient. This bill removes decision-making about medical
 17 appropriateness from the physician and the patient. ACOG’s members,
 18 whatever their beliefs about abortion, share an interest in opposing laws that
 19 interfere with a physician’s ability to exercise his or her best medical judgment in
 20 providing care for each patient.

21 ACOG opposes legislation such as HR 4965 as inappropriate, ill-advised and
 22 dangerous intervention into medical decision-making. HR 4965 is vague and
 23 broad, with the potential to restrict other techniques in obstetrics and
 24 gynecology. It fails to use recognized medical terminology and fails to define
 25 explicitly the prohibited medical techniques it criminalizes. ACOG notes
 26 particularly that imposing criminal penalties for use of a procedure that includes
 27 elements of recognized gynecologic and obstetric techniques could outlaw use
 28 of those techniques in both abortion and non-abortion circumstances. Some of
 these techniques can be critical to the lives and health of American women.

Record Exh. B, at 197.

⁴⁷All of the quotations attributed to a “prominent medical association” in the Congressional findings refer to statements made by the AMA, primarily in its Fact Sheet issued June 1997. See Act § 2 (14)(C), (I); see also Record Exh. B, at 146-152.

⁴⁸Citing to ACOG’s amicus brief filed in that case, the Supreme Court rejected the defendant’s mischaracterization of ACOG’s position on intact D&E. Specifically, the Court noted ACOG’s reasoning regarding why intact D&E may be the most appropriate and safest abortion procedure under certain circumstances, and safer than the alternatives. See *Stenberg*, 530 U.S. at 936.

1 **iii. Congressional Debate**

2 The Act itself and especially the Act’s ultimate finding that “partial-birth abortion is
3 never medically indicated to preserve the health of the mother,” were hotly contested within
4 Congress. See generally, e.g., Record Exh. A, at 147-154 (dissenting views signed by
5 fourteen legislators). Dissenting legislators opposed the Act on numerous grounds, both legal
6 and policy-based, including that: (1) the Act unconstitutionally omits an exception to protect
7 maternal health; (2) that the Supreme Court will not defer to erroneous factual and legal
8 conclusions masked as congressional “findings;” (3) the threat to the separation of powers; (4)
9 the Act’s overbreadth and undue burden on a woman’s right to obtain an abortion; (5) the
10 danger to women’s health posed by the Act’s ban on safe abortion procedures; and (6) the
11 criminalization of doctors and the conflict the Act encourages between pregnant women and
12 their husbands, or in the case of minors, their parents. *Id.*

13 Opponents of the Act argued before Congress that the Act was both legally unsound
14 and a mischaracterization of abortion procedures. Opponents contended that:

15 This bill as written fails every test the Supreme Court has laid down for what may
16 or may not be a constitutional regulation on abortion. . . . While . . . proponents of
17 this bill view all abortion as tantamount to infanticide, that is not a mainstream
18 view. This bill attempts to foist a marginal view on the general public by
19 characterizing this bill as having to do only with abortions involving healthy, full-
20 term fetuses. If the proponents of this bill really want to deal with post-viability
21 abortions in situations in which a woman’s life and health are not in jeopardy,
22 then they should write a bill dealing with that issue.

23 Record Exh. A, at 73-74.

24 Moreover, Congress debated and ultimately rejected an amendment that would have
25 added a health exception to the Act. *Id.* at 27, 65. Arguing in favor of a health exception,
26 opponents asserted that:

27 [T]he families that are affected by this bill are dealing with the tragic
28 circumstances of crisis pregnancies. In most cases, they have just learned that
their babies will not survive. They are then confronted by choices that none of us
would wish on any human being. This is the context in which . . . this legislation
comes into play. And any suggestion to the contrary deceives the American
public about the realities of this issue.

. . . .

Typically, women who must face this decision want nothing more than to have a

1 child and are devastated to learn that their baby would not survive outside the
2 womb. In consultation with their doctors and families, they make difficult
3 decisions to terminate pregnancies to preserve their own health, and in many
4 cases to preserve their ability to have children in the future.

5 *Id.* at 69-70.

6 iv. Comparison with *Stenberg* Record

7 In support of its conclusion that “partial-birth abortion” is never necessary, Congress
8 asserted, and the government has argued, that following the courts’ decisions in *Stenberg*,
9 Congress had evidence available to it that was not available at the time *Stenberg* was
10 decided. In its findings, Congress stated:

11 [O]verwhelming evidence presented and compiled at extensive congressional
12 hearings, *much of which was compiled after the district court hearing in*
13 *Stenberg*, and thus not included in the *Stenberg* trial record, demonstrates that
14 a partial-birth abortion is never necessary to preserve the health of a woman,
15 poses significant risks to a woman upon whom the procedure is performed, and
16 is outside the standard of medical care.

17 Act, § 2 (5) (emphasis added). However, this court’s review of the Congressional Record
18 reveals that the opposite is true.

19 Although Congress utilized the *Stenberg* district court’s decision from July 1998, as the
20 benchmark regarding the status of the medical evidence on the issue, the real benchmark
21 must be the Supreme Court’s decision in *Stenberg*, which was issued on June 28, 2000. As
22 noted, the district court record was just one of the “medically related evidentiary
23 circumstances” supporting the Supreme Court’s determination that a health exception was
24 required. *Stenberg*, 530 U.S. at 936-37. The Supreme Court considered also the division of
25 opinion among medical experts and the state of medical studies that *existed at the time the*
26 *Supreme Court decided Stenberg* – including the Congressional Record to date and
27 numerous amicus briefs submitted by interested parties. *Id.* at 933-36.

28 However, regardless of which benchmark is utilized – the *Stenberg* district court’s
29 decision in 1998, or the Supreme Court’s decision in June 2000 – this congressional finding
30 is inaccurate and contrary to the very record that existed before Congress. The majority of
31 congressional hearings and evidence were conducted before and collected by the 104th and
32 105th Congresses from 1995-1997, prior to both the district court’s and the Supreme Court’s

1 decisions. Following the district court's decision in *Stenberg* in 1998, Congress held only two
2 hearings on the intact D&E procedure. None of the testimony received by Congress at those
3 hearings can reasonably be considered "new" medical evidence not available to the courts at
4 the time *Stenberg* was decided.⁴⁹

5 Outside of the *Stenberg* record, which included the amicus briefs considered by the
6 Supreme Court, several medical organizations, including ACOG, APHA, PRCH, and AMWA,
7 submitted new materials in opposition to the Act. PHACT, the organization co-founded by Dr.
8 Cook, also submitted new material in support of the Act. Additionally, there were numerous
9 letters from physicians and other interested individuals both in support of and in opposition to
10 the Act. However, review of these documents and materials confirms that there was no new
11 medical evidence before Congress, and that the post-*Stenberg* submissions simply reiterated
12 the same arguments and positions that Congress had before it prior to the courts' decisions in
13 *Stenberg*.

14 Accordingly, based on the record before this court and a review of the Congressional
15 Record, this court finds that at the time that it made its findings, Congress did not have before
16 it any *new* medical evidence or studies not available to both the district court and Supreme
17 Court in *Stenberg*, at the time that the courts issued their decisions.

18 c. Specific Congressional Findings

19 As noted, in support of its conclusion that the partial-birth abortion procedure is never
20 necessary to preserve the health of the mother, Congress also made numerous other findings
21 at sections 14(A) through (O). See Act, § 2(14)(A)-(O). These findings include Congress'
22 more specific or particular factual findings pertinent to its ultimate conclusion. Many of these
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25 ⁴⁹Of the three physicians who testified before Congress regarding the proposed ban and
26 the necessity or safety of the procedure, all three offered positions supporting the ban. Two of
27 the three included Dr. Cook, who testified before this court, and Dr. Neerhof, the physician who
28 co-authored the pre-*Stenberg* 1998 article relied on by Congress extensively for its findings.
Moreover, two of the three, Dr. Cook and Dr. Aultman, had testified prior to the *Stenberg*
decision. Dr. Neerhof, who had not testified previously, offered testimony that mirrored the
Sprang/Neerhof article published in 1998.

1 findings were also disputed within Congress.⁵⁰

2 In support of its argument that this court must defer to Congress' determination that the
3 procedure is never medically necessary, the government argues that Congress' finding is
4 reasonable because "numerous express findings" support its "considered judgment" or
5 ultimate finding that the procedure is never necessary. However, based on the evidence
6 before this court, which includes the Congressional Record, and this court's review of
7 Congress' specific findings in support of its conclusion, this court finds that Congress'
8 conclusion that the procedure is never medically necessary is not reasonable and is not based
9 on substantial evidence.

10 The individual findings, which Congress and the government contend support
11 deference to Congress' ultimate finding, tend to fall into one of two categories: (1) the findings
12 are factually wrong; or (2) there is a split in the medical evidence regarding the particular
13 issue, and Congress has chosen a position. With respect to this latter category, there are,
14 however, several findings that are legally irrelevant to the necessity of a health exception, as
15 discussed in this court's conclusions of law below.

16 It is noteworthy that all of the government's own witnesses disagreed with many of the
17 specific congressional findings. In particular, Dr. Bowes, who had submitted several letters to
18 Congress in support of a ban and one of the government witnesses whom this court found

19 _____
20 ⁵⁰Congress rejected an amendment to strike the congressional findings of fact. See
21 Record Exh. A, at 29. Proponents of the amendment argued that:

22 [M]any of the findings are incorrect and inaccurate. As we have already discussed,
23 the majority of medical evidence indicates that intact D&E . . . procedure is a safe
24 abortion procedure and may be the safest option for some women. . . . It's not just
25 these medical experts who believe that [intact D&E] is a safe and effective
26 procedure that is most appropriate in certain cases, [but] [t]he United States
27 Supreme Court came to the same decision in *Stenberg v. Carhart*. . . . The
28 findings in this bill simply ignore the significant evidence of medical experts and the
reasoned judgment of the Supreme Court. . . . The second reason to remove these
findings is that they are not supported by any sort of legislative record. These
findings, which are identical to last year's bill, were drafted and introduced before
the Constitution Subcommittee even had a legislative hearing to establish any case
to justify the bill. Talk about putting the cart before the horse.

Id. at 83-84.

1 particularly credible, disagreed not only with particular findings, but with Congress' ultimate
2 finding that:

3 Partial-birth abortion remains a disfavored procedure that is not only
4 unnecessary to preserve the health of the mother, but, in fact, poses serious
risks to the long-term health of women, and in some circumstances their lives.

5 Act, § (2); see Tr. Vol. 6 at 975: 1-8 (Bowes).⁵¹

6 **i. Alleged Consensus of Opinion Regarding Procedure**

7 In support of its ultimate finding, Congress found that “[a] moral, medical, and ethical
8 consensus exists that the practice of performing a partial-birth abortion . . . is a gruesome and
9 inhumane procedure that is never medically necessary and should be prohibited.” Act § 2, (1).
10 This particular finding resembles the assertion in the Sprang/Neerhof article that “[a]n
11 extraordinary medical consensus has emerged that intact [D&E] is neither necessary nor the
12 safest method for late-term abortions,” and the article’s reference to the procedure as
13 “needlessly inhumane.” Exh. A-55, at 745.

14 However, the evidence available to Congress in passing the Act in 2003, and currently
15 before this court, very clearly demonstrates the opposite: that there is no medical or ethical
16 consensus regarding either the humanity, necessity, or safety of the procedure. Instead, the
17 same division of opinion among physicians and the relevant ethical groups exists today as
18 existed when *Stenberg* was decided. There is no consensus that intact D&E, which this court
19 has found is a variant of the D&E procedure, is any less humane than other surgical abortion
20 procedures. Nor is there a consensus regarding its safety or necessity.

21 Indeed, Congress’ very findings contradict its assertion that there is a consensus.
22 Congress subsequently noted in its findings that “a prominent medical association,” the AMA,

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24 ⁵¹Dr. Bowes, testified that he disagreed with this congressional finding, and asserted that
25 it was his view that “no valid scientific evidence support[ed] the finding.” *Id.* at 975:9-11. Dr.
26 Bowes asserted that no one in Congress “sought his opinion whether [he] thought the findings in
27 the bill were accurate,” and that if they had, he would have advised Congress that “they were not
28 accurate.” *Id.* at 986:5-11. Moreover, he noted that his support for the Act is not “based on any
concerns for protecting maternal health” because he does not “think that those have been
established.” *Id.* at 976:8-11. Instead, his “support for the Act is based on [his] ethical opposition
to abortion in general,” and his “ethical opposition to abortion procedures previability is not in any
way particular to the intact D&E procedure as opposed to other methods of abortion.” *Id.* at
976:17-21.

1 concluded that “there is no consensus among obstetricians about” the use of intact D&E. See
2 Act, §2 (14)(C) (citing AMA Fact Sheet 6/97). In fact, there was no consensus even within the
3 AMA itself regarding the procedure. See Tr. Vol. 7 at 1163 (Sprang) (agreeing that AMA
4 task force did not reach a consensus regarding the ethics of intact D&E). As noted, Congress
5 also had before it a joint statement from the AMA and ACOG, the two largest medical
6 organizations taking positions on the issue, which recognized the disagreement among and
7 within the two organizations. See *also* Record Exh. A, at 66 (opponents to the Act in
8 Congress argued that the “medical community does not support banning partial-birth
9 abortions,” and cited to ACOG findings and sixteen medical organizations in addition to
10 ACOG who oppose a ban).

11 Moreover, three of the four government witnesses that testified on the subject
12 recognized that there was no consensus regarding the procedure. This included Dr. Sprang,
13 who testified contrary to his 1998 article, and agreed that “there is a variation of opinion”
14 among the medical community regarding whether intact D&E should be banned. Tr. Vol. 7 at
15 1170:6 (Sprang); *see also id.* at 1168:22-1169:1 (also agreeing that there is no ethical
16 consensus among physicians and professors at Northwestern University, where he teaches
17 and practices). Another government witness, Dr. Shadigian, further agreed that “there is no
18 consensus in the medical community that the procedures banned by the [Act] are not safer for
19 some women in some circumstances than other available procedures.” Tr. Vol. 8 at 1297:18-
20 24 (Shadigian). She testified that “responsible physicians could reach different conclusions
21 as to the medical appropriateness of banning the procedures covered by the Act.” *Id.* at
22 1297:12-17; *see also* Tr. Vol. 6 at 960:13-22 (Bowes) (agreeing that “there is a body of
23 medical opinion which consists of [a] responsible group of physicians that hold the opinion that
24 intact removal of a fetus during a surgical abortion may be the safest procedure for some
25 women in some circumstances”); *see also* Cain Depo. 37:12-22; 220:14-222:21; 234:20-
26 235:12; Exh. 14 (noting that ACOG’s Executive Board reaffirmed the group’s January 1997
27 policy statement regarding “partial-birth abortion” and that it remains the policy of ACOG
28 today); Kissell Depo. Exh. 41, 42, 43 (AMWA position); Baker Depo. Exh. 5 (APHA position);

1 Whitelaw Depo. Exh. 70 (CMA); CMA Amicus Brief.

2 **ii. Current Medical Practice Regarding Intact D&E**

3 Additionally, Congress found that “particularly among physicians who routinely
4 perform other abortion procedures, partial-birth abortion remains a disfavored procedure . . .
5 [within] the medical community” and asserted that it “is in fact unrecognized as a valid abortion
6 procedure by the mainstream medical community.” Act, § 2 (2); 14(O).

7 Congress appears to have based this finding on the testimony of a few physicians who
8 themselves never perform intact D&E procedures. However, as demonstrated both by the
9 lack of consensus in the medical community as discussed above, and by twelve of the
10 plaintiffs’ witnesses before this court who routinely perform abortion procedures at highly-
11 respected institutions, this finding is simply inaccurate. Several of plaintiffs’ witnesses were,
12 in the course of caring for their patients, performing intact D&E procedures at the time
13 Congress conducted its hearings and was gathering evidence regarding intact D&Es. See,
14 e.g., Tr. Vol. 2 at 187:15-19 (Sheehan); Tr. Vol. 4 at 584:16-585:3 (Broekhuizen). Had
15 Congress attempted to obtain an opinion from “physicians who routinely perform other
16 abortion procedures,” it would have learned that this was the case.

17 Moreover, among the government experts that testified, it is apparent that it is not just
18 intact D&Es that they disfavor. Those experts who disfavored intact D&E, which included all of
19 the government’s witnesses, tend to disfavor elective abortion generally and *all* D&E
20 procedures, whether intact or by disarticulation.

21 Among these are Dr. Cook and Dr. Sprang. As noted, Dr. Cook’s preference for
22 induction over D&E, intact or by disarticulation, is so strong that there are circumstances
23 under which Dr. Cook would utilize induction, or an even less safe alternative, hysterotomy,
24 when the medical evidence and literature suggests that the safest procedure is D&E. See,
25 e.g., Tr. Vol. 6 at 972:6-8 (Bowes) (“in most cases an intact D&E would be preferable to a
26 hysterotomy”).

27 Dr. Sprang attested that his ethical objections could be extended to any D&E, and even
28 to an induction abortion in which a fetus was delivered partially, and having become lodged in

1 the mother's cervix, was subject to demise outside the body of the mother. Tr. Vol. 7 at
2 1165:10-15 (Sprang). He asserted that his ethical objections "were not limited to intact D&E,
3 but to any situation where the act that killed the fetus occurred outside of the body of the
4 mother." *Id.* Dr. Shadigian and Dr. Bowes likewise testified that they did not find intact D&E
5 any more objectionable than D&E in general. Tr. Vol. 8 at 1303:25-1304:12 (Shadigian); Tr.
6 Vol. 6 at 976:17-21 (Bowes).

7 **iii. Alleged Complications Associated with Intact D&E**

8 Congress further found that intact D&E "poses serious risks to the long-term health of a
9 woman and in some circumstances, their lives." Act, § 2 (2); 14(A). Again, this finding is very
10 similar to the Sprang/Neerhof article, which concludes that "intact [D&E] poses serious
11 medical risks to the mother." Exh. A-55, at 744. The specific risks listed by Congress mirror
12 those listed in the article:

13 (1) an alleged risk of cervical incompetence, a result of cervical dilation making it
14 difficult or impossible for a woman to successfully carry a subsequent pregnancy to
term;

15 (2) an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma
16 to the uterus as a result of converting the fetus to a footling breech position, a
17 procedure which, according to a leading obstetrics textbook, "there are very few, if any
indications for other than delivery of a second twin;⁵²

18 (3) a risk of lacerations and secondary hemorrhaging due to the doctor blindly
19 forcing a sharp instrument into the base of the unborn child's skull while he or
she is lodged in the birth canal;⁵³

20 ⁵²According to the Sprang/Neerhof article:

21 An integral part of the [intact D&E] procedure is an internal podalic version, during
22 which the physician. . . convert[s] the lie to a footling breech. The internal version
23 carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the
uterus. According to *Williams Obstetrics*, 'there are very few, if any indications for
24 internal podalic version other than for delivery of a second twin.'

25 Exh. A-55, at 744.

26 ⁵³The Sprang/Neerhof article provides in pertinent part:

27 The second potential complication of intact [D&E] is the risk of iatrogenic
28 laceration and secondary hemorrhage. Following internal version and partial
breech extraction, scissors are forced into the base of the fetal skull while it is
lodged in the birth canal. This blind procedure risks maternal injury from laceration
of the uterus or cervix by the scissors. . . .

1 (4) a risk [that the procedure described above in #3] could result in severe
2 bleeding, bringing with it the threat of shock, and ultimately resulting in maternal
3 death.⁵⁴

3 See *id.* at § 2 (14)(A).

4 The risks described above, however, to the extent that they exist, are not specific to
5 intact D&E, but instead may be present in any D&E, a procedure whose necessity and safety
6 are not at issue because it is generally considered both necessary and safe. See, e.g., Tr.
7 Vol. 7 at 1148:4-6 (Sprang) (agreeing with AMA task force that it is unresolved whether these
8 complications are more likely to result from D&E or intact D&E than from labor induction
9 techniques). Moreover, this court has already found, based on medical evidence – evidence
10 that was available to Congress at the time that it made its findings -- that the government has
11 not shown that intact D&E increases the likelihood of cervical incompetence, and that the risk
12 of laceration caused by instrumentation or fetal bone fragments is minimal and no greater than
13 that associated with all D&E procedures.

14 Additionally, the evidence before this court demonstrated that abruption, the separation
15 of the placenta from the uterus prior to birth, and amniotic fluid embolus, in which amniotic fluid
16 enters the mother's blood stream via the placenta, resulting in a potentially lethal maternal
17 infection, are not risks specific or relevant to an intact D&E. See Grunebaum Depo 198:11-
18 22; 200:7-201:2; Tr. Vol. 4 at 669:20-671:8 (Creinin) (explaining that in an abortion,
19 “separating the placenta from the uterus is an innate part of the D&E” and that it is irrelevant to
20 the procedure when the placenta is removed); *id.* at 673:5-675:17 (amniotic fluid embolus
21 likewise irrelevant to D&E abortion because the amniotic fluid is removed at the beginning of
22 the procedure); Tr. Vol. 5 at 827:19-829:1 (Westhoff). While the parties did not offer
23 testimony at trial on the issue of whether intact D&E is more likely to cause maternal death, the
24 court notes that abortion, generally, remains an extremely safe procedure in terms of mortality.
25 Moreover, none of the physicians who testified before this court and who perform intact D&Es

26 _____
27 Exh. A-55, at 745.

28 ⁵⁴ The article continues, that the “blind procedure,” quoted above, “could result in severe
bleeding and the threat of shock or even maternal death.” *Id.*

1 have had a patient die as a result of the procedure.⁵⁵

2 **iv. Comparative Safety of Intact D&E**

3 Congress further found that “[t]here is no credible medical evidence that partial-birth
4 abortions are safe or are safer than other abortion procedures.” Act. § 2, 14(B). In support
5 Congress asserted that:

6 (1) No controlled studies of partial-birth abortions have been conducted nor have
7 any comparative studies been conducted to demonstrate its safety and efficacy
8 compared to other abortion methods;⁵⁶

8 (2) there have been no articles published in peer-reviewed journals that establish
9 that partial-birth abortions are superior in any way to established abortion
10 procedures;

10 (3) there are currently no medical schools that provide instruction on abortions
11 that include the instruction in partial-birth abortions in their curriculum.⁵⁷

11 See *id.* at § 2, (14)(B).

12 However, for the reasons discussed above in this court’s findings, the trial evidence in
13 this case demonstrates that the intact D&E procedure is as safe as D&E, and under some
14 circumstances, is safer.

15 Even the government’s witnesses, including Dr. Sprang, testified that there is no
16 medical proof that intact D&E is less safe. See Tr. Vol. 7 at 1167:23-24 (Sprang) (agreeing
17 that there is no absolute proof that intact D&E is less safe than D&E generally); see *also* Tr.
18 Vol. 9 at 1486:22-1487:5 (Cook) (agreeing that with respect to instrumentation, “when
19 comparing D&E with intact D&E at the same gestational age, there appear to be some
20 benefits to intact D&E”); Tr. Vol. 8 at 1293:1-3; 1298:4-7 (Shadigian) (agreeing that “there is
21 no basis in the literature to prove that [intact D&E] is less safe” and that the necessity of a
22

23 ⁵⁵Additionally, Chasen’s study, completed following the congressional findings,
24 preliminarily indicated that the intact D&E method led to fewer major health complications than
25 D&Es by disarticulation, which leads to the inference that the death rate for intact D&E would be
lower as well.

26 ⁵⁶The Sprang/Neerhof article states: “There exist no credible studies on intact [D&E] that
evaluate or attest to its safety.” Exh. A-55, at 744.

27 ⁵⁷Again, Congress appears to have taken this at least in part from the Sprang/Neerhof
28 article which asserts that the intact D&E “procedure is not recognized in medical textbooks nor
is it taught in medical schools or in obstetrics and gynecology residencies.” *Id.*

1 procedure is not the same thing as its safety).

2 Government witness Dr. Bowes testified that it has been established that “overall D&E
3 is a safer procedure than induction.” Tr. Vol. 6 at 946:5-7 (Bowes). Moreover, he noted that
4 he was “not aware of any evidence-based medicine that establishes that the removal of the
5 fetus intact during the D&E is less safe than a D&E with disarticulation.” *Id.* at 971:14-17;
6 972:9-13 (agreeing also that “there is no reliable medical basis upon which to say that intact
7 removal of a fetus during a D&E is any more dangerous to a woman than any other abortion
8 method”). Dr. Bowes further agreed that “intuitively, it is safer if the fetus can be removed with
9 fewer instrumental passes” and generally that, intact D&E may be safer for this reason. *Id.* at
10 944:21-25.

11 *Absence of Controlled Studies or*

12 *Peer-Reviewed Articles*

13 As was the case at the time the Supreme Court decided *Stenberg*, there was a similar
14 absence of studies or peer-reviewed articles at the time that Congress made its findings
15 regarding the comparative safety of intact D&E.⁵⁸

16 However, the court notes, based on the Supreme Court’s decision in *Stenberg*, that the
17 absence of studies does not support Congress’ ultimate finding that the procedure is never
18 necessary or that a health exception is never necessary. Instead, the Supreme Court
19 specifically held that the “absence of controlled medical studies that would help answer these
20 medical questions” was one of the “medically related evidentiary circumstances,” which led it
21 to conclude that the Nebraska law “requires a health exception.” *Stenberg*, 530 U.S. at 937.

22 *Medical School Instruction/Curriculum*

23 Congress appears to have based its erroneous conclusion that “there are currently no
24 medical schools that provide instruction on abortions that include the instruction of partial-birth

25
26 ⁵⁸However, as noted above in this court’s findings, since the enactment of the Act, the
27 Chasen study, a historical cohort study comparing the safety of D&E with intact D&E has been
28 accepted for publication by a leading peer-reviewed obgyn journal. Government witness Dr.
Bowes agreed “that a study like Dr. Chasen’s is often the first step in the process towards a
randomized controlled trial.” Tr. Vol. 6 at 961:5-8 (Bowes).

1 abortions in their curriculum” on the testimony of one of the witnesses in the *Stenberg* case.
2 See Act, § 2 (14)(B).

3 Based on the evidence available to this court, the intact D&E procedure is taught at
4 several major medical schools, including those that are a part of New York University,
5 Columbia University, Cornell University, Albert Einstein College of Medicine, Northwestern
6 University, UCSF, UCSD, and the University of Pittsburgh, and is performed at some of the
7 leading medical institutions in the country, including the hospitals associated with those
8 universities. Tr. Vol. 5 at 795:15-22; 805:1-6; 830:10-832:6 (Westhoff) (the procedure “lies
9 within the standard of medical care” as it is taught and performed safely at “a number of . . .
10 university-based abortion services” and is “widely accepted among academically-based
11 abortion providers”). Moreover, intact D&E is discussed in authoritative medical texts,
12 including those authored or co-authored by Drs. Paul and Westhoff. See, e.g. Tr. Vol. 6 at
13 950:16-24 (Bowes) (agreeing that Dr. Paul’s abortion textbook is authoritative and that
14 Westhoff’s reputation was high in the obgyn community).

15 Accordingly, because there are circumstances in which intact D&E may be the safest
16 procedure, contrary to the congressional finding otherwise, a ban on intact D&E does not
17 promote or advance the health interest of pregnant women seeking to terminate a pregnancy.
18 The opposite is true because the Act, as written, may force pregnant women to undergo a
19 procedure that is less safe under their particular circumstances.

20 v. **Characterization of Intact D&E as “Infanticide”**

21 Congress also found that the ban “will draw a bright line that clearly distinguishes
22 between abortion and infanticide.” Act, § 2 (14)(G). It found that intact D&E constitutes “the
23 killing of a child that is in the process, in fact mere inches away from becoming a ‘person.’”
24 See *id.* at § 2 (14)(H). Congress further analogized the procedure to the “killing of a newborn
25 infant,” and asserted that the “vast majority of babies killed during partial-birth abortions are
26
27
28

1 'alive' until the end of the procedure." See *id.* at § 2 (14)(L),(M).⁵⁹

2 However, what the congressional findings omit, as discussed, is that the Act applies
3 regardless of gestational age or viability. It is not disputed in this case that the "newborn
4 infant" or "baby" "mere inches away from being born," as referred to by Congress, and with
5 respect to all of the intact D&E procedures at issue in this case, *is not viable*, meaning that
6 the fetus would be unable to survive outside of the mother. Tr. Vol. 1 at 74:14-80:20 (Paul); Tr.
7 Vol. 1 at 165:7-21 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr.
8 Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2
9 (Westhof); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

10 Congress' grossly misleading and inaccurate language, comparing the procedure to
11 the "killing of a newborn infant," appears to have been intentional. Congress was aware that
12 the Act as written applied to previable fetuses. In fact, as noted in this court's discussion
13 regarding the Act's undue burden, Congress rejected alternatives and amendments to the Act
14 that would have limited its applicability to viable fetuses. See 149 Cong. Rec. S3600 (daily
15 ed. March 12, 2003) (statement of Sen. Feinstein); 149 Cong. Rec. H4939 (daily ed. June 4,
16 2003) (statement of Rep. Greenwood); 149 Cong. Rec. H4948 (daily ed. June 4, 2003)
17 (statement of Rep. Baldwin). Moreover, government witness, Dr. Cook, who testified twice
18 before Congress, testified before this court that he suggested to Congress limiting the
19 applicability of the law to 20 weeks Imp, and his advice was ignored. Tr. Vol. 9 at 1529:7-21
20 (Cook).

21 Finally, for reasons that this court has already discussed with respect to the undue

22 _____
23 ⁵⁹Again, these "findings" were undoubtedly derived in part from the Sprang/Neerhof article,
which provides in pertinent part:

24 The intact [D&E] procedure involves literally delivering the fetus so that only the
25 head remains within the cervix. At this juncture, the fetus is merely inches from
26 being delivered and obtaining the full legal rights of personhood under the US
Constitution. . . . [M]any otherwise prochoice individuals have found intact [D&E]
too close to infanticide to ethically justify its continued use.

27 Exh. A-55, at 745. In support, that article cites to one Senator's statement that intact D&E "is as
28 close to infanticide as anything I have come upon," as reported by *The Washington Post*. *Id.* at
746 & n.20.

1 burden and overbreadth of the law, a “live” fetus is not the same as a “viable” fetus. In using
2 the term “live,” Congress appears to have intentionally disregarded the relevant medical
3 distinction.

4 **vi. Fetal Pain**

5 Congress also made findings that, in the course of an intact D&E, the fetus
6 experiences pain.⁶⁰ See Act, § 2 (14)(M). This finding appears to have been based on the
7 testimony of a nurse from Dr. Haskell’s office who claimed that she observed an intact D&E on
8 a 26 week Imp fetus who visibly showed signs of pain,⁶¹ and on the testimony and
9 submissions of other physicians, including several articles on the subject authored by Dr.
10 Anand, a government witness before this court.⁶²

11 For the reasons discussed in this court’s findings, there is debate within the medical
12 community on this issue. Therefore, the position that Congress has taken is neither incorrect
13 nor entirely unsupported. It is, however, irrelevant to the question of whether the Act requires a
14 health exception, as discussed in this court’s conclusions of law.

15 **vii. Impact on Medical Profession**

16 Finally, Congress also found that the Act preserves the integrity of the medical
17 profession. See Act, § 2(14)(G). In support, Congress found that intact D&E “confuses the
18 medical, legal, and ethical duties of physicians to preserve and promote life” because the

19 _____
20 ⁶⁰Congress found that “ the fetus’ perception of pain is even more intense than that of
21 newborn infants and older children when subjected to the same stimuli” and that the “fetus fully
22 experiences the pain associated with decompression of the skull and suction of its contents.”
23 See *id.* at § 2(14)(M). This is commensurate with the Sprang/Neerhof article, which concluded
that: “[W]ith intact [D&E], pain management is not provided for the fetus, which is literally within
inches of being delivered. Forcibly incising the cranium with a scissors and then suctioning out
the intracranial contents is certainly excruciatingly painful.” Exh. A-55, at 745.

24 ⁶¹Dr. Haskell’s office rebutted the nurse’s testimony with a letter to Congress attesting that
25 he did not perform the procedure on fetuses post-24 wks. Additionally, the nurse’s testimony to
26 that effect was ruled inadmissible in subsequent litigation. See Record Exh. F, at 17-21, 205-
206.

27 ⁶²All of those articles were published considerably prior to any of the *Stenberg* decisions.
28 See, e.g., Record Exh. A, at 4 & n.6 (citing Anand & Hickey, *Pain and Its Effects in the Human
Neonate and Fetus*, 317 *New England Journal of Medicine* 1321 (Nov. 1987) in support of the
proposition that “[i]t is well documented that a baby is highly sensitive to pain stimuli at [around
20 weeks] and even earlier”).

1 “physician acts directly against the physical life of a child, whom he or she had just delivered,
2 all but the head, out of the womb, in order to end that life.” *Id.* at § 2(14)(J). Congress further
3 asserts that the procedure “appropriates the terminology and techniques used by
4 obstetricians in the delivery of living children . . . and instead uses those techniques to end the
5 life of the partially-born child.” *Id.* Accordingly, Congress found that intact D&E “undermines
6 the public’s perception of the appropriate role of a physician during the delivery process, and
7 perverts a process during which life is brought into the world, in order to destroy a partially-
8 born child.” *Id.* at § 2 (14)(K).

9 Aside from Congress’ mischaracterization of the intact D&E procedure, which is
10 already discussed above and in this court’s findings, Congress’ conclusion that the Act would
11 somehow promote the integrity of the medical profession is not supported by the evidence
12 before Congress or before this court. In addition to the plaintiffs’ witnesses who all discussed
13 the extraordinarily negative impact that the Act would have and has had on their relationships
14 with their patients and on their ability to provide the care that they deem to be in their patients’
15 best interests, many, if not all, of the government witnesses also testified contrary to this
16 congressional finding.

17 Dr. Cook, who testified before Congress, testified at trial that if he had written the bill,
18 he probably would have written it so that physicians had greater leeway depending on whether
19 fetal demise had already occurred. Tr. Vol. 9 at 1524:10-1526:8 (Cook). Moreover, Dr.
20 Shadigian agreed, testifying that “the decision of whether there is a threat to the woman’s life
21 must be left to the physician’s best medical judgment.” Tr. Vol. 8 at 1322:1-4 (Shadigian); see
22 *also* Tr. Vol. 6 at 944:15-19 (Bowes) (agreeing that regarding a medical exception, “a
23 physician should be permitted to rely on his or her own best medical judgment to determine if
24 there is such an emergency”).

25 Further, as noted above, many major medical organizations, including ACOG, AMWA,
26 and the CMA oppose the Act on this basis alone. The CMA submitted an amicus brief before
27 this court that was especially illustrative of the negative impact that the ban will have on the
28 medical profession. The CMA was persuasive in noting that the Act will likely have the

1 following adverse consequences:

2 (1) it will disrupt the informed consent relationship between physicians and their
 3 patients because physicians are ethically bound to assist the patient in choosing
 4 among safe medical options and providing the safest care possible consistent
 with the patients' wishes;

5 (2) because of the ambiguity in the act, it will have a particularly chilling effect on
 6 all abortion practices since physicians will have difficulty interpreting what
 conduct is prohibited by the Act;

7 (3) the Act's lack of a health exception will prevent physicians from exercising
 8 their best medical judgment in light of a woman's particular condition and
 situation;

9 (4) the Act could have the effect of placing physicians in an awkward situation
 10 with their staff, and could result in a conflict of interest very similar to the nurse
 who testified before Congress;

11 (5) the Act's civil liability provisions may force physicians to violate patients'
 12 confidentiality, requiring the consent of the patients' husband or parents under
 certain circumstances; and

13 (6) the Act could hinder medical advancements in reproductive health.

14 See generally March 25, 2004 CMA amicus brief.

15 **d. Conclusion Regarding Deference to Congress' Finding that**
 16 **a Health Exception is Unnecessary**

17 It is apparent to this court, upon examination of the record before Congress and the
 18 evidence presented at trial, that Congress' ultimate finding that "partial-birth abortion" is never
 19 necessary to preserve the health of the mother is the type of "finding" described by Justice
 Thomas in *Lamprecht v. FCC*.⁶³ In that case, Justice Thomas noted:

20 We know of no support . . . for the proposition that if the constitutionality of a
 21 statute depends in part on the existence of certain facts, a court may not review
 22 a legislature's judgment that the facts exist. If a legislature could make a statute
 23 constitutional simply by "finding" that black is white or freedom, slavery, judicial
 review would be an elaborate farce. At least since *Marbury v. Madison*, 5 U.S.
 (1 Cranch) 137, 2 L.Ed. 60 (1803), that has not been the law.

24 958 F.2d 382, 392 n. 2 (D.C. Cir. 1992).

25 For all of the reasons discussed above, this court concludes that Congress' "finding"
 26 that the intact D&E procedure is never medically necessary is unreasonable and is not

27 _____
 28 ⁶³In *Lamprecht*, the D.C. Circuit held that an FCC preference for female owners of radio
 stations violated equal protection principles. 958 F.2d 382 (D.C. Cir. 1992).

1 supported by substantial evidence as was available to Congress at the time. Accordingly, this
2 court declines to defer to Congress' "finding." See *Turner II*, 520 U.S. at 196.

3 Instead, this court will rely on its own findings set forth above, based on the evidence
4 before this court, deferring also to the Supreme Court's decision in *Stenberg* because:

5 When the Court has interpreted the Constitution, it has acted within the province
6 of the Judicial Branch, which embraces the duty to say what the law is. When
7 the political branches of the Government act against the background of judicial
8 interpretation of the Constitution already issued, it must be understood that in
later cases and controversies the Court will treat its precedents with the respect
due them under settled principles, including *stare decisis*, and contrary
expectations must be disappointed.

9 *City of Boerne*, 521 U.S. at 534 (citations omitted) (striking down the RFRA and concluding
10 that it "is the Court's precedent, not RFRA, which must control").

11 **E. Conclusions of Law: A Health Exception is Constitutionally Required**

12 Based on the evidence before this court, and the court's determination that Congress'
13 ultimate finding that partial-birth abortion is never necessary to preserve the health of the
14 mother is not entitled to deference, the court finds that the Act's life exception is constitutionally
15 inadequate.

16 As noted, the Supreme Court was clear in *Stenberg* that a health exception is required
17 "[w]here substantial medical authority supports the proposition that banning a particular
18 abortion procedure could endanger women's health." 530 U.S. at 938. Under those
19 circumstances, the *Stenberg* Court held that "*Casey* requires the statute to include a health
20 exception when the procedure is 'necessary, in appropriate medical judgment, for the
21 preservation of the life or health of the mother.'" *Id.*

22 Here, the evidence establishes that the Act would ban procedures performed prior to
23 24 weeks Imp, which is generally considered previability. However, based on the Supreme
24 Court's holding in *Stenberg*, the necessity of a health exception does not depend on whether
25 the 24 week period is considered pre- or postviability. *Id.* at 931. Accordingly, to the extent
26 that there is any dispute regarding fetal viability in accordance with the evidence before this
27 court, the court's conclusion that a health exception is required does not depend on whether
28 the procedures at issue are performed pre- or postviability.

1 The Act here excepts only “a partial-birth abortion that is necessary to save the life of a
2 mother.” The court finds, however, that a health exception is necessary as well because, the
3 three “medically related evidentiary circumstances” present before the Supreme Court in
4 *Stenberg* exist here as well. See *id.* at 936-37.

5 First, the record before this court, like the district court’s record in *Stenberg*,
6 demonstrates that “significant medical authority supports the proposition that in some
7 circumstances, [intact D&E] is the safest procedure.” *Id.* at 932. These include the following
8 considerations, present also in the *Stenberg* case, that among other maternal and fetal
9 conditions for some woman, other abortion procedures present “a larger than necessary risk”
10 of:

11 (1) a longer operating time; (2) greater blood loss and infection; (3)
12 complications from bony fragments; (4) instrument-inflicted damage to the
13 uterus and cervix; (5) exposure to the most common causes of maternal
mortality (DIC and amniotic fluid embolus); [and] (6) complications arising from
retained fetal parts.

14 *Carhart II*, 11 F.Supp.2d at 1127.

15 While this court has also found that an intact D&E, under these circumstances, may not
16 be the *only* safe option available to preserve the life or the health of a woman, that finding
17 does not undermine the necessity of a health exception in this case. As the Supreme Court
18 explained in *Stenberg*, such a finding is irrelevant where the evidence demonstrates that intact
19 D&E is “significantly safer.” *Stenberg*, 530 U.S. at 934. This court has similarly found that
20 intact D&E may be significantly safer for certain women under the particular circumstances
21 listed above.⁶⁴

22 Second, for the reasons explained above, this court has also found that there
23 continues to be a division of opinion among highly qualified experts regarding the necessity or
24 safety of intact D&E. If anything, since the Supreme Court’s decision in *Stenberg*, the
25 evidence before this court suggests that the majority of highly-qualified experts on the subject
26

27 ⁶⁴Moreover, to the extent that the Act bans D&E by disarticulation, which this court has
28 found that it does (in accordance with the undue burden analysis), a health exception is
undoubtedly necessary, and the Act is unconstitutional on that basis alone.

1 believe intact D&E to be the safest, most appropriate procedure under certain circumstances.

2 Finally, as discussed, there continues to be an absence of controlled medical studies
3 that provide a definitive answer regarding the safety and necessity of intact D&E. However,
4 those studies that have been conducted since the Supreme Court decided *Stenberg*,
5 including the Chasen study, provide medical support for the conclusion that intact D&E is a
6 safe, and sometimes necessary, procedure. While the government has suggested a lack of
7 diligence or effort on the part of the Act's opponents in conducting such controlled medical
8 studies, as this court has noted, experts agree that the Chasen study is the "first step" in
9 conducting even more comprehensive studies regarding intact D&E.⁶⁵

10 The government's interests in protecting potential life and minimizing
11 potential pain to the fetus do not alter this court's finding regarding the necessity of a health
12 exception. In *Stenberg*, the Supreme Court rejected the same arguments that were made by
13 Nebraska regarding the state's interests in that case. 530 U.S. at 930-931. The Court
14 recognized that "subsequent to viability, the State in promoting its interest in the potentiality of
15 human life may, if it chooses, regulate, and even proscribe, abortion. . . ." *Id.* at 931.
16 Nevertheless, it found Nebraska's argument regarding its interest in the potentiality of life
17 unpersuasive because, like the Act here, Nebraska's law did not "sav[e] the fetus from
18 destruction," but instead simply "regulate[d] only a *method* of performing abortion." *Id.* Most
19 significantly, the Supreme Court held that Nebraska's alleged interests did not "make any
20 difference to the question at hand, namely, the application of the 'health' requirement." *Id.*

21 Accordingly, for these reasons, this court does not find that the government's asserted
22 fetal interests override the necessity of a health exception to preserve the life and health of the
23 mother.

24 Nor does this court find that the possibility of inducing fetal demise prior to performing
25 an intact D&E obviates the need for a health exception. The government has suggested that
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27 ⁶⁵The court notes that enforcement of the Act would make any further studies impossible
28 to conduct.

1 physicians and patients can avoid falling within the Act’s prohibitions if fetal demise, by
2 chemical injection or otherwise, is induced prior to the procedure. However, to read into the
3 Act such a requirement would, for the reasons discussed in this court’s findings, subject
4 women to unnecessary side effects and risks, however small, without providing any medical
5 benefit to them. Moreover, there are certain circumstances under which inducing fetal demise
6 is not possible or effective.

7 Accordingly, for all the reasons discussed above, this court finds that the Act’s
8 omission of a health exception renders the Act unconstitutional.⁶⁶

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27 ⁶⁶In view of this finding, it is unnecessary for the court to reach the plaintiffs’ challenge to
28 the adequacy of the existing life exception on the basis that it does not provide for a determination
made pursuant to the physician’s “appropriate medical judgment.”

CONCLUSION

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For all of the reasons discussed above, this court concludes that the Act is unconstitutional because it (1) poses an undue burden on a woman’s ability to choose a second trimester abortion; (2) is unconstitutionally vague; and (3) requires a health exception as set forth by the Supreme Court in *Stenberg*. Permanent injunctive relief is appropriate given that plaintiffs have demonstrated that the Act violates their constitutional rights on the above three bases. See *Elrod v. Burns*, 427 U.S. 347, 373 (1976); see also *Monterey Mech. Co. v. Wilson*, 125 F.3d 702, 715 (9th Cir. 1997).

Accordingly, defendant John Ashcroft, in his official capacity as Attorney General of the United States, and his employees, officers, agents, attorneys, and successors in office are PERMANENTLY ENJOINED from enforcing the Partial-Birth Abortion Ban Act of 2003 against plaintiffs Planned Parenthood Federation of America and Planned Parenthood Golden Gate, intervenors City and County of San Francisco, their members, officers, agents, servants, employees, contractors, and those persons in active concert or participation with those persons listed above. This order applies to those persons set forth above as they render services in any facility, including facilities that are not owned or operated by plaintiffs and/or intervenors.⁶⁷

The clerk shall close the file.

IT IS SO ORDERED.

Dated: June 1, 2004

/s/
PHYLLIS J. HAMILTON
United States District Judge

⁶⁷While recognizing that a nationwide injunction may be appropriate, in deference to the New York and Nebraska courts, this court declines plaintiffs’ request to issue a nationwide injunction at this time. See *Bresgal v. Brock*, 843 F.2d 1163, 1170-71 (9th Cir. 1988) (nationwide injunction not necessarily overbroad where “such breadth is necessary to give prevailing parties the relief to which they are entitled”).