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July 11, 1995

The Honorable Charles Canady  
Chairman, Subcommittee on the Constitution  
House Committee on the Judiciary  
1222 Longworth House Office Building  
Washington, D.C. 20515  
FAX: (202 225-3746)

Dear Congressman Canady:

I have reviewed the Partial-Birth Abortion Ban Act (HR 1833, S. 939) and the related materials that you submitted to me.

Your bill would ban the use of the "partial-birth abortion" method, which you define as "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."

As regards the use of the term "partial-birth abortion" to describe the procedure:

The term "partial-birth abortion" is accurate as applied to the procedure described by Dr. Martin Haskell in his 1992 paper entitled "Dilation and Extraction for Late Second Trimester Abortion," distributed by the National Abortion Federation. (1) Dr. Haskell himself refers to that procedure as "dilation and extraction," but that is only a term, as he wrote, he "coined." Another practitioner, Dr. James McMahon, who uses a similar technique, uses the term "intact dilation and evacuation." (2)

There is no standard medical term for this method. The method, as described by Dr. Haskell in his paper, involves dilatation of the uterine cervix followed by breech delivery of the fetus up to the point at which only the head of the fetus remains undelivered. At this point surgical scissors are inserted into the brain through the base of the skull, after which a suction catheter is inserted to remove the brain of the fetus. This results in collapse of the fetal skull to facilitate delivery of the fetus. From this

description there is nothing misleading about describing this procedure as a "partial-birth abortion," because in most of the cases the fetus is partially born while alive and then dies as a direct result of the procedure (brain aspiration) which allows completion of the birth.

As regards when fetal death occurs during this procedure:

Although I have never witnessed this procedure, it seems likely from the description of the procedure by Dr. Haskell that many if not all of the fetuses involved in this procedure are alive until the scissors and the suction catheter are used to remove brain tissue. (1) Dr. Haskell, explicitly contrasts his procedure with two other late abortion methods that do induce fetal death prior to removal of the fetus (these alternative methods being intra-amniotic infusion of urea, and rupture of the membranes and severing of the umbilical cord). (1) Also, Doctors Haskell, in an interview with Diane Gianelli of American Medical News that the majority of the fetuses aborted this way are alive until the end of the procedure." (2) This is consistent with the observations of Brenda Shafer, R.N. who, in a letter to Congressman Tony Hall, described partial-birth abortions performed by Dr. Haskell which she observed. (3)

Moreover, in a document entitled "Testimony Before the House Subcommittee on the Constitution", June 23, 1995, Dr. James McMahon states that narcotic analgesic medications given to the mother induce "a medical coma" in the fetus, and he implies that this causes "a neurological fetal demise." (3) This statement suggests a lack of understanding of maternal/fetal pharmacology. It is a fact that the distribution of analgesic medications given to a pregnant woman result in blood levels of the drugs which are less than those in the mother. Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know that they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die.

Dr. Dru Carlson, a maternal/fetal medicine specialist from Cedars-Sinai Medical Center in Los Angeles, writes that she has personally observed Dr. McMahon' perform this procedure. In a letter to Congressman Henry Hyde she described the procedure and wrote that after the fetal body is delivered, it is removal of cerebrospinal fluid from the brain that causes instant brain herniation and death. (5) This statement clearly suggests that the fetus is alive until the suction device is inserted into the brain.

As regards whether the fetus experiences pain during this procedure:

Dr. McMahon states that the fetus feels no pain through the entire series of procedures. (4) Although it is true that analgesic medications given to the mother will reach the fetus and presumably provide some degree of pain relief, the extent to which this renders this procedure pain free would be very difficult to document. I have performed in-utero procedures on fetuses in the second trimester, and in these situations the response of the fetuses to painful stimuli, such as needle sticks, suggest that they are capable of experiencing pain. Further evidence that the fetus is capable of feeling fetal pain is the response of extremely preterm infants to painful stimuli.

As regards the accuracy of the illustrations of this procedure which have been distributed by the National Right to Life Committee:

I have read the letters dated June 12, 1995 and June 27, 1995 sent to members of Congress by the National Abortion Federation, which state that the drawings of the partial-birth abortion procedure that have been distributed by you and by the National Right to Life Committee are "highly imaginative...with little relationship to the truth" and "misleading." (6,7)

Having read Dr Haskell's paper (1), I can assure you that these drawings accurately represent the procedure described therein. Furthermore, Dr. Haskell is reported as saying that the illustrations were accurate "from a technical point of view." (2) First hand renditions by a professional medical illustrator, or photographs or a video recording of the procedure would no doubt be more vivid, but not necessarily more instructive for a non-medical person who is trying to understand how the procedure is performed.

As regards the impact of the banning of the procedure on other indicated standard medical procedures:

Critics of your bill who say that this legislation will prevent doctors from performing certain procedures which are standard of care, such as cephalocentesis (removal of fluid from the enlarged head of a fetus with the most severe form of hydrocephalus) are mistaken. In such a procedure a needle is inserted with ultrasound guidance through the mother's abdomen into the uterus and then into the enlarged ventricle of the brain (the space containing cerebrospinal fluid).

Fluid is then withdrawn which results in reduction in the size of the head so that delivery can occur. This procedure is not intended to kill the fetus, and, in fact, is usually associated with the birth of a live infant. This is an important distinction between a needle cephalocentesis which is intended to facilitate the birth of a living fetus as contrasted with the procedure described by Doctors Haskell and McMahon, which is intended to kill a living fetus which has been partially delivered.

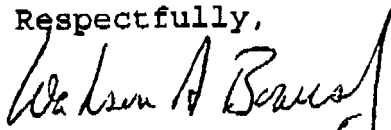
The technique of the partial-birth abortion could be used to remove a fetus that had died in utero of natural causes or accident. Such a procedure would not be covered by the definition in your bill, because it would not involve partially delivering a live fetus and then killing it.

As regards viability of preterm infants in the second trimester of pregnancy:

I have reviewed a "fact sheet" distributed by the National Abortion and Reproductive Rights Action League (NARAL) in opposition to your legislation. (8) This document states, "Very few premature infants born at 24 weeks' gestation actually survive. The chance for survival at 25 weeks' gestation is 10-15%; one week later -- at 26 weeks -- the chances of survival double to 24-45%. A survival rate of 50% is achieved only in live births at 27 or more weeks gestation." These figures are outdated and misleading. In a recent study from the National Institute of Child Health and Human Development Neonatal Network, survival was documented in a large number of premature infants born at the seven participating institutions. (9) At 23 weeks gestation the neonatal survival was 23 percent and at 24 weeks' gestation survival was 34 percent. As you can see in Figure 3 in the enclosed article by Maureen Hack et al., there are wide inter-institutional variations in neonatal survival at each gestational age. For example, at 24 weeks' gestation neonatal survival varied from a low of 10 percent to a high of 57 percent. This data applies to infants born without major congenital defects.

I trust this information will be helpful.

Respectfully,



Watson A. Bowes Jr., M.D.  
Professor

[Dr. Watson Bowes, an internationally recognized authority on maternal and fetal medicine, is a professor of both obstetrics/gynecology and pediatrics. He is co-editor of Obstetrical and Gynecological Survey, and has served on the Congressional Biomedical Ethics Advisory Committee.]

References:

1. Haskell M. Dilation and extraction for late second trimester abortion. Presented at the National Abortion Federation Risk Management Seminar, Dallas, Texas, September 13, 1992.
2. Gianelli D. M. Shock-tactic ads target late-term abortion procedure. American Medical News, July 5, 1993, p 3 ff.
3. Shafer B. Letter written to Congressman Tony Hall, July 9, 1995.
4. McMahon JT. Written submission to the House Subcommittee on the Constitution, Washington D.C., June 23, 1995.
5. Carlson DE. Letter to The Honorable Henry Hyde, Chairman, House Judiciary Committee, June 27, 1995.
6. Saporta V, Prohaska G. Letter to members of Congress, U.S. House of Representatives, June 12, 1995.
7. Saporta V. Letter to members of Congress, U.S. House of Representatives, June 27, 1995.
8. National Abortion and Reproductive Rights Action League. Third-Trimester Abortion: The Myth of "Abortion on Demand". (Date not listed)
9. Hack M, Horbar JD, Malloy MH, et al. Very low birth weight outcomes of the National Institute of Child Health and Human Development Neonatal Network. Pediatrics. 1991;87:587-597