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. :

10 - x

11 Washington, D.C.

12 Wednesday, November 8, 2006

13

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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1 P R O C E E D I N G S

2 (11:08 a.m.)

3 CHIEF JUSTICE ROBERTS: Now we'll hear

4 argument in 05-1382, Gonzales versus Planned Parenthood

5 Federation of America.

6 General Clement.

7 ORAL ARGUMENT OF PAUL D. CLEMENT

8 ON BEHALF OF PETITIONER

9 GENERAL CLEMENT: Mr. Chief Justice and may

10 it please the Court:

11 This case presents the same basic

12 constitutional question concerning the Federal

13 Partial-Birth Abortion Act as the first case. Of

14 course, the Ninth Circuit in the decision under review

15 here went much further in invalidating the Federal act.

16 If I could begin by talking about whether what we're

17 talking about here is medical necessity or just some

18 marginal effect on the risks. I think in order to

19 fairly understand the argument that Respondents are

20 making in this case, their argument has to be a matter

21 of simply marginal risks, because one illustration of

22 this, as I indicated in the first argument, if a doctor

23 really believes that a D&X procedure is the way to go in

24 a case then there's no ban on the procedure as such.

25 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, which I have hundreds

8 of references from this thing, has 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, and 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 risk 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 what I think what you have is that

8 it's very clear that their position is one of zero

9 tolerance 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? You know, you fill

14 out forms when you go to the dentist about risks. If

15 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 were 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 require additional dilation,

25 which can be associated with risks of losing

1 future pregnancies. And that was borne 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 preterm pregnancy in the
6 follow-up.
7 So I think those risks are borne 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, 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
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, they're right, there's marginal
22 risk, 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 that 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 the fetus. And in
10 those cases, of course, the intent of the doctor
11 performing the D&E isn't to deliver the fetus at all;
12 it's to 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 presents 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 interpretation.
4 JUSTICE BREYER: I'm probably wrong about
5 this, but just before you leave it, I mean, this is why
6 this so hard for me to get into the medical procedure.
7 I heard you as saying, perhaps wrongly, that well, the
8 doctor can always use a lethal injection to kill the
9 fetus. All right? That rang a bell. So I look up and
10 see what the lower courts said about that and what they
11 said is nearly everyone agrees it is not always
12 possible to kill the fetus by injection.
13 GENERAL CLEMENT: Oh, but can I respond to
14 that specifically?
15 JUSTICE BREYER: And if you agree it is not
16 always possible -- what?
17 GENERAL CLEMENT: Can I respond to that
18 specifically?
19 JUSTICE BREYER: Well, he then goes on; he
20 tells you why. He says there is a Dr. Knorr who says
21 you can't do it when the woman has a prior surgery,
22 pelvic inflammatory disease. And then another one says
23 they are not considered appropriate candidates because
24 of medical illness or cardiovascular disease, et cetera.
25 So there's a list of medical situations where they

1 couldn't use a fetal injection.
2 GENERAL CLEMENT: Justice Breyer, if I could
3 respond to that.
4 JUSTICE BREYER: Yes.
5 GENERAL CLEMENT: I mean, there are certain
6 situations where the injection is contraindicated. I
7 think they'd be relatively rare situations. And I
8 think, you know, you could imagine I suppose that the
9 statute might pose a problem if you could identify
10 particular conditions where a D&X was particularly
11 useful, and those were also situations where an
12 injection would be contraindicated. I think, you know,
13 the universe of that may be zero, it may be one in a
14 million; I don't know, but it's very small.
15 Another point that's made in the record
16 which I think is important is they suggest well, you
17 know, maybe, maybe if you can't do the injection into
18 the heart of the fetus, then you're only going to be
19 successful something like 92 percent of the times. I
20 think though for purposes of the mens rea requirement
21 would certainly take care of any concern that the
22 physician would have --
23 JUSTICE BREYER: -- bothering me, but why
24 I'm using this as an illustration is that there are so
25 many of these things. Of course they're special cases.

1 We are only talking about a few, rare special cases. And
2 as soon as you tell me that what's supposed to happen is
3 that the judges are supposed to start deciding whether
4 this is one of these unusual cases or not, rather than
5 relying upon significant medical opinion, as this doctor
6 is now illustrating, I don't see how it's going to work.
7 At least I don't see how it's going to work without some
8 people suffering serious illness as a result of mistakes
9 by the judge.
10 GENERAL CLEMENT: Justice Breyer, I wish we
11 were talking about just a few rare cases because I think
12 if we were, there would be, the statute would be
13 amenable to not being applied in those rare cases. But
14 this is one thing that I think my colleagues on the
15 other side of the podium will agree with me on, is that
16 their doctors don't think that this is a safer procedure
17 in rare cases. They think it's a safer procedure every
18 single time. And that's why doctors like Dr. Chasen and
19 Dr. Frederickson try to do the D&X procedure every
20 single time, and they don't do it because they are
21 indifferent to health, I suppose. In their best
22 judgment they think that's the better way to go.
23 And it's just a question ultimately of
24 whether you're going to defer to individual doctors'
25 judgments, even when it's very much of a minority

1 judgment; I mean anything you want to say about this
2 procedure it is the heterodox procedure, not the
3 orthodoxy. Most ob-gyns are going to do the D&E
4 procedure, not the D&X procedure. Even in the Nebraska
5 case three out of the four plaintiffs don't try to do the
6 intact removal, so I think that just gives you, just a,
7 you know, an anecdotal observation that you are talking
8 about the rare procedure, the heterodox procedure.
9 And so the question is when you have a
10 perfectly safe alternative, and you have some doctors
11 who like to do it a different way, can Congress
12 countermand the doctors' judgment or do the doctors get
13 the final word?
14 JUSTICE KENNEDY: Suppose the doctor has the
15 intent, the good faith intent to perform a standard in
16 utero D&E, and he knows because of what's happened in
17 the last three months, with women with this particular
18 shaped fetus and particular position of the fetus, that
19 the chances are 50 percent, 60 percent that it's going
20 to be an intact delivery, at which point he is presented
21 with the problem.
22 Does he have the prohibitive intent?
23 Because aren't you -- don't you have an intent to commit
24 the most likely consequences of your acts?
25 GENERAL CLEMENT: I don't think so. I mean

1 that might be a situation -- I don't know that that's a
2 realistic hypothetical, I mean, let me just say that.
3 If that turned out to be a realistic hypothetical, that
4 might be an example of where this question I talked
5 about with Justice Stevens might matter. Which is in
6 that case it might matter whether or not the intent was
7 measured --
8 JUSTICE KENNEDY: Well, that's important to
9 me because you seem to think that there is a standard
10 D&E. In reading the medical testimony it seemed to me
11 that D&Es often result in -- in intact deliveries
12 quite without the intent of the doctor. Now maybe
13 that's wrong.
14 GENERAL CLEMENT: With respect, Justice
15 Kennedy, I don't think that's borne out in this record,
16 it's the other way, which is to say the doctors that want
17 to perform a D&X, often, in a majority of the cases end
18 up performing a D&E. But the doctors that set out to
19 perform a D&E, in Dr. Vibhakar's case she says a hundred
20 percent of the time, she ends up with dismemberment.
21 Dr. Creinen says it's 99% of the time that he ends up
22 with dismemberment.
23 CHIEF JUSTICE ROBERTS: And I gather your
24 submission is that we can tell who is setting out to
25 perform which, by the dilation protocol. Those were the

1 record references that you gave earlier?

2 GENERAL CLEMENT: Yes. And you can -- you

3 can -- you can tell from the fact that a doctor,

4 like one of the plaintiffs in the Nebraska case,

5 Dr. Fitzhugh, says, that, well, I don't do the intact

6 removal because if I wanted to do that I would have to

7 do a second round of dilation with a second round of

8 laminaria. And of course, that second round of

9 laminaria is also a medical procedure. Like the

10 injection, every medical procedure has some risks, risks

11 of infection. If you looked at Dr. Creinen's testimony,

12 this is at 174 A to 177 A in the Eighth Circuit petition

13 appendix, he says that he doesn't like to do a second

14 round of laminaria dilation because it's painful to the

15 patient. And that's his testimony.

16 So there are countervailing indications

17 here. And as I say, this idea of trying to prohibit a

18 practice that involves further dilation is not an

19 irrelevant concern from a health standpoint, because one

20 of the things that Congress heard was that there were

21 risks to future pregnancies from cervical incompetence.

22 And that's a particularly important concern because

23 first of all, the plaintiff's experts aren't in a very

24 good position to evaluate that risk because they provide

25 abortion services, not follow-up services. So they're

1 not in a good position to judge that risk.

2 Second of all, the only study we have here

3 points out that there is a greater incidence of that

4 preterm delivery in the group that had a D&X procedure.

5 Now again they say, they are going to come up and say

6 well it's not statistically significant. But the

7 numbers I think are striking. They had 17 women in the

8 group that had a D&X and came back. Two of them had a

9 preterm pregnancy. The D&E group was much larger, 45,

10 and two of them had a preterm delivery. Now I think as

11 a commonsense matter, if you know that you were going to

12 be in a room with 17 people where two people were going

13 to have something bad happen to them, or in a room with

14 45 and two -- bad things were going to happen to two, I

15 know which room I'd like to be in. And all I'm pointing

16 out --

17 JUSTICE BREYER: Well, if you're making a

18 point of that study, I think it was also the case that

19 the ones that had the intact were older or rather

20 further along in pregnancy; isn't that true?

21 GENERAL CLEMENT: That's right.

22 JUSTICE BREYER: Therefore the risks were

23 greater.

24 GENERAL CLEMENT: Well if I could just --

25 JUSTICE BREYER: And therefore since the

1 risks were greater, the other side says that this
2 actually shows it was safer. I mean, I don't know how
3 to evaluate that.
4 GENERAL CLEMENT: I think it's even more
5 complicated than that, Justice Breyer, because in fact,
6 you're right that the D&X patients were at a further
7 gestational age, but the D&E patients were actually
8 older. And so I think --
9 JUSTICE BREYER: I meant --
10 GENERAL CLEMENT: Right. But it happens
11 that, the D&E patients were on average two years older,
12 which I think also would be associated with greater
13 risk. So I think it's a wash. But I still think the
14 Chasen study net is quite helpful to our side. For one
15 thing, this is a study put together by one of the
16 plaintiff practitioners, a plaintiff in the Southern
17 District case, based on a study of his own practice.
18 And of course one of the intuitions about the D&X
19 procedure is because you remove it intact it's going to
20 be a faster procedure and there is going to be less
21 blood loss.
22 JUSTICE GINSBURG: General Clement --
23 GENERAL CLEMENT: Well, what did he find
24 when he studied that? It was exactly the same for the
25 two procedures. I'm sorry.

1 JUSTICE GINSBERG: Because your time is
2 running out I did want to ask you about a feature of
3 this legislation that hasn't come up so far, and that is
4 perhaps stimulated by Stenberg. But up until now, all
5 regulation on access to abortion has been State
6 regulation and this measure is saying to the States,
7 like it or not, the Federal Government is going to ban a
8 particular practice and we are going to take away the
9 choice from the States, in an area where up until now
10 it's, it's been open to the States to make those
11 decisions. How should that weigh in this case? It
12 is something new.
13 GENERAL CLEMENT: Well, I mean I don't think
14 it should figure in this Court's decision. I mean
15 principally because the other side in neither case makes
16 a challenge based on the Commerce Clause, and I suppose
17 there is two reasons for that. The legal reason that
18 they don't bring the challenge is because there is a
19 jurisdictional element that I think would address the
20 challenges as a doctrinal matter. The practical reason
21 I think is because this isn't the only instance in which
22 the Federal Government has gotten involved to address
23 issues related to the abortion context.
24 JUSTICE GINSBERG: Well I know, when it is a
25 question of funding --

1 GENERAL CLEMENT: Well but also access to
2 clinics, in the FACE Act, which is also --
3 JUSTICE SCALIA: The best example where the
4 Federal Government has gotten involved in overriding what
5 the States want to do is Casey. It seems rather odd for
6 this Court to be concerned about stepping on the toes of
7 the States.
8 GENERAL CLEMENT: I mean, it's certainly
9 true that abortion has been dealt with at a Federal
10 level one way or another since 1973. So I think that's
11 also part of the backdrop, but I also think, I mean, you
12 know, the Federal Government gets involved in this
13 issue, you know, depending on your perspective, for good
14 or for harm. It's there to protect access to the
15 abortion clinics --
16 JUSTICE STEVENS: General Clement, that
17 brings up a question I was intending to ask you. I
18 notice the findings said nothing about interstate
19 commerce but the statute says any physician who in or
20 affecting interstate or foreign commerce performs the
21 procedure. Does that mean that the procedure is performed
22 in a free clinic, as opposed to a profit organization, it
23 would not be covered?
24 GENERAL CLEMENT: Justice Stevens, I don't
25 think we have taken, the Federal Government hasn't taken

1 a definitive position on that. I think it could be
2 interpreted either way. I think my understanding is that
3 in the FACE context, a free clinic would be covered.
4 There's not a jurisdictional element in the FACE statute.
5 So there may be differences as, in application.
6 JUSTICE STEVENS: But how could the Commerce
7 Clause justify application to a free clinic? I don't
8 understand.
9 GENERAL CLEMENT: Well, I think by, I mean,
10 you know, this Court's precedents in other areas have
11 suggested it's not just a matter of whether the ultimate
12 service is provided in commerce but in order to get the
13 services they have to take --
14 JUSTICE STEVENS: Activities that --
15 GENERAL CLEMENT: Yes. Exactly. I don't, I
16 mean, that hasn't been briefed up in this case. If it
17 had been we'd probably have a definitive position one
18 way or another. But I don't think the constitutionality
19 in this facial challenge where that hasn't been a
20 feature of the challenge turns on the answer to that
21 question one way or another.
22 I think in regards to the Chasen study the
23 last thing I would say about it though is that it's
24 important because most of the arguments on the other
25 side are intuitive arguments. They are intuitive

1 arguments, that there will be less passes, so that will
2 be more safe. And what I think is telling is that the
3 same intuition would lead to the notion that it would be
4 quicker and there will be less blood loss. And when
5 that was actually tested in a controlled study, it
6 turned out not to be the case.
7 The last thing I'll say about the Chasen
8 study is there was this indication that the two most
9 serious complications were associated with the D&E
10 procedure. But one thing that I think is important to
11 understand about the Chasen study is it is a
12 retrospective study of Dr. Chasen and his partner's own
13 practice. Now what they do in every case is they set
14 out to perform a D&X procedure, and so what they are
15 studying and what they call the D&X procedures, that
16 cohort are the times when they tried to do a D&X
17 procedure and they were successful.
18 The D&E cohort from this study, are those
19 circumstances where he and his partner tried to do
20 a D&X procedure, weren't successful and did a D&E
21 procedure.
22 Now why is that significant? Because it
23 shows as Chasen noted in his article that in those
24 situations that were D&Es and they were associated with
25 serious complications there was nothing he could have

1 done about it. He couldn't have performed a D&X, he tried
2 to perform a D&X and it wasn't successful, so he ended
3 up performing a D&E. And so I really think on balance
4 the Chasen study ends up supporting our position,
5 because the first time you have any kind of controlled
6 study what you find is that some of the intuition turns
7 out not to be true, and the safety benefits from these
8 are a wash, and the one sort of loose end from the study
9 is the threat that you do see from the greater dilation.
10 Now it's not statistically robust, but I think that it
11 does bear out one of Congress's concerns.
12 JUSTICE BREYER: Could you address the
13 question I asked Respondent's counsel in the last case
14 about the availability of other facilities? Because
15 there are alternate methods but some of these require
16 hospitalization, and my understanding is the hospitals
17 aren't always open.
18 GENERAL CLEMENT: Right, I -- I --
19 JUSTICE BREYER: So it doesn't make much
20 sense to say well, there is an alternate procedure if
21 you can't be admitted to the facility.
22 GENERAL CLEMENT: Sure. And as I tried to
23 indicate in rebuttal, that's really not a concern
24 because, the difference is whether some clinics will
25 only offer the D&X and the D&E and will say that

1 basically you've got to go to a hospital to get the
2 induction procedure. But that doesn't really, I don't
3 think matter, because the point is anybody who can get
4 a D&X who is at a clinic can also get a D&E. In every
5 single case the doctor that can perform the D&X can also
6 offer the D&E. And since the D&E is what the district
7 court in the Nebraska case described as the gold
8 standard of safety, I think every woman in every case is
9 going to have that option of a safe, of a safe pregnancy
10 option. And again one way to illustrate that is Chasen.
11 JUSTICE KENNEDY: But then you pin your
12 whole case on the availability of D&E even though D&Es
13 sometimes inadvertently turn into intact D&Es.
14 GENERAL CLEMENT: Well, but, Justice
15 Kennedy, I think we have our answer to that, which is
16 the best reading of the statute requires the intent at
17 the outset of the procedure, and therefore nobody -- in
18 the 99 percent of the cases that Dr. Crainer sets out to
19 performs a D&E and succeeds, there's no issue in the
20 world because everybody would look at that and say
21 that's a D&E. In the one case --
22 JUSTICE BREYER: How do you do that, because
23 I looked at that part of the statute and, comparing it
24 with the statute in Cathcart, the statute in Cathcart,
25 the relevant part forbid a doctor from doing this method

1 for the purpose of performing an abortion that the doctor
2 knows will kill the fetus. That's the language basically,
3 right. And in this one it says you can't deliver past the
4 fetal trunk for the purpose of performing an overt act that
5 the doctor knows will kill the fetus. So I look at those
6 two sets of words. I mean, I've simplified them slightly,
7 but I don't see the difference.
8 So if the one in Cathcart was viewed as too
9 vague, why is the other one here not too vague?
10 GENERAL CLEMENT: Well, Justice Breyer, it's
11 because of the addition of the anatomical landmark
12 language to the Federal statute.
13 JUSTICE BREYER: Well, I'll grant you that
14 in respect -- if what Cathcart was worried about I guess
15 was you didn't know what the words "significant
16 substantial portion of the child," that tends to be
17 cured. But if what Cathcart was worried about was the
18 fact that a doctor who sets out to perform a D&E will,
19 making a pass, think he'll have the fetus dismembered
20 and, lo and behold, it doesn't dismember, so the bottom
21 portion of the fetus descends outside the womb. And
22 there he is and now what happens? If that's the
23 concern, then I guess you'd agree that that same concern
24 exists here.
25 GENERAL CLEMENT: Well, only with the

1 caveat, though, is that I think this Court really didn't
2 have to confront the second concern because it had the
3 first concern. And if you thought that a leg, which
4 this Court did, was a substantial portion, and that was
5 the, that was the act that induced fetal demise, either
6 way it was covered no matter what your purpose was,
7 because the doctor's purpose in removing the leg was to
8 induce fetal demise.
9 Here the compound mens rea requirement works
10 with the anatomical landmark language, so that what you
11 need to satisfy the statute is the deliberate and
12 purposeful intent to remove the fetus past the navel
13 with the purpose of performing an overt act that will,
14 will lead to fetal demise, which is not covered when you
15 don't even have the intent to take it out of the -- past
16 the anatomical landmark in the first place and you're
17 trying to do something that's going to take place in
18 utero.
19 If I could reserve the remainder of my time
20 for rebuttal.
21 CHIEF JUSTICE ROBERTS: Thank you, General
22 Clement.
23 Miss Gartner.
24 ORAL ARGUMENT OF EVE C. GARTNER
25 ON BEHALF OF RESPONDENTS

1 MS. GARTNER: Mr. Chief Justice and may it
2 please the Court:
3 In Casey, this Court reaffirmed that the
4 government cannot ban pre-viability abortions. Despite
5 Casey, Stenberg suggested that there is a narrow
6 category of pre-viability abortions, intact D&Es, as
7 this Court understood that term in Stenberg, that can be
8 banned so long as the ban contains a health exception.
9 But I'd like to leave the health exception question
10 aside for a minute and turn to the scope of the law that
11 Congress has enacted here.
12 The question is whether Congress can enact a
13 pre-viability abortion ban that does not track the
14 hallmarks of intact D&E abortions as this Court
15 understood that term in Stenberg and by doing so to ban
16 a substantially greater array of abortions than would be
17 banned had the law faithfully tracked the language in
18 the Stenberg opinions about what constitutes an intact
19 D&E. And I'm referring both to the majority opinion in
20 Stenberg and in the dissents.
21 It is our position that this Court must
22 reject Congress's effort to exploit the limited license
23 that this Court seemingly granted in Stenberg because to
24 allow such an expansion of pre- viability abortions that
25 can be banned would set the stage for continued

1 legislative efforts to ban other iterations of the
2 classic D&E method of abortion until truly there would
3 be nothing left at all of Casey's holding that it is
4 unconstitutional to ban pre-viability second trimester
5 abortions.
6 The government in this case has conceded
7 that the act bans more abortions than merely the intact
8 D&E as this Court understood it in Stenberg. But I want
9 to highlight for the Court how the language of this act
10 departs from the hallmarks of intact D&E and how these
11 departures place doctors at risk of prosecution for the
12 very facet of D&E abortions, and by that I mean all D&E
13 abortions, that enhance their safety.
14 There are three respects in which the act
15 departs from the hallmarks of intact D&E as understood
16 in Stenberg. First, the act does not require breach
17 extraction of an intact fetus to the head, one of the
18 primary hallmarks that this Court understood in
19 Stenberg. Instead, the act applies once the fetus is
20 extracted past the navel, a far more frequent occurrence
21 than extraction to the head. And in fact the government
22 in its briefing both in their initial brief and in their
23 reply concedes that in any of what the government calls
24 standard D&Es a living fetus can be extracted past the
25 fetal navel before demise occurs.

1 In addition, the act does not require the
2 fetus to be delivered intact at the end of the
3 procedure, another component of what is considered to be
4 a hallmark of intact D&E in Stenberg.
5 In fact, the word intact appears nowhere in
6 the statute and again the government concedes that some
7 non-intact D&Es would violate this law as drafted. In
8 fact, the government contends that one of the
9 "advantages," in its words, is that the law would ban
10 more than intact D&E. And finally, the act does not
11 require that the fetus be extracted in a breach
12 presentation at all, even though in Stenberg the Court
13 thought of the breach extraction as one of the hallmarks
14 of intact D&E.
15 Now this --
16 CHIEF JUSTICE ROBERTS: Do you -- I think
17 this question was asked earlier, but I want your
18 position. How often does the vertex delivery occur in a
19 D&X procedure? I --
20 MS. GARTNER: Your Honor, two -- two doctors
21 in particular, Dr. Chasen and Dr. Hammond, testified
22 that they have used in their practice the vertex
23 presentation to treat women who, as Ms. Smith indicated,
24 the fetus suffered from a serious lethal anomaly that
25 involved a greatly distended abdomen. The fetus

1 presented in a head-first presentation. The head
2 delivered through the dilated cervix, but the only way
3 to complete the procedure was to reduce the size of the --
4 of the abdomen that was -- that was anomalous in size
5 because of the underlying fetal condition.
6 In those cases, those doctors testified that
7 that was absolutely the safest way to terminate the
8 pregnancy for the woman. The only alternative way would
9 have been abdominal surgery, which, which all the,
10 virtually all of the doctors, even the government's
11 doctors, agreed carries far greater risks for the woman
12 than a vaginal surgical abortion.
13 JUSTICE SOUTER: Miss Gartner, with respect
14 to your argument that the statute here did not track
15 what you have described as the characteristics, the
16 hallmarks, I think the answer from the other side is
17 that the -- the theory of this statute is a theory of a
18 clear line between a legitimate abortion and
19 infanticide. And if that is the theory, then whether
20 it's a breach delivery or a non-breach delivery is
21 irrelevant. What would your answer be to that?
22 MS. GARTNER: Well, two answers, Your Honor.
23 First of all, the clear line that this Court drew in
24 Stenberg was essentially the line at intact delivery to
25 the head followed by an act that results in fetal

1 demise. That was very clearly what this Court understood
2 in Stenberg could -- was what an intact D&E and
3 several members of the Court suggested that that would
4 be constitutional to ban.
5 In addition, the government today seems to
6 suggest --
7 JUSTICE SOUTER: Well, we said that that
8 would be an appropriate line. But the question here is
9 is it really essential to an appropriate line that we
10 talk, that we describe it as a, as a breach delivery or
11 a non-breach delivery.
12 MS. SMITH: Your Honor, I would agree that
13 of the three hallmarks that the Court recognized in
14 Stenberg, the breach delivery is probably the least, the
15 least central; that the other two hallmarks, the
16 extraction to the head followed by a completely intact
17 delivery after demise, were absolutely the hallmarks
18 that everyone on this Court understood in Stenberg, and
19 those -- those lines, are nowhere in the statute that
20 Congress enacted.
21 Today General Clement seems to be arguing
22 that there is a different line that's protected in this
23 statute, a different line than the Court recognized in
24 Stenberg, and the line is about where the fetus is when
25 demise occurs. But, but this Court in Stenberg

1 understood that even in a classical D&E, a standard D&E,
2 as the government calls it, part of the fetus is outside
3 the woman's uterus when fetal demise occurs. The Court
4 recognized that fetal demise occurs even in a standard
5 D&E when, after a part of the fetus is drawn out of the
6 women's uterus, resistance is met, disarticulation
7 occurs, and after that fetal demise. So even in a
8 standard D&E the line that the government today is
9 offering up, the line of inside or outside the uterus,
10 would be violated in any D&E --
11 CHIEF JUSTICE ROBERTS: I understood the
12 statute here to apply only when the, in the words of the
13 statute, the partially delivered infant is killed
14 after passing the anatomical landmark.
15 MS. GARTNER: Well, that's right, Your
16 Honor.
17 CHIEF JUSTICE ROBERTS: So your hypothetical
18 about extraction of the leg it seems to me would not
19 be covered by the statute.
20 MS. GARTNER: Absolutely, Your Honor, that's
21 right. But what I'm saying is that some part of the
22 fetus, no matter what, is outside the women's uterus,
23 whether it's an intact D&E, a non-intact D&E --
24 JUSTICE SCALIA: But we don't talk about a
25 leg dying. We talk about the fetus dying, I think, and

1 I think that's not the leg.

2 MS. GARTNER: I think the important point is

3 that the government acknowledges that in a standard D&E,

4 what it calls standard D&Es, the fetus can be extracted

5 past the anatomical landmark. So the anatomical

6 landmark isn't a bright-line division between intact

7 D&Es and non-intact D&Es. But in Stenberg this Court

8 drew that line between intact D&Es and non-intact D&Es.

9 It suggested --

10 CHIEF JUSTICE ROBERTS: Where does the

11 government concede that in a standard D&E the living

12 fetus is extracted past the anatomical landmark?

13 MS. GARTNER: It does so --

14 CHIEF JUSTICE ROBERTS: I thought that was

15 -- I thought their position was that that was not the

16 standard D&E.

17 MS. GARTNER: Right. It does so in two

18 places, Your Honor. On page 32 of their initial brief

19 they refer to, they describe two circumstances that they

20 say or two parts of the law that they say saved the law

21 from banning non-intact D&Es. The first is the

22 anatomic landmark and the second is the requirement of

23 an overt act. They describe the overt act as saving

24 non-intact D&Es that were not already excluded by the

25 anatomical landmark requirement. So that suggests that

1 there are some standard D&Es that would not be saved by
2 the anatomic landmark requirement.
3 In addition, in their reply brief on page 22
4 they explicitly say that the fetus is usually not
5 delivered past the anatomic landmark in the standard
6 D&E, but they don't say that that never occurs. So they
7 do admit that that sometimes is the case, and in fact
8 the government witness, doctor --
9 CHIEF JUSTICE ROBERTS: I thought their
10 answer on that was that sometimes the D&E procedure will
11 lead to a D&X procedure, but that the requirement of
12 deliberately and intentionally removes those situations
13 from the scope of the statute.
14 MS. GARTNER: Well, I think that's not how I
15 understood it, Your Honor. But in addition, the
16 government witnesses -- witness, Dr. Sadigian, admitted
17 that in any standard D&E the fetus can be extracted past
18 the navel, the anatomic landmark of the navel -- of the
19 navel, even in a standard.
20 CHIEF JUSTICE ROBERTS: Prior to demise?
21 MS. GARTNER: That's right, Your Honor.
22 JUSTICE KENNEDY: Did you understand the
23 government's argument or answer to that to be, well, if
24 the intent did not exist, if there was not an intent to
25 do that, then the doctor is not liable?

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

1 if this law stands with the past the navel line the
2 inevitable result is that doctors in order to try to
3 avoid the reach of this statute will have to stop trying
4 to minimize the instrumentation and stop trying to draw
5 the fetus out as intact as possible because often when
6 that happens --
7 CHIEF JUSTICE ROBERTS: My concern with your
8 argument is it's not just the anatomical line. The
9 statute, I guess the Solicitor General referred to this
10 as the multiple mens rea requirement. It's not simply
11 the extraction to a particular anatomical landmark but
12 with the purpose of demise at that point. So, if in the
13 typical D&E the demise is going to be accomplished
14 before extraction passed the anatomical landmark, it
15 wouldn't be covered by this law.
16 MS. GARTNER: Well, Your Honor, I guess to
17 some extent it comes down to what intent means but if
18 what it means is that the doctors would prefer, would
19 like it to come out as far as possible before they have
20 to take any -- any kind of action to clear an obstructing
21 part, that's -- that's what they intend.
22 The doctor only uses disarticulation when
23 it's necessary to clear an obstruction because the
24 continued extraction --
25 CHIEF JUSTICE ROBERTS: What about the

1 Solicitor General's record references with respect to
2 the differing protocols on dilation which suggests a
3 different intent going into the procedure for a D&E
4 and a D&X?
5 MS. GARTNER: Well, two points on that,
6 Your Honor. One is of course the statute makes no mention of
7 dilation protocols even though some group like the
8 American College of Obstetricians and Gynecologists when
9 they've attempted to define an intact D&E abortion they've
10 defined it specifically by reference to dilation protocols.
11 And some State statutes have also used dilation protocols
12 as part of the definition of intact D&E but this statute
13 makes no mention of dilation protocols.
14 JUSTICE SOUTER: No, but the dilation
15 protocol certainly would be relevant on the question of
16 intent which this statute does refer to, wouldn't it?
17 MS. GARTNER: I think it would be relevant,
18 Your Honor, but I think it's not -- it really can't be
19 dispositive of the physician's intent because --
20 JUSTICE SOUTER: Because?
21 MS. GARTNER: Some doctors use a one-day
22 protocol, some doctors use a two-day protocol but that
23 in itself isn't --
24 JUSTICE SOUTER: But you're telling us
25 some do this, some do that and the question is why

1 wouldn't following one protocol rather than another
2 protocol be very significant evidence of what was intended?
3 MS. GARTNER: Because some doctors use a
4 two-day protocol, Your Honor, even if they don't expect to
5 get an intact D&E. There is not a direct correlation,
6 there's some correlation but not a complete correlation
7 between the amount of dilation and the percentage of times
8 that a physician achieves intact D&E. To some extent
9 doctors also use other agents to dilate, they use
10 misoprostol and medication. That even if they're doing a
11 one-day protocol --
12 JUSTICE SOUTER: Do we have any indication in
13 the record in your case about the effect on safety or any
14 other aspect of the procedure if these doctors would
15 change their, their method of operation and go to a
16 one-day protocol?
17 MS. SMITH: In terms of the 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 the way that they are most accustomed to.
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 off 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 specific
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 stop once they
10 have started with a different intent?
11 MS. GARTNER: That's right, Your Honor.
12 JUSTICE SOUTER: As opposed to adopting a
13 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 what I'm trying to do is remove in this
23 emergency situation as much of the fetus as possible as
24 quickly as possible, would such a doctor often, never,
25 sometimes be thinking what I think is likely to happen

1 here, I'll make a pass at the fetus, try to draw it out,
2 and what's most likely to happen is that the trunk, a lot
3 of it 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 a significant number of cases
4 in which there was a deliberate decision to cause fetal
5 demise before doing any extraction?
6 MS. GARTNER: Your Honor, there is
7 testimony in our case, in the California case, that a
8 few doctors that testified said that 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 that
22 as 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. But if she would prefer --
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 is
3 affected? And the evidence here is overwhelming.
4 JUSTICE STEVENS: Doesn't the answer to that
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 has 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 findings 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 the 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 got to reflect some kind
20 of 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 affected is not large, but for the women
16 who are 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 actually needed a banned
25 abortion for her health, and file a proceeding and wait

1 for the court to grant relief, undoubtedly she would not
2 get the relief she needed in time.
3 JUSTICE KENNEDY: Well, the answer that the
4 Solicitor gave -- General gave to that was that 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 bans intact D&E abortions even when the
12 doctor believes it's, it would have significant health
13 benefits for the patient.
14 Now 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 this
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 non-intact 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 recognizes 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 D&E.

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 pregnancies, 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 Just a few final points. First of all, I
16 don't think the constitutionality of Congress's act
17 depends on whether the anatomical landmark is the navel
18 or up to the head. Congress, as everyone recognizes, had
19 to draw a line. I think drawing the line at more than
20 halfway 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 facial challenge,
25 and if the Court rejects this 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. That's a heterodox position, it's not the majority
11 position, but it's not focused 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, or the potassium chloride injection is the
5 other side concedes that the mother gets to make the
6 choice as to whether or not to do that procedure. Well,
7 Dr. Carhart does it as a matter of course after 17 weeks,
8 and I certainly don't think anyone would suggest that Dr.
9 Carhart is needlessly inflicting significant risks on his
10 patients by following that regimen in every case after
11 17 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 the same judgment. That
17 it's important to draw a line here, and say that fetal
18 demise 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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