IN THE SUPREME COURT OF THE UNITED STATES

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ALBERTO R. GONZALES, :

ATTORNEY GENERAL, :

Petitioner :

v. : No. 05-1382

PLANNED PARENTHOOD :

FEDERATION OF AMERICA, :

INC., ET AL. :

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Washington, D.C.

Wednesday, November 8, 2006

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

APPEARANCES:

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

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

C O N T E N T S

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

on a living fetus.

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

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

Get it out as fast as possible. All right.

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

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

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

risk?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL CLEMENT: Can I respond to that specifically?

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

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

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

JUSTICE BREYER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL CLEMENT: That's right.

JUSTICE BREYER: Therefore the risks were greater.

GENERAL CLEMENT: Well if I could just --

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

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

JUSTICE BREYER: I missed that.

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

JUSTICE GINSBURG: General Clement --

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

two procedures. I'm sorry.

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

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

JUSTICE GINSBERG: Well I know, when it is a

question of funding --

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

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

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

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

GENERAL CLEMENT: Justice Stevens, I don't

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

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

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

JUSTICE STEVENS: Activities that --

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

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

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

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

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

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

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

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

GENERAL CLEMENT: Right, I -- I --

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

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

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

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

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

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

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

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

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

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

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

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

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

CHIEF JUSTICE ROBERTS: Thank you, General Clement.

Miss Gartner.

ORAL ARGUMENT OF EVE C. GARTNER

ON BEHALF OF RESPONDENTS

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

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

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

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

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

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

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

fetal navel before demise occurs.

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

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

Now this --

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

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

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

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

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

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

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

In addition, the government today seems to suggest --

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

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

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

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

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

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

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

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

JUSTICE SCALIA: But we don't talk about a

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

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

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

MS. GARTNER: It does so --

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

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

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

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

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

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

CHIEF JUSTICE ROBERTS: Prior to demise?

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

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

do that, then the doctor is not liable?

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

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

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

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

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

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

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

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

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

JUSTICE SOUTER: Because?

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

JUSTICE SOUTER: But you're telling us that

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

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

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

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

JUSTICE SOUTER: Yes.

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

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

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

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

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

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

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

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

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

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

Is that --

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

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

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

JUSTICE STEVENS: Would you clear up one

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

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

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

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

CHIEF JUSTICE ROBERTS: Why would the

doctors in that case propose that option to their patients?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. GARTNER: Absolutely, Justice Souter.

JUSTICE SOUTER: So to that extent --

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

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

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

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

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

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

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

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

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

between intact D&E and nonintact D&E.

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

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

The Solicitor General talks at length about

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

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

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

CHIEF JUSTICE ROBERTS: Thank you, Ms. Gartner.

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

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

REBUTTAL ARGUMENT OF PAUL D. CLEMENT

ON BEHALF OF PETITIONER

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

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

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

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

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

The other thing I should point out is that,

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

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

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

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