

1 IN THE SUPREME COURT OF THE UNITED STATES

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3 ALBERTO R. GONZALES, :

4 ATTORNEY GENERAL, :

5 Petitioner :

6 v. : No. 05-1382

7 PLANNED PARENTHOOD :

8 FEDERATION OF AMERICA, :

9 INC., ET AL. :

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11 Washington, D.C.

12 Wednesday, November 8, 2006

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14 The above-entitled matter came on for oral
15 argument before the Supreme Court of the United States
16 at 11:08 a.m.

17 APPEARANCES:

18 GEN. PAUL D. CLEMENT, ESQ., Solicitor General,
19 Department of Justice, Washington, D.C.; on behalf
20 of the Petitioner.

21 EVE C. GARTNER, ESQ., New York, N.Y.; on behalf of the
22 Respondent.

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P R O C E E D I N G S

(11:08 a.m.)

CHIEF JUSTICE ROBERTS: Now we'll hear argument in 05-1382, Gonzales versus Planned Parenthood Federation of America.

General Clement.

ORAL ARGUMENT OF PAUL D. CLEMENT

ON BEHALF OF PETITIONER

GENERAL CLEMENT: Mr. Chief Justice and may it please the Court:

This case presents the same basic constitutional question concerning the Federal Partial-Birth Abortion Act as the first case. Of course, the Ninth Circuit in the decision under review here went much further in invalidating the Federal act. If I could begin by talking about whether what we're talking about here is medical necessity or just some marginal effect on the risks. I think in order to fairly understand the argument that respondents are making in this case, their argument has to be a matter of simply marginal risks, because one illustration of this, as I indicated in the first argument, if a doctor really believes that a D&X procedure is the way to go in a case then there's no ban on the procedure as such. What the act bans is the infliction of the D&X procedure

1 on a living fetus.

2 So if a doctor really thinks the D&X
3 procedure is the way to go, he can induce fetal demise
4 at the outset of the procedure.

5 JUSTICE BREYER: But the problem with this
6 is that there -- well, some doctors absolutely agree. I
7 mean, you know, my list over here, in which I have
8 hundreds of references from this thing, is doctor after
9 doctor who takes the other position, and they say:
10 Look, all that we're doing here is trying to remove the
11 fetus in a single pass. The fetus is going to die
12 anyway. It's not viable. We're trying to remove it in
13 a single pass, and the reason we're trying to do that is
14 if we don't, there may be bone fragments left inside the
15 womb. There may be fetal parts left inside the womb.
16 Every time you make another pass, it turns out there's
17 an added risk of scarring or hurting the inside of the
18 womb. If you try to induce demise through a drug
19 before, there is serious risks of introducing drugs into
20 the system. If the woman has uterine cancer, it's a
21 serious problem of not trying to get the child out as
22 quickly as possible. If you have preeclampsia or
23 eclampsia, where you're in a situation where the woman
24 will be dead in five minutes or 10 minutes, there could
25 be such a situation. The doctor thinks only one thing:

1 Get it out as fast as possible. All right.

2 Now, I know there are doctors who think the
3 contrary. There's lots of testimony of the doctors who
4 think roughly along the lines I've taken. That was true
5 in Stenberg as well. So I think the issue is not that
6 you don't have support -- you do -- but that the support
7 is contraverted, and therefore, what do we do in that
8 case?

9 GENERAL CLEMENT: Well, Justice Breyer, let
10 me take as a point of departure the specific risks that
11 you associated with the injection that induces fetal
12 demise, because if there isn't a significant risk to
13 that injection, then all the other benefits that are
14 associated with the D&X procedure don't matter because
15 they can perform the D&X procedure. Now if you look
16 through the record on this point, I think you will not
17 find any testimony that supports a significant risk from
18 that injection. Yes, there are risks because there are
19 risks from any medical procedure, but the risks are not
20 significant.

21 JUSTICE BREYER: Is there a definition in
22 the law of significant risk, other than doctors saying,
23 I've been trained to try to save life and I want to
24 perform the safest possible way? Is there some legal
25 definition of what's a small risk, a big risk, a giant

1 risk?

2 GENERAL CLEMENT: With all respect, I think
3 if a single injection that doesn't take any particular
4 risk other than the fact that it's an injection, if that
5 counts as a significant risk, then we might as well
6 strike the word "significant" from the discussion in
7 Stenberg. And Then I think what you have is that it's
8 very clear that their position is one of zero tolerance
9 for any marginal risk to maternal health.

10 JUSTICE KENNEDY: Well, my question is the
11 same as Justice Breyer's. Is there anything in the
12 literature, including medical literature, that talks
13 about significant or minor risks? I mean, you fill out
14 forms when you go to the dentist about risks. Now,
15 if -- if the chance of death is one out of 100, is that
16 significant? I mean, I don't know.

17 GENERAL CLEMENT: Well, it's a very
18 difficult question to evaluate in the abstract, Justice
19 Kennedy. And I think it actually, that question,
20 though, has direct bearing on this case, because
21 Congress after all found that there was some risks with
22 the D&X procedure. The most prominent one that I would
23 point to is the risk of cervical incompetence because
24 the D&X procedure does -- it does require additional
25 dilation, which can be associated with risks of losing

1 future pregnancies. And that was born out, although not
2 at a level of statistical significance, in the Chasen
3 study by a plaintiff practitioner, where 2 of the 17
4 women who had the D&X procedure and were available for
5 follow-up care had an early pre-term pregnancy in the
6 follow-up.

7 So I think those risks are born out in the
8 only study that's available. And I think the question
9 becomes, now, if D&X were some life-saving procedure for
10 something that there was no other known cure for, you
11 might think, well, those are the risks you run. But
12 when there remains available the D&E procedure, which
13 has been well tested and works every single time as a
14 way to terminate the pregnancy, then I think risks that,
15 if you were talking about a life-saving treatment for
16 some life-threatening condition with no known cure,
17 those risks might not be significant in that context.

18 JUSTICE KENNEDY: Well, but there is a risk
19 if the uterine wall is compromised by cancer or some
20 forms of preeclampsia and it's very thin, there's a risk
21 of being punctured.

22 GENERAL CLEMENT: There is a risk, Justice
23 Kennedy, but I think that, first of all, that even in
24 those limited circumstances, that the marginal risk
25 between the D&X procedure and the D&E procedure are

1 really as far as I can tell nonexistent. Even in that
2 condition, unless there's some reason not to put the
3 injection in, if the doctor really thought the D&X
4 procedure was the way to go, he could begin, as
5 Dr. Carhart does in every single case after the 17th
6 week and start off with a digoxin injection or potassium
7 chloride injection, induce fetal demise, and he has
8 nothing to worry about from this statute.

9 And I think the very fact that they are
10 attributing significant risks to a single injection
11 shows that at bottom their position is a zero tolerance
12 position. And that's a legitimate position, I suppose,
13 but it's completely inconsistent with this Court's
14 precedence, most notably the Casey decision. Because if
15 all you needed to do is point to some marginal risk,
16 then this Court should have struck down the 24-hour
17 waiting period in the Casey decision, because the
18 plaintiffs there said the 24-hour waiting condition has
19 imposed significant risks. They were backed in that
20 point by an amicus brief by ACOG. But this Court didn't
21 say, well, you know, you're right, there's marginal
22 risks, we're going to apply a zero tolerance rule.

23 This Court instead upheld the 24-hour
24 period, even though it required overruling Akron I's
25 contrary decision and this Court pointed, of course, to

1 Akron I as an exemplar of the pre-Casey decisions that
2 put too little weight on the legitimate countervailing
3 interest that the government has in this area.

4 And so with respect, I think that the
5 argument they are making is effectively an argument for
6 returning to Akron I and Thornburgh, where the rule of
7 law was that there would be no interference between a
8 doctor and the doctor's patient and the doctor's best
9 judgment as to how to treat the patient. This Court of
10 course consciously moved away from that in Casey and
11 expressly repudiated the language in Akron I and
12 Thornburgh to that effect.

13 JUSTICE STEVENS: May I follow up on a
14 question the Chief Justice asked you during the last
15 argument? We got into the government's construction of
16 the statute to narrow it to intentional situations.
17 Would you explain a little more exactly what situations
18 you would exclude and what you would include in your
19 interpretation of the statute?

20 GENERAL CLEMENT: Well, justice Stevens, let
21 me answer it this way and maybe if you want me to take
22 you specifically to the text, I can do that. But I
23 think the bottom line would be that under our view of
24 the statute, the most important thing is for those
25 doctors, like Dr. Cranen or Dr. Vivicar, who try to do

1 the D&E procedure every time, and they succeed 99 or 100
2 percent of the time. Well, in the 1 percent of the
3 cases where they inadvertently deliver the fetus past
4 the anatomical landmark, we would say they are not
5 covered by the statute because they would not satisfy
6 what is really a compound mens rea requirement in the
7 statute, which requires that the delivery of the fetus
8 be intentional and deliberate and for the purpose of
9 committing the overt act of killing fetus. And in those
10 cases, of course, the intent of the doctor performing
11 the D&E isn't to deliver the fetus at all; it's to
12 deliver a fetal arm or a fetal leg as part of the
13 dismemberment procedure. So they would not be covered
14 by the mens rea requirement of the statute.

15 JUSTICE STEVENS: Would you measure the mens
16 rea at the outset of the procedure when they begin the
17 dilation a day or two before the actual operation is
18 performed, or is it at the time of beginning the
19 operation?

20 GENERAL CLEMENT: I think you could measure
21 it from either time point. I think the better view is
22 actually that it would be measured from the beginning of
23 the surgical operation, though the evidence of their
24 intent at the beginning of the dilation would be very,
25 very relevant. The reason I would say that is I think

1 if somebody tries to dilate and then gets an extreme
2 amount of dilation at the point they start the
3 procedure, I think the intent of Congress would still be
4 for them to do a dismemberment procedure at that point,
5 rather than an intact removal.

6 But if this Court thought that the
7 constitutional line mattered on the answer to that, then
8 you could start from the beginning of the dilation
9 because I think in fairness the differences between the
10 two procedures are probably most manifest in the
11 dilation regimen. I also think, though, the record
12 supports the notion that there are differences even once
13 you begin the procedure as to how you manipulate the
14 fetus. I mean, Dr. Chasen for example, who is trying to
15 do the intact removal, says that after he has one leg
16 removed he effectively tries to reach back up and swing
17 the second leg across so he can remove the entire fetal
18 body. If you're -- obviously if you're performing a
19 dismemberment D&E you're not trying to swing the second
20 leg across; you're simply continuing to pull or twist on
21 the first extremity that prevents itself.

22 So I think there are differences even at the
23 procedural level. So I think that it would probably be
24 most consistent with Congress's intent to measure it
25 from the beginning of the surgical part of the

1 procedure. But if you, as I say, in order to save the
2 statute, I think it's amenable to the contrary
3 interpretatio.

4 JUSTICE BREYER: I think you're wrong about
5 -- you're probably wrong about this. But just before
6 you leave, I mean, this is why it's so hard for me to
7 get into the medical procedure. I heard you as saying,
8 perhaps wrongly, that well, the doctor can always use a
9 lethal injection to kill the fetus. All right? That
10 rang a bell. So I look up and see what the lower courts
11 said about that and what they said is that nearly
12 everyone agrees it is not always possible to kill the
13 fetus by injection.

14 GENERAL CLEMENT: Oh, but can I respond to
15 that specifically?

16 JUSTICE BREYER: He says It is not always
17 possible -- what?

18 GENERAL CLEMENT: Can I respond to that
19 specifically?

20 JUSTICE BREYER: Well, he then goes; he
21 tells you why. He says there is a Dr. Knorr who says
22 you can't do it when the woman has a prior surgery,
23 pelvic inflammatory disease. And then another one says
24 they are not considered appropriate candidates because
25 of medical illness or cardiovascular disease, etcetera.

1 So there's a list of medical situations where they
2 couldn't use a fetal injection.

3 GENERAL CLEMENT: Justice Breyer, if I could
4 respond to that.

5 JUSTICE BREYER: Yes.

6 GENERAL CLEMENT: I mean, there are certain
7 situations where the injection is contraindicated. I
8 think they'd be relatively rare situations. And I
9 think, you know, you could imagine I suppose that the
10 statute might pose a problem if you could identify
11 particular conditions where a D&X was particularly
12 useful, and those were also situations where an
13 injection would be contraindicated. I think, you know,
14 the universe of that may be zero, it may be one in a
15 million; I don't know, but it's very small.

16 Another point that's made in the record
17 which I think is important is they suggest well, you
18 know, maybe, maybe if you can't do the injection into
19 the heart of the fetus, then you're only going to be
20 successful something like 92 percent of the times. I
21 think though for purposes of the mens rea requirement
22 would certainly take care of any concern that the
23 physician would have --

24 JUSTICE BREYER: It's bothering me, why I'm
25 using this as an illustration is that there are so many

1 of these things. Of course there are special cases. We
2 are only talking about a few, rare special cases. And
3 as soon as you tell me that what's supposed to happen is
4 that the judges are supposed to start deciding whether
5 this is one of these unusual cases or not, rather than
6 relying upon significant medical opinion, as this doctor
7 is now illustrating, I don't see how it's going to work.
8 At least I don't see how it's going to work without some
9 people suffering serious illness as a result of mistakes
10 by the judge.

11 GENERAL CLEMENT: Justice Breyer, I wish we
12 were talking about just a few rare cases because I think
13 if we were, there would be, the statute would be
14 amenable to not being applied in those rare cases. But
15 this is one thing that I think my colleagues on the
16 other side of the podium will agree with me on, is that
17 their doctors don't think that this is a safer procedure
18 in rare cases. They think it's a safer procedure every
19 single time. And that's why doctors like Dr. Chasen and
20 Dr. Frederickson try to do the D&X procedure every
21 single time, and they don't do it because they are
22 indifferent to health, I suppose. In their best
23 judgment they think that's the better way to go.

24 And it's just a question ultimately of
25 whether you're going to defer to individual doctors'

1 judgments, even when it's very much of a minority
2 judgment; I mean anything you want to say about this
3 procedure it is the heterodox procedure, not the
4 orthodoxy. Most ob-gyns are going to do the D&E
5 procedure, not the D&X procedure. Even in the Nebraska
6 case three of the four plaintiffs don't try to do the
7 intact removal, so I think that just gives you, just a,
8 know you, anecdotal observation that you are talking
9 about the rare procedure, the heterodox procedure.

10 And so the question is when you have a
11 perfectly safe alternative, and you have some doctors
12 who like to do it a different way, can Congress
13 countermand the doctors' judgment or do the doctors get
14 the final word?

15 JUSTICE KENNEDY: Suppose the doctor has the
16 intent, the good faith intent to perform a standard in
17 utero D&E, and he knows because of what's happened in
18 the last three months, with women with this particular
19 shaped fetus and particular position of the fetus, that
20 the chances are 50 percent, 60 percent that it's going
21 to be an intact delivery, at which point he is presented
22 with the problem.

23 Does he have the prohibitive intent?
24 Because aren't you, don't you have an intent to commit
25 the, most likely consequences of your acts?

1 GENERAL CLEMENT: I don't think so. I mean
2 that might be a situation -- I don't know that that's a
3 realistic hypothetical, I mean, let me just say that.
4 If that turned out to be a realistic hypothetical, that
5 might be an example of where this question I talked
6 about with Justice Stevens might matter. Which is in
7 that case it might matter whether or not the intent was
8 measured --

9 JUSTICE KENNEDY: Well, that's important to
10 me because you seem to think that there is a standard
11 D&E. In reading the medical testimony it seemed to me
12 that D&Es ought to result in result in intact deliveries
13 quite without the intent of the doctor. Now maybe
14 that's wrong.

15 GENERAL CLEMENT: With respect, Justice
16 Kennedy, I don't think that's born out in this record,
17 it's the other way, which is doctors who want to perform
18 a D&X, often, in a majority of the cases end up
19 performing a D&E. But the doctors that set out to
20 perform a D&E, in Dr. Vibhakar's case she says a hundred
21 percent of the time, she ends up with dismemberment.
22 Dr. Creinen says it's 99% of the time that he ends up
23 with dismemberment.

24 CHIEF JUSTICE ROBERTS: And I gather your
25 submission is that we can tell who is setting out to

1 perform which, by the dilation protocol. Those were the
2 record references that you gave earlier?

3 GENERAL CLEMENT: Yes. And you can, you
4 can, you can tell you can tell from the fact that a
5 doctor, like one of the plaintiffs in the Nebraska case,
6 Dr. Fitzhugh, says, that, well, I don't do the intact
7 removal because if I wanted to do that I would have to
8 do a second round of dilation with a second round of
9 laminarias. And of course, that second round of
10 laminaria is also a medical procedure. Like the
11 injection, every medical procedure has some risks, risks
12 of infection. If you looked at Dr. Creinen's testimony,
13 this is at 174 A to 177 A in the Eighth Circuit petition
14 appendix, he says that he doesn't like to do a second
15 round of laminaria dilation because it's painful to the
16 patient. And that's his testimony.

17 So there are countervailing indications
18 here. And as I say, this idea of trying to prohibit a
19 practice that involves further dilation is not an
20 irrelevant concern from a health standpoint, because one
21 of the things that Congress heard was that there were
22 risks to future pregnancies from cervical incompetence.
23 And that's a particularly important concern because
24 first of all, the plaintiff's experts aren't in a very
25 good position to evaluate that risk because they provide

1 abortion services, not follow-up services. So they're
2 not in a good position to judge that risk.

3 Second of all, the only study we have here
4 points out that there is a greater incidence of that
5 preterm delivery in the group that had a D&X procedure.
6 Now again they say, they are going to come up and say
7 well it's not statistically significant. But the
8 numbers I think are striking. They had 17 women in the
9 group that had a D&X and came back. Two of them had a
10 preterm pregnancy. The D&E group was much larger, 45,
11 and two of them had a preterm delivery. Now I think as
12 a commonsense manner, if you know that you were going to
13 be in a room with 17 people where two people were going
14 to have something bad happen to them, or in a room with
15 45 and two -- bad things were going to happen to two, I
16 know which room I'd like to be in. And all I'm pointing
17 out --

18 JUSTICE BREYER: Yes, once you're making a
19 point of that study, I think it was also the case that
20 the ones that had the intact were older or rather
21 further along in pregnancy; isn't that true?

22 GENERAL CLEMENT: That's right.

23 JUSTICE BREYER: Therefore the risks were
24 greater.

25 GENERAL CLEMENT: Well if I could just --

1 JUSTICE BREYER: And therefore since the
2 risks were greater, the other side says that this
3 actually shows it was safer. I mean, I don't know how
4 to evaluate that.

5 GENERAL CLEMENT: I think it's even more
6 complicated than that, Justice Breyer, because in fact,
7 you're right that the D&X patients were at a further
8 gestational age, but the D&E patients were actually
9 older. And so I think --

10 JUSTICE BREYER: I missed that.

11 GENERAL CLEMENT: Right. But it happens
12 that, the D&E patients were on average two years older,
13 which I think also would be associated with greater
14 risk. So I think it's a wash. But I still think the
15 Chasen study net is quite helpful to our side. For one
16 thing, this is a study put together by one of the
17 plaintiff practitioners, a plaintiff in the Southern
18 District case, based on a study of his own practice.
19 And of course one of the intuitions about the D&X
20 procedure is because you remove it intact it's going to
21 be a faster procedure and there is going to be less
22 blood loss.

23 JUSTICE GINSBURG: General Clement --

24 GENERAL CLEMENT: Well, what did he find
25 when he studied that? It was exactly the same for those

1 two procedures. I'm sorry.

2 JUSTICE GINSBERG: Because your time is
3 running out I did want to ask you about a feature of
4 this legislation that hasn't come up so far, and that is
5 perhaps stimulated by Stenberg. But up until now, all
6 regulation on access to abortion has been state
7 regulation and this measure is saying to the states,
8 like it or not, the Federal Government is going to ban a
9 particular practice and we are going to take away the
10 choice from the states, in an area where up until now
11 it's, it's been open to the states to make those
12 decisions. How should that weigh in this case? And it
13 is something new.

14 GENERAL CLEMENT: Well, I mean I don't think
15 it should figure in this Court's decision. I mean
16 principally because the other side in neither case makes
17 a challenge based on the Commerce Clause, and I suppose
18 there is two reasons for that. That legal reason that
19 they don't bring the challenge is because there is a
20 jurisdictional element that I think would address the
21 challenges as a doctrinal matter. The practical reason
22 I think is because this isn't the only instance in which
23 the Federal Government has gotten involved to address
24 issues related to the abortion context.

25 JUSTICE GINSBERG: Well I know, when it is a

1 question of funding --

2 GENERAL CLEMENT: Well but also access to
3 clinics, in the the face act, which is also --

4 JUSTICE SCALIA: The bes example where
5 government has gotten involved in overriding what the
6 states want to do is Casey. It seems rather odd for
7 this Court to be concerned about stepping on the toes of
8 the states.

9 GENERAL CLEMENT: Well -- it's certainly
10 true that abortion has been dealt with at a Federal
11 level one way or another since 1973. So I think that's
12 also part of the backdrop, but I also think, I mean, you
13 know, the Federal Government gets involved in this
14 issue, you know, depending on your perspective, for good
15 or for harm. It's there to protect access to the
16 abortion clinics --

17 JUSTICE STEVENS: General Clement, That
18 brings up a question I was intending to ask you. I
19 notice the finding says nothing about interstate
20 commerce but the statute says any physician who in or
21 affecting interstate commerce performs the procedures.
22 Does that mean that the procedure is performed in a free
23 clinic, as opposed to a profit organization, it would
24 not be covered?

25 GENERAL CLEMENT: Justice Stevens, I don't

1 think we have taken, the Federal Government hasn't taken
2 a definitive position on that. I think it could be
3 interpreted either way. I think my understanding is the
4 face context, a free clinic would be covered. There's
5 not a jurisdictional element in the face statute. So
6 there may be differences as, in application.

7 JUSTICE STEVENS: But how could the Commerce
8 Clause justify application to a free clinic? I don't
9 understand.

10 GENERAL CLEMENT: Well, I think by, I mean,
11 you know, the Court's precedents in other areas has
12 suggested it's just not a matter of whether the ultimate
13 service is provided in commerce but in order to get the
14 services they have to take --

15 JUSTICE STEVENS: Activities that --

16 GENERAL CLEMENT: Yes. Exactly. I don't, I
17 mean, that hasn't been briefed up in this case. If it
18 had been we'd probably have a definitive position one
19 way or another. But I don't think the constitutionality
20 in this facial challenge where that hasn't been a
21 feature of the challenge turns on the answer to that
22 question one way or another.

23 I think in regards to the Chasen study the
24 last thing I would say about it though is that it's
25 important because most of the arguments on the other

1 side are intuitive arguments. They are intuitive
2 arguments, that they would be less passive, so that will
3 be more safe. And what I think is telling is that the
4 same intuition would lead to the notion that it would be
5 quicker and there will be less blood loss. And when
6 that was actually tested in a controlled study, it
7 turned out not to be the case.

8 The last thing I'll say about the Chasen
9 study is there was this indication that the two most
10 serious complications were associated with the D&E
11 procedure. But one thing that I think is important to
12 understand about the Chasen study is it is a
13 retrospective study of Dr. Chasen and his partner's own
14 practice. Now what they do in every case is they set
15 out to perform a D&X procedure, and so what they are
16 studying and what they call the D&X procedures, that
17 cohort are the times when they tried to do a D&X
18 procedure and they were successful.

19 The D&X cohort from this study, is you know,
20 are those circumstances where he and his partner tried
21 to do a D&X procedure, weren't successful and did a D&E
22 procedure.

23 Now why is that significant? Because it
24 shows as Chasen noted in his article that in those
25 situations that were D&Es and they were associated with

1 serious complications there was nothing he could have
2 done about it. He could have performed a D&X, he tried
3 to perform a D&X and it wasn't successful, so he ended
4 up performing a D&E. And so I really think on balance
5 the Chasen study ends up supporting our position,
6 because the first time you have any kind of controlled
7 study what you find is that some of the intuition turns
8 out not to be true, and the safety benefits from these
9 are a wash, and the one sort of loose end from the study
10 is the threat that you do see from the greater dilation.
11 Now it's not statistically robust, but I think that it
12 does bear out one of Congress's concerns.

13 JUSTICE BREYER: Could you address the
14 question I asked respondent's counsel in the last case
15 about the availability of other facilities? Because
16 there are alternate methods but some of these require
17 hospitalization, and my understanding is the hospitals
18 aren't always open.

19 GENERAL CLEMENT: Right, I -- I --

20 JUSTICE BREYER: So it doesn't make much
21 sense to say well, there is an alternate procedure if
22 you can't be admitted to the facility.

23 GENERAL CLEMENT: Sure. And as I tried to
24 indicate in rebuttal, that's really not a concern
25 because, the difference is whether some clinics will

1 only offer the D&X and the D&E and will say that
2 basically you've got to go to a hospital to get the
3 induction procedure. But that doesn't really, I don't
4 think matter, because the point is anybody could get
5 a D&X who is at a clinic can also get a D&E. In every
6 single case the doctor that can perform the D&X can also
7 offer the D&E. And since the D&E is what the district
8 court in the Nebraska case described as the gold
9 standard of Casey, I think every woman in every case is
10 going to have that option of a safe, of a safe pregnancy
11 option. And again one way to illustrate that is Chasen.

12 JUSTICE KENNEDY: But then you pin your
13 whole case on the availability of D&E even though D&Es
14 sometimes inadvertently turn into intact D&Es.

15 GENERAL CLEMENT: Well, but, Justice
16 Kennedy, I think we have our answer to that, which is
17 the best reading of the statute requires the intent at
18 the outset of the procedure, and therefore nobody -- in
19 the 99 percent of the cases that Dr. Crainer sets out to
20 performs a D&E and succeeds, there's no issue in the
21 world because everybody would look at that and say
22 that's a D&E. In the one case --

23 JUSTICE BREYER: How do you do that, because
24 I looked at that part of the statute and, comparing it
25 with the statute in Cathcart, the relevant part forbid a

1 doctor from doing this for the purpose of performing an
2 abortion that the doctor knows will kill the fetus.
3 That's the language basically, right. And in this one
4 it says you can't deliver past the fetal trunk for the
5 purpose of performing an overt act that the doctor knows
6 will kill the fetus. So I look at those two sets of
7 words. I mean, I've simplified them slightly, but I
8 don't see the difference.

9 So if the one in Cathcart is viewed as too
10 vague, why is the other one here not too vague?

11 GENERAL CLEMENT: Well, Justice Breyer, it's
12 because of the addition of the anatomical landmark
13 language to the Federal statute.

14 JUSTICE BREYER: Well, I'll grant you that
15 in respect -- if what Cathcart was worried about I guess
16 was you didn't know what the words "significant
17 substantial portion of the child," that tends to be
18 cured. But if what Cathcart was worried about was the
19 fact that a doctor who sets out to perform a D&E will,
20 making a pass, think he'll have the fetus dismembered
21 and, lo and behold, it doesn't dismember, so the bottom
22 portion of the fetus descends outside the womb. And
23 there he is and now what happens? If that's the
24 concern, then I guess you'd agree that that same concern
25 exists here.

1 GENERAL CLEMENT: Well, only with the
2 caveat, though, is that I think this Court really didn't
3 have to confront the second concern because it had the
4 first concern. And if you thought that a leg, which
5 this Court did, was a substantial portion, and that was
6 the, that was the act that induced fetal demise, either
7 way it was covered no matter what your purpose was,
8 because the doctor's purpose in removing the leg was to
9 induce fetal demise.

10 Here the compound mens rea requirement works
11 with the anatomical landmark language, so that what you
12 need to satisfy the statute is the deliberate and
13 purposeful intent to remove the fetus past the navel
14 with the purpose of performing an overt act that will,
15 will lead to fetal demise, which is not covered when you
16 don't even have the intent to take it out of the -- past
17 the anatomical landmark in the first place and you're
18 trying to do something that's going to take place in
19 utero.

20 If I could reserve the balance of my time
21 for rebuttal.

22 CHIEF JUSTICE ROBERTS: Thank you, General
23 Clement.

24 Miss Gartner.

25 ORAL ARGUMENT OF EVE C. GARTNER

1 ON BEHALF OF RESPONDENTS

2 MS. GARTNER: Mr. Chief Justice and may it
3 please the Court:

4 In *Casey*, this Court reaffirmed that the
5 government cannot ban pre-viability abortions. Despite
6 *Casey*, Stenberg suggested that there is a narrow
7 category of pre-viability abortions, intact D&Es, as
8 this Court understood that term in Stenberg, that can be
9 banned so long as the ban contains a health exception.
10 But I'd like to leave the health exception question
11 aside for a minute and turn to the scope of the law that
12 Congress has enacted here.

13 The question is whether Congress can enact a
14 pre-viability abortion ban that does not track the
15 hallmark of intact D&E abortions as this Court
16 understood that term in Stenberg and by doing so to ban
17 a substantially greater array of abortions than would be
18 banned had the law faithfully tracked the language in
19 the Stenberg opinions about what constitutes an intact
20 D&E. And I'm referring both to the majority opinion in
21 Stenberg and in the dissents.

22 It is our position that this Court must
23 reject Congress's effort to exploit the limited license
24 that this Court seemingly granted in Stenberg because to
25 allow such an expansion of pre- viability abortions that

1 can be banned would set the stage for continued
2 legislative efforts to ban other iterations of the
3 classic D&E method of abortion until truly there would
4 be nothing left at all of Casey's holding that it is
5 unconstitutional to ban pre- viability second trimester
6 abortions.

7 The government in this case has conceded
8 that the act bans more abortions than merely the intact
9 D&E as this Court understood it in Stenberg. But I want
10 to highlight for the Court how the language of this act
11 departs from the hallmarks of intact D&E and how these
12 departures place doctors at risk of prosecution for the
13 very facet of D&E abortions, and by that I mean all D&E
14 abortions, that enhance their safety.

15 There is three respects in which the act
16 departs from the hallmarks of intact D&E as understood
17 in Stenberg. First, the act does not require breach
18 extraction of an intact fetus to the head, one of the
19 primary hallmarks that this Court understood in
20 Stenberg. Instead, the act applies once the fetus is
21 extracted past the navel, a far more frequent occurrence
22 than extraction to the head. And in fact the government
23 in its briefing both in their initial brief and in their
24 reply concedes that in any of what the government calls
25 standard D&Es a living fetus can be extracted past the

1 fetal navel before demise occurs.

2 In addition, the act does not require the
3 fetus to be delivered intact at the end of the
4 procedure, another component of what is considered to be
5 a hallmark of intact D&E in Stenberg.

6 In fact, the word intact appears nowhere in
7 the statute and again the government concedes that some
8 non-intact D&Es would violate this law as drafted. In
9 fact, the government contends that one of the
10 "advantages," in its words, is that the law would ban
11 more than intact D&E. And finally, the act does not
12 require that the fetus be extracted in a breach
13 presentation at all, even though in Stenberg the Court
14 thought of the breach extraction as one of the hallmarks
15 of intact D&E.

16 Now this --

17 CHIEF JUSTICE ROBERTS: Do you -- I think
18 this question was asked earlier, but I want your
19 position. How often does the vertex delivery occur in a
20 D&X procedure? I --

21 MS. GARTNER: Your Honor, two, two doctors
22 in particular, Dr. Chasen and Dr. Hammond, testified
23 that they have used in their practice the vertex
24 presentation to treat women who, as Ms. Smith indicated,
25 the fetus suffered from a serious lethal anomaly that

1 involved a greatly distended abdomen. The fetus
2 presented in a head-first presentation. The head
3 delivered through the dilated cervix, but the only way
4 to complete the procedure was to reduce the size of the,
5 of the abdomen that was, that was anomalous in size
6 because of the underlying fetal condition.

7 In those cases, those doctors testified that
8 that was absolutely the safest way to terminate the
9 pregnancy for the woman. The only alternative way would
10 have been abdominal surgery, which, which all the,
11 virtually all of the doctors, even the government's
12 doctors, agreed carries far greater risks for the woman
13 than a vaginal surgical abortion.

14 JUSTICE SOUTER: Miss Gartner, with regard
15 to your argument that the statute here did not track
16 what you have described as the characteristics, the
17 hallmarks, I think the answer from the other side is
18 that the, the theory of this statute is a theory of a
19 clear line between a legitimate abortion and
20 infanticide. And if that is the theory, then whether
21 it's a breach delivery or a non-breach delivery is
22 irrelevant. What would your answer be to that?

23 MS. GARTNER: Well, two answers, Your Honor.
24 First of all, the clear line that this Court drew in
25 Stenberg was essentially the line at intact delivery to

1 the head followed by an act that results in fetal
2 demise. Very clearly what this Court understood in
3 Stenberg could -- was, was an intact D&E and several
4 members of the court suggested that that would be
5 constitutional to ban.

6 In addition, the government today seems to
7 suggest --

8 JUSTICE SOUTER: Well, we said that that
9 would be an appropriate line. But the question here is
10 is it really essential to an appropriate line that we
11 talk, that we describe it as a, as a breach delivery or
12 a non-breach delivery.

13 MS. SMITH: Your Honor, I would agree that
14 of the three hallmarks that the Court recognized in
15 Stenberg, the breach delivery is probably the least, the
16 least central; that the other two hallmarks, the
17 extraction to the head followed by a completely intact
18 delivery after demise, were absolutely the hallmarks
19 that everyone on this Court understood in Stenberg, and
20 those, those lines, are nowhere in the statute that
21 Congress enacted.

22 Today General Clement seems to be arguing
23 that there is a different line that's protected in this
24 statute, a different line than the Court recognized in
25 Stenberg, and the line is about where the fetus is when

1 demise occurs. But, but this Court in Stenberg
2 understood that even in a classical D&E, a standard D&E,
3 as the government calls it, part of the fetus is outside
4 the woman's uterus when fetal demise occurs. The Court
5 recognized that fetal demise occurs even in a standard
6 D&E when, after a part of the fetus is drawn out of the
7 women's uterus, resistance is met, disarticulation
8 occurs, and after that fetal demise. So even in a
9 standard D&E the line that the government today is
10 offering up, the line of inside or outside the uterus,
11 would be violated in any D&E --

12 CHIEF JUSTICE ROBERTS: I understood the
13 statute here to apply only when the, in the words of the
14 statute, that the partially delivered infant is killed
15 after passing the anatomical landmark.

16 MS. GARTNER: Well, that's right, Your
17 Honor.

18 CHIEF JUSTICE ROBERTS: So we just say your
19 hypothetical about extraction of the leg it seems to be
20 would not be covered by the statute.

21 MS. GARTNER: Absolutely, Your Honor, that's
22 right. But what I'm saying is that some part of the
23 fetus, no matter what, is outside the women's uterus,
24 whether it's an intact D&E, a non-intact D&E --

25 JUSTICE SCALIA: But we don't talk about a

1 leg dying. We talk about the fetus dying, I think, and
2 I think that's not the leg.

3 MS. GARTNER: I think the important point is
4 that the government acknowledges that in a standard D&E,
5 what it calls standard D&Es, the fetus can be extracted
6 past the anatomical landmark. So the anatomical
7 landmark isn't a bright-line decision between intact
8 D&Es and non-intact D&Es. But in Stenberg this Court
9 drew that line between intact D&Es and non-intact D&Es.
10 It suggested --

11 CHIEF JUSTICE ROBERTS: Where does the
12 government concede that in a standard D&E the living
13 fetus is extracted past the anatomical landmark?

14 MS. GARTNER: It does so --

15 CHIEF JUSTICE ROBERTS: I thought that was
16 -- I thought their position was that that was not the
17 standard D&E.

18 MS. GARTNER: Right. It does so in two
19 places, Your Honor. On page 32 of their initial brief
20 they refer to, they describe two circumstances that they
21 say or two parts of the law that they say saved the law
22 from banning non-intact D&Es. The first is the
23 anatomical landmark and the second is the requirement of
24 an overt act. They describe the overt act as saving
25 non-intact D&Es that were not already excluded from the

1 anatomical landmark requirement. So that suggests that
2 there are some standard D&Es that would not be saved by
3 the anatomical landmark requirement.

4 In addition, in their reply brief on page 22
5 they explicitly say that the fetus is usually not
6 delivered past the anatomic landmark in the standard
7 D&E, but they don't say that that never occurs. So they
8 do admit that that sometimes is the case, and in fact
9 the government witness, doctor --

10 CHIEF JUSTICE ROBERTS: I thought their
11 answer on that was that sometimes the D&E procedure will
12 lead to a D&X procedure, but that the requirement of
13 deliberately and intentionally removes those situations
14 from the scope of the statute.

15 MS. GARTNER: Well, I think that's not how I
16 understood it, Your Honor. But in addition, the
17 government witnesses, witness, Dr. Sadigian, admitted
18 that in any standard D&E the fetus can be extracted past
19 the navel, the anatomic landmark of the navel, of the
20 naval, even in a standard.

21 CHIEF JUSTICE ROBERTS: Prior to demise?

22 MS. GARTNER: That's right, Your Honor.

23 JUSTICE KENNEDY: Did you understand the
24 government's argument or answer to that to be, well, if
25 the intent did not exist, if there was not an intent to

1 do that, then the doctor is not liable?

2 MS. GARTNER: Well, Your Honor, I think this
3 gets to the point I was going to make about the safety
4 of doing abortions in a way that would be banned by the
5 law, and that's that in every D&E, regardless of whether
6 the intent is to do an intact D&E or not an intact D&E,
7 the intent is to minimize the insertion of instruments
8 into the uterus and to extract the fetus as intact as
9 possible, because each insertion of the instruments
10 increases the risk of causing harm to the woman's
11 uterus. And so in every D&E, regardless of whether the
12 physician expects to have an intact fetus at the very
13 end of the procedure, they do want to minimize the --
14 the amount of instrumentation and bring it out in as few
15 parts as possible and so there is a deliberate and
16 intentional delivery of the fetus as far as possible
17 which often can be past the navel, though in most cases
18 it won't be up to the head. So that's why the line that
19 this Court drew in Stenberg is the line that first of
20 all delineates between two distinct procedures: intact
21 D&E and nonintact D&E. The difference between those two
22 procedures is whether the fetus is extracted to the head
23 or not to the head before demise occurs. This, this
24 statute doesn't draw that line. It draws a different
25 line and in doing that, it captures far more abortions

1 than the other law would and, and the key thing is that
2 if this law stands with the past the navel line the
3 inevitable result is that doctors in order to try to
4 avoid the reach of this statute will have to stop trying
5 to minimize the instrumentation and stop trying to draw
6 the fetus out as intact as possible because often when
7 that happens --

8 CHIEF JUSTICE ROBERTS: My concern with your
9 argument is it's not just the anatomical line. The
10 statute, I guess the Solicitor General referred to this
11 as the multiple mens rea requirement. It's not simply
12 the extraction to a particular anatomical landmark but
13 with the purpose of demise at that point. So, if in the
14 typical D&E the demise is going to be accomplished
15 before extraction passed the anatomical landmark. It
16 wouldn't be covered by this law.

17 MS. GARTNER: Well, Your Honor, I guess to
18 some extent it comes down to what intent means but if
19 what it means that the doctors would prefer, would like
20 it to come out as far as possible before they have to
21 take any, any kind of action to clear an obstructing
22 part, that's, that's what they intend.

23 The doctor only uses disarticulation when
24 it's necessary to clear an obstruction because the
25 continued extraction --

1 CHIEF JUSTICE ROBERTS: What about the
2 Solicitor General's reference with respect to the
3 differing protocols on dilation which suggests a
4 different intent going into the procedure for the D&E
5 and D&X?

6 MS. GARTNER: Well, two points, Your Honor.
7 One is the statute makes no mention of dilation
8 protocols even though some group like the American
9 College of Obstetricians and Gynecologists when they
10 intend to define an intact D&E abortion they've defined
11 it specifically by reference to dilation protocols. And
12 some state statutes have also used dilation protocols as
13 part of the definition of intact D&E but this statute
14 makes no mention of dilation protocols.

15 JUSTICE SOUTER: No, but the dilation
16 protocol certainly would be relevant on the question of
17 intent which this statute does refer to, wouldn't it?

18 MS. GARTNER: I think it would be relevant,
19 Your Honor, but I think it's not -- it really can't be
20 dispositive of the physician's intent be --

21 JUSTICE SOUTER: Because?

22 MS. GARTNER: Some doctors use a one day
23 protocol, some doctors use a two day protocol but that
24 in of itself isn't --

25 JUSTICE SOUTER: But you're telling us that

1 some do this and some do that and the question is why
2 wouldn't following one protocol rather than another
3 protocol very significant evidence of what was intended?

4 MS. GARTNER: Because some doctors use a two
5 day protocol, Your Honor, even if they don't expect to
6 get an intact D&E. There is not a direct correlation,
7 there's some correlation between the amount of dilation
8 and the percentage of times that a physician achieves
9 intact D&E. To some extent doctors also use other
10 agents to dilate, they use misoprostol and medication.
11 That even if they're doing a one day protocol --

12 JUSTICE SOUTER: Do we have any indication
13 in your case about the effective safety of any other
14 aspect of this procedure if these doctors would change
15 their, their method of operation and go to a one-day
16 protocol?

17 MS. SMITH: In terms, one-day protocol?

18 JUSTICE SOUTER: Yes.

19 MS. GARTNER: Some doctors -- I think one
20 thing is that doctors perform abortions most safely when
21 they do them in a way that they are most accustomed do.
22 They are doing them the way they were trained to do
23 them.

24 JUSTICE SOUTER: I don't want to cut your
25 answer but I want to know whether there is anything

1 specifically in the record in your case that bears on my
2 question.

3 MS. GARTNER: There is nothing specific
4 about doctors changing protocols. There is significant
5 evidence about increased risks if doctors were to stop
6 trying to extract the fetus as intact as possible.
7 Several witnesses, including several government
8 witnesses have agreed.

9 JUSTICE SOUTER: Do you mean start and stop
10 with a different intent?

11 MS. GARTNER: That's right, Your Honor.

12 JUSTICE SOUTER: As opposed to adopting a
13 completely different procedure entirely -- a different
14 protocol entirely.

15 MS. GARTNER: Well, no actually even the
16 other government witness, Dr. Cook, agreed that -- and
17 the other government witness, Dr. Lockwood, agreed that
18 removing the fetus as intact as possible in any D&E is
19 the safest way to perform a D&E procedure regardless of
20 whether the intent was to do an intact D&E procedure.

21 JUSTICE BREYER: For such a doctor, a doctor
22 who thinks that I'm trying to remove in this emergency
23 situation as much of the fetus as possible as quickly as
24 possible, would such a doctor often, never, sometimes be
25 thinking what I think is likely to happen here, I'll

1 make a pass at the fetus, try to draw it out, and what's
2 most likely to happen is that the trunk, a lot of it
3 will come out and then the head of the fetus will
4 dismember, after a lot of the trunk comes out.

5 Is that --

6 MS. GARTNER: I would say it certainly is
7 not never and it's not always. It's somewhere in
8 between but I think --

9 JUSTICE BREYER: So if a doctor is being
10 honest about that, is there any way that such a doctor
11 could escape the language of the statute on the
12 government's interpretation?

13 MS. GARTNER: I think not Your Honor because
14 the intent is to extract the fetus as intact as
15 possible. In a good many cases it will be extracted
16 past the navel though not to the head. So the doctor
17 falls within the deliberately and intentionally language
18 and I don't think, the government also proffers the idea
19 of specific intent, but again because this statute
20 doesn't track the actual differences between the two
21 procedures, the having the specific intent doesn't save
22 the statute. The doctor may intend to perform the
23 abortion as defined in this law but not intend to do an
24 intact D&E and that was the testimony in these cases.

25 JUSTICE STEVENS: Would you clear up one

1 thing for me? You say it's always the doctor's intent
2 to extract as much as possible before causing fetal
3 demise. I thought there was significant number of cases
4 in which there was a deliberate decision to cause fetal
5 demise before I start any extraction?

6 MS. GARTNER: Well, Your Honor there is
7 testimony in our case, in the California case, that a
8 few doctors that testified said the beginning at
9 approximately 22 weeks of pregnancy, they offered women
10 the option of undergoing a fetal demise injection before
11 the procedure began. But the testimony was also
12 overwhelming, including from the government witnesses,
13 that that injection procedure carries significant risks
14 for some women. For example, women with either
15 susceptibility to infection, like women with HIV or
16 hepatitis, you definitely don't want to do an additional
17 injection. That in addition --

18 JUSTICE STEVENS: From the point of view of
19 the doctor it would be the safest thing to avoid
20 criminal responsibility.

21 MS. GARTNER: It -- but the problem is as
22 the district court, found it's an unnecessary medical
23 procedure that subjects the woman to additional risk.
24 Now if the doctors --

25 CHIEF JUSTICE ROBERTS: Why would the

1 doctors in that case propose that option to their
2 patients?

3 MS. GARTNER: At 22 weeks and later, as the
4 abortion is getting closer to the viability line, the
5 doctors feel that some women would feel more -- it's for
6 psychological reasons for the woman. That's why it's an
7 offer; it's not a requirement.

8 CHIEF JUSTICE ROBERTS: Well, what -- what
9 are the psychological reasons?

10 MS. GARTNER: If she would prefer that the
11 fetus undergo demise before the extraction begins, some
12 women may feel better about that. The testimony was
13 also that other women absolutely don't want that. And
14 you know, feel that they -- you know, it's a very
15 personal question that really goes to the heart of this
16 case. It's a very personal decision how the woman who
17 has made this very difficult moral/religious decision to
18 end her pregnancy, often for very tragic reasons, how
19 does she want the fetus to undergo demise? Different
20 people will have different views about this. But here
21 Congress has legislated that for the woman and done so
22 pre-viability, when the state interests really are
23 insufficient to require the woman to undergo a procedure
24 that is not marginally safer but significantly safer for
25 her.

1 CHIEF JUSTICE ROBERTS: Well is there a
2 difference between, in your view, in the
3 constitutionality, marginally safer and significantly
4 safer? In other words, I take it we don't, you
5 obviously were here for the discussion in the prior
6 case. We don't have evidence on marginal significant.
7 And do you think it matters; if in fact it's a marginal
8 difference in safety, does that, is that still enough to
9 override Congress's interests in this case?

10 MS. GARTNER: Yes, Your Honor, it does
11 matter. Marginal safety would not be enough but I think
12 what is important is that you assess, you assess the
13 question of marginal versus significant by looking at
14 the averted harms. It's not a question of quantifying
15 how many women would avert the harms.

16 CHIEF JUSTICE ROBERTS: Well, do we just
17 look at the averted harms, or -- or do we, or Congress,
18 also look at the incidence of the averted harms? Is it
19 a theoretical -- is it a theoretical inquiry or is it to
20 some extent a quantified inquiry?

21 MS. GARTNER: Well, Your Honor, I think it
22 can't be a quantified, quantified inquiry. Ultimately
23 this Court has never looked at the constitutional
24 question of when an abortion statute interferes with a
25 woman's health to an extent that it's unconstitutional,

1 in terms of how many women are affected. The question
2 is, is how seriously would a woman be affected if she
3 affected? And the evidence here is overwhelming.

4 JUSTICE STEVENS: Doesn't the answer to my
5 question turn largely on the age of the fetus? Isn't it
6 a vast difference between the kind of decision the
7 mother that is to make if it's a 14 week fetus on the
8 one hand and 26 week fetus on the other?

9 MS. GARTNER: Well, I'm not sure if that's.

10 JUSTICE STEVENS: For example, one of the
11 congressional interests described in the finding is
12 avoiding fetal pain to the fetus. And I guess they
13 don't suffer any pain prior to 20 weeks but after 20
14 weeks there is some risk of pain. And that seems to me,
15 that could affect a calculus very dramatically for the
16 woman making the decision.

17 MS. GARTNER: For the woman, but I think the
18 important point, Your Honor, is that this, that the
19 intact D&E procedure, and the testimony was overwhelming
20 to this effect, that -- in some cases this procedure
21 averts catastrophic health consequences for the woman.
22 It averts uterine perforation, it averts the spread of
23 sepsis or infection; it averts the spread of --
24 potentially the spread of malignant cancer throughout
25 the women's body.

1 CHIEF JUSTICE ROBERTS: If -- if the woman
2 can take into account the impact on the fetus at a
3 certain point in time, and your option, as you said some
4 physicians give, of fetal demise prior to the procedure,
5 why is that beyond the scope of things that Congress can
6 take into account?

7 MS. GARTNER: Because what Congress has done
8 here is take away from women the option of what may be
9 the safest procedure for her. This Court has never
10 recognized a state interest that was sufficient to trump
11 the woman's interest in her health. If the woman and
12 her doctor together agree that proceeding in this way is
13 going to avert significant health risks to her, and the
14 testimony here is overwhelming that there are situations
15 where that occurs, this Court has never recognized a
16 state interest that was sufficient to trump that woman's
17 paramount interest in her health.

18 JUSTICE SOUTER: Well, but we have -- we
19 have said that that judgment has to reflect some kind of
20 substantial medical judgment. It can't be an
21 idiosyncratic determination by one doctor alone.

22 MS. GARTNER: Absolutely, Justice Souter.

23 JUSTICE SOUTER: So to that extent --

24 MS. GARTNER: And that's -- and I take that
25 -- and maybe that was my -- and I take this as a given

1 here. Given the overwhelming testimony from doctors
2 from the American College of Obstetricians and
3 Gynecologists, and this Court's holding in Stenberg,
4 where the record was less robust, that we have that
5 substantial medical authority here. And given that
6 substantial medical authority, doctors need to be able
7 to use their appropriate medical judgment, in the words
8 of Roe and Casey, to provide this procedure for their
9 patients when in their judgment -- not in their
10 unfettered discretion, but in their sound clinical
11 experience and medical judgment it's going to be the
12 safest for her and avert catastrophic health
13 consequences.

14 So this is -- again, it may be that the
15 number of women is not large, but for the women who are
16 affected the impact of this ban is undoubtedly
17 significant.

18 JUSTICE KENNEDY: I don't want to
19 misinterpret the Attorney General, the Solicitor
20 General's remarks but he indicated in those case there
21 could be an as applied challenge.

22 MS. GARTNER: Well, I think, Justice
23 Kennedy, you answered that question as well as I could.
24 If a woman had to wait until she needed a banned
25 abortion for her health, and file a proceeding wait for

1 the court to grant relief, undoubtedly she would not get
2 the relief she needed in time.

3 JUSTICE KENNEDY: Well, the answer that the
4 Solicitor gave -- General gave to that was, you could
5 have a pre-enforcement proceeding. That you can back up
6 the clock.

7 MS. GARTNER: Right. I'm not sure that I
8 actually understood his answers though, because I think
9 that that's what we have here, in fact, is a
10 pre-enforcement proceeding to, to determine that this
11 law blanketly banned intact D&E abortions even when the
12 doctor believes it's, it would have significant health
13 benefits for the patient.

14 So this is not, I want to go back to,
15 because my light is on, Stenberg suggested that there
16 was a line that could constitutionally be drawn between
17 banned, between permissibly banned procedures and, and
18 procedures that have constitutional protection. But the
19 statute didn't draw the line and it didn't draw that
20 line in two ways. This, this statute defiantly rejected
21 this Court's view that because there is substantial
22 medical authority for the proposition that intact D&E is
23 sometimes safer, a health exception is absolutely needed
24 here, and they also refused to draw the line at what
25 this Court understood was the defining difference

1 between intact D&E and nonintact D&E.

2 In the Solicitor General's reply brief they
3 talk about the promise of Stenberg. Well, the promise
4 of Stenberg was absolutely betrayed by Congress in this
5 case in both respects, both in terms of preserving the
6 health of the woman and allowing her to use what a
7 substantial medical authority thinks is the safest
8 procedure for the woman, and in terms of holding the
9 line at a limited ban on pre-viability abortions given
10 that Casey recognized that women have a constitutional
11 right to choose to end their pregnancy pre-viability.

12 I was going to address briefly some of the
13 concerns that the Solicitor General offered about some
14 of the health risks of intact D&E and cervical
15 incompetence. Just briefly. The, all of the government
16 witnesses in this case agreed that the congressional
17 findings completely overstate any risks of intact --
18 there is no, there is no reasonable basis to conclude
19 that intact D&E puts a woman at any greater risk of harm
20 than standard D&E, and in fact the evidence is quite to
21 the contrary. It averts catastrophic health
22 consequences in some circumstances. There is no strong
23 evidence that intact D&E has any impact on cervical
24 incompetence.

25 The Solicitor General talks at length about

1 the two cases in Dr. Jason's study, but both of those
2 women who experienced cervical incompetence had, in
3 future pregnancy, had had cervical incompetence in prior
4 pregnancies, and that's a condition that tends to stay
5 with the woman. So there is no reason to think that it
6 was the intact D&E itself that caused cervical
7 incompetence in the subsequent pregnancies because of
8 intact D&E.

9 And finally, yes, it's true that Dr. Chasen
10 used intact D&E or attempted to use intact D&E in all
11 cases, and the women who had D&Es, three of them
12 suffered very serious medical consequences after having
13 a D&E. The Solicitor General says well, Dr. Chasen tried
14 to do intact and he failed so, so there was really
15 nothing to say about this law. But the fact is, if this
16 law went into effect, no woman could have intact D&E. So
17 even though, even in those cases where Dr. Chasen was
18 able to do intact D&E, he would no longer be able to do
19 that. So the incidence of those women having
20 catastrophic health consequences, which in the Chasen
21 study, three of the women having D&Es had catastrophic
22 health consequences. Inevitably if this law is upheld,
23 an intact D&E is not available as an option to doctors
24 when in their judgment based on substantial medical
25 authority, it's the best option for the woman.

1 Inevitably there will be more and more women having D&Es
2 and suffering catastrophic health consequences in
3 situations where if intact D&E had been available, those
4 catastrophic consequences could have been averted.

5 CHIEF JUSTICE ROBERTS: Thank you,
6 Ms. Gartner.

7 MS. GARTNER: Thank you for your
8 consideration, Your Honor.

9 CHIEF JUSTICE ROBERTS: General Clement, you
10 have three minutes remaining.

11 REBUTTAL ARGUMENT OF PAUL D. CLEMENT

12 ON BEHALF OF PETITIONER

13 GENERAL CLEMENT: Mr. Chief Justice, and may
14 it please the Court:

15 A few final points. First of all, I don't
16 think the constitutionality of Congress's act depends on
17 whether the anatomical landmark is the navel or up to
18 the head. Congress, as everyone recognizes, had to draw
19 a line. I think drawing the line at more than halfway
20 out is a pretty good place to draw the line.

21 Second, my learned co-counsel is certainly
22 correct. This is a pre-enforcement challenge, in
23 response to your question, Justice Kennedy. But the
24 point is, this is a pre-enforcement spatial challenge,
25 and if the Court rejects it and allows this statute to

1 go into operation, it will not foreclose the possibility
2 of a future pre-enforcement as applied challenge that
3 focuses on particular medical conditions. That's not
4 something, though, that one can reach in this record,
5 because as the district court in this case found at
6 147a, there is no specific condition here in which the
7 D&X procedure is particularly ready met for or otherwise
8 is medically necessary. Rather, the claims in this case
9 are that it's always better. That's what some doctors
10 say. It's a heterodox position, it's not the majority
11 position, but it's not focussed on specific situations.

12 The other thing it's not focused on, and
13 this is in reference to something that Justice Breyer
14 mentioned, it's not focused on emergencies. Another
15 thing that the district court noted at page 128a of its
16 opinion is that the D&E procedure and the D&X procedure,
17 neither of them are particularly good in dealing with
18 true medical emergencies where time is of the essence,
19 because both these procedures require substantial
20 advance time to do the dilation. And since the D&X
21 procedure requires more dilation, I actually think in an
22 emergency, you'd probably end up performing the D&E
23 procedure if you performed either one, because you'd
24 need less time for the dilation in an emergency.

25 The other thing I should point out is that,

1 of course, there is this question about what's a
2 significant risk. And one thing about the lethal
3 injection at the beginning of the process, the Digoxin
4 injection, is the other side concedes that the mother
5 gets to make the choice as to whether or not to do that
6 procedure. Well, Dr. Carhart does it as a matter of
7 course after 17 weeks, and I certainly don't think
8 anyone would suggest that Dr. Carhart is needlessly
9 inflicting significant risks on his patients after 17
10 weeks by following that regimen in every case after 17
11 weeks.

12 And I think it's worth noting that the legal
13 regime that respondents would construct is a legal
14 regime where the woman can decide whether or not to have
15 that shot, Dr. Carhart can decide it for her and that's
16 okay, but Congress can't make this judgment. But it's
17 important to draw a line here, and say that fetal demise
18 that takes place in utero is one thing. That is
19 abortion as it has always been understood. But this
20 procedure, the banned procedure is something different.
21 This is not about fetal demise in utero. This is
22 something that is far too close to infanticide for
23 society to tolerate. Thank you.

24 CHIEF JUSTICE ROBERTS: Thank you, General
25 Clement. The case is submitted.

1 (Whereupon, at 12:07 p.m., the case in the
2 above-entitled matter was submitted.)

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