[LB847 LB1043 LB1089 LB1103]

The Committee on Judiciary met at 12:30 p.m. on Thursday, February 25, 2010, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1089, LB847, LB1043, and LB1103. Senators present: Brad Ashford, Chairperson; Steve Lathrop, Vice Chairperson; Mark Christensen; Colby Coash; Brenda Council; Scott Lautenbaugh; Amanda McGill; and Kent Rogert. Senators absent: None. []

SENATOR ASHFORD: Good afternoon, everyone. We're going to start...as you can see, we're starting our hearings early today by an hour to accommodate the hearing on LB1103 which will begin at 1:30, so we're going to start first...doing three bills first. The first one is LB1089, Senator Karpisek, and it's...and he's here, so Russ. Thank you for indulging us by... []

SENATOR KARPISEK: Thank you, Senator Ashford. Not a problem. I thought there might be lunch but (laughter). []

SENATOR ASHFORD: Yeah, I should have ordered food (laugh). []

SENATOR KARPISEK: Right. Oh, a free lunch, right, sorry. []

SENATOR ASHFORD: We assumed you'd eat fast and you'd be done by now. You'd still be in the line down at the cafeteria probably but. []

SENATOR KARPISEK: I'll try to talk fast (laugh). I think they're in the line at the metal detector. My name, for the record, is Russ Karpisek, R-u-s-s K-a-r-p-i-s-e-k, and I represent the 32nd Legislative District. LB1089 would adopt the Uniform Guardianship and Protective Proceedings Act from the Uniform Law Commission. The bill is designed to address many problems relating to multiple jurisdiction, transfer, and out-of-state recognition of adult guardianship and protective proceedings. I would like to mention that it is adult. This is not anything to do with minors. In addition to LB1089, would facilitate communication and cooperation between courts in different states about adult guardianship. Due to an increasing population mobility, cases involving simultaneous and conflicting jurisdictions over guardianship are increasing. Even when all parties agree, steps such as transferring a guardianship to another state can require that the parties start over from scratch in the second state. Obtaining recognition of a guardian's authority in another state in order to sell property or arrange for a residential placement is often impossible. LB1089 will then be enacted and when enacted will help effectively address these problems. This bill was brought to me by the Alzheimer's Association, and I guess on a personal note, my mother-in-law lives with us, has dementia, and I do worry that if something were to happen to us, her siblings are out-of-state, what could happen. And by looking at this, it could really cause a big problem. Again, with the aging

baby boomers, I think it is something we need to look at, and it will need to be adopted by more states. And I'm not sure that we have a map; have some testifiers behind us, but it will have to be looked through and I guess this is the start of that process to get Nebraska looking at being involved in the compact. So I would take any questions if I can try to answer them. [LB1089]

SENATOR ASHFORD: Any questions for Russ? I think you're good. Thanks, Russ. [LB1089]

SENATOR KARPISEK: Thank you. [LB1089]

SENATOR ASHFORD: Proponents on LB1089. [LB1089]

LARRY RUTH: (Exhibit 1) I don't know where this goes. Here you go. My name is Larry Ruth, L-a-r-r-y R-u-t-h. Senator Ashford and members of the committee, thank you very much for having this bill a little bit ahead of the others, so we have a chance to spend some quick time with it. I'm acutely aware of the time situation. I would just say that the...I'm representing the Uniform Law Commission. I'm a commissioner. I have circulated a kit of material on this uniform act. It's an act that 13 states have now enacted, and that's just been in the last two years, and it's to address the questions of conflicts of law and which courts in different cases have jurisdiction. This is one of the courses I think we all kind of did not look forward to in law school is conflict of laws and jurisdictions of courts because it's a very difficult case or a very difficult area of the law. It probably...we've had that problem since. There have been two courts in two different jurisdictions, and which one has jurisdiction? In this particular case, the matter is looking at the courts as they address conflicts between courts on adult guardianships and conservatorships. In the case of jurisdictional conflicts with guardianships and conservatorships, we're really having more and more problems arise as we have a more mobile society. And others, we'll talk about that. That was down in Arizona last week at a family gathering, and you'd just be surprised at the combinations we had with children living here and parents living here, and a property being over here. And I asked them, where would you like to have the court decide your fate if you had to have a guardian? And they had no clue about what it would be. I just bring this information to you and let you know we'll be willing to work with you over the summertime. I don't want to get into the details any more than you want to, and so I would stand for questions. [LB1089]

SENATOR LATHROP: Thanks, Larry. And we do appreciate your work with the Uniform Law Commission. Usually when stuff comes in this committee from that commission, it's been well thought through. And this particular bill, there are no customizations to the bill for Nebraska? [LB1089]

LARRY RUTH: Not...there are a couple I'm dealing with, some definition. But nothing that we would think you'd need to look at right now. If you're going to be looking at this

next year, and I'm assuming at this point it's a next year bill, we'll do more work on customization. [LB1089]

SENATOR LATHROP: Okay, very good. Any questions? I see none. Thanks, Larry. [LB1089]

LARRY RUTH: Okay. Thank you very much. [LB1089]

SENATOR LATHROP: Next proponent? [LB1089]

CLAYTON FREEMAN: (Exhibit 2) Good afternoon, Senators. My name is Clayton Freeman, C-l-a-y-t-o-n F-r-e-e-m-a-n, and I am the program director for the Alzheimer's Association, Midlands Chapter. The Alzheimer's Association of Nebraska supports LB1089 which establishes a uniform set of rules for determining jurisdiction and thus simplifies the process for determining jurisdiction between multiple states in adult guardianship cases. It also establishes a framework that allows state court judges in different states to communicate with each other about guardianship issues. Due to the impact of Alzheimer's disease and other dementias on a person's ability to make decisions and in the absence of advance directives, people with Alzheimer's disease may need the assistance of a guardian. Often jurisdiction in adult guardianship cases is complicated because multiple states, each of which has its own guardianship system, may have an interest in the case. Consequently, it may be unclear which state court has jurisdiction. For the Alzheimer's Association, this is an issue of quality care, and advocating for the adoption of a more uniform and efficient adult guardianship system will help remove uncertainty for individuals with dementia who are in crisis and help them reach appropriate resolution faster. The national Alzheimer's Association is working with the Uniform Law Commission and the Council of State Governments to adopt the Uniform Guardianship and Protective Proceedings Act in all 50 states. The goal of the Alzheimer's Association of Nebraska is to humanize the complicated jurisdictional issues of adult guardianship and add a strong consumer voice to the existing group of professionals calling for change. We therefore ask that LB1089 be advanced to General File, and I would take any questions. [LB1089]

SENATOR ASHFORD: Any questions? Seeing none, thank you, sir. [LB1089]

CLAYTON FREEMAN: Thank you very much. [LB1089]

SENATOR ASHFORD: Other proponents. How many proponents do we have, other testifiers on this bill? Okay. [LB1089]

MARLA FISCHER-LEMPKE: (Exhibit 3) Chairman Ashford and members of the committee, my name is Marla Fischer-Lempke, M-a-r-l-a F-i-s-c-h-e-r-L-e-m-p-k-e, and I'm the Executive Director for the Arc of Nebraska. The Arc of Nebraska is a support

and advocacy organization, working with and for people with intellectual and other developmental disabilities. We're a statewide organization with 17 local chapters and approximately 1,500 members across the state. We're also an affiliate of The Arc of the United States. The Arc of Nebraska supports LB1089 which provides for the adoption of the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act which I'm not going to say all over again later (laugh). While each state has its own guardianship statutes and procedures for creating guardianships, LB1089 will give states a uniform way to recognize guardianships from state to state without having to engage in potentially complicated and costly proceedings to establish the same relationship that already is in effect in another state. The act ensures that guardianship orders in one state can be enforced or recognized in another. Established cases can be efficiently transferred from one state to another. And initial jurisdiction to appoint a guardian is fixed in the court of one and only one state. Passing LB1089 will also assist in reducing the likelihood of abuse. Specifically, the act will assist to address abusive situations by facilitating the monitoring of guardianships, bringing an awareness of the potential for abuse to non-home states, which are states other than that where the guardianship originated; facilitating communication among courts in other states; establishing transfer procedures that could remove people from abusive situations; and establishing a mechanism that will aid in notification and monitoring of abuse. LB1089 will also serve to decrease the costs for individuals and families. An example of this or one example is a gentleman I know who has a disability and who also is under a guardianship will be graduating from college soon and will be looking for a job, possibly out of the state. And he is concerned that because he's under a guardianship, that he's going to have difficulty or his parents will have to spend more money to establish the guardianship in another state which he might move to and find a job. So that's one way that this could really affect families. It also saves states money, conserves judicial resources, and provides a similar format as the child custody process. So far approximately 13 states have passed the act, and we urge Nebraska to do the same and move this to General File. Thank you. [LB1089]

SENATOR ASHFORD: Any questions? Seeing none, Senator Karpisek, you want to close or are you...? I think that's the...we've...I asked already I think. [LB1089]

SENATOR KARPISEK: (Inaudible) did you ask? [LB1089]

SENATOR ASHFORD: I did ask; I'll ask again. Are there any opponents or neutral testifiers to this bill? Okay. [LB1089]

SENATOR KARPISEK: (Exhibit 4) I threatened them all so, thank you very much, committee. This is, I think, a very good piece to look at. I kind of jumped the gun a little bit on Mr. Ruth, and Senator Council were working together on this a little bit. It was in your stack, in your pile, and the Alzheimer's group was working on it with me. So wanted to get it in and kind of get the ball rolling on it. I do think that it's needed, and

with Mr. Ruth working together with the committee, I'm sure that we can get something done, and I appreciate that, and that's all I have. Thank you. [LB1089]

SENATOR ASHFORD: Thanks, Russ. Thank you. [LB1089]

SENATOR KARPISEK: Thank you. [LB1089]

SENATOR ASHFORD: Senator Council. LB847. Good afternoon. [LB1089]

SENATOR COUNCIL: Good afternoon, Chairman Ashford, fellow members of the Judiciary Committee. I'm Brenda Council, last name spelled C-o-u-n-c-i-l, and I appear before the committee this afternoon for the purpose of introducing LB1043 (sic), and in a nutshell, the intent of LB1043 (sic) is to restore a right to a litigant in Small Claims Court that existed prior to legislation that was enacted that would allow a small claims litigant who wanted to appeal the decision right of appeal to the district court with the right to retain counsel in the event that a small claims litigant appealed a decision to the district court. Well, prior to that enactment, a litigant in a Small Claims Court action who had been the subject of a default judgment had a method for seeking to have that default judgment vacated or set aside. And for my colleagues who are not practicing attorneys, more commonly default judgments are the result of simply not appearing at the proceeding. And there were various reasons why people failed to appear at Small Claims Court proceedings, but in any event, there used to be a procedure for a person who found themselves in that situation to move to have the default judgment set aside and have to provide the court with some justification for that action. Under the current law now, if a litigant is the subject of a default judgment, while he or she has a right to appeal that default judgment to the district court, they can only appeal it on the record, and if they did not appear, and that's the reason they have a default judgment, there really is no error on the record that would provide a foundation for an appeal to the district court. So all that LB1043 (sic) is designed to do is restore the ability of a litigant to seek to vacate or set aside a default judgment, and in that instance, that litigant would be allowed to employ legal counsel to represent him or her, and it also just maintains the direct appeal to the district court on the record. Are there any questions? [LB847]

SENATOR ASHFORD: Senator Lautenbaugh. [LB847]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thank you for bringing this, Senator Council. Did we also do a bill this year that increased the jurisdictional limit for Small Claims Court? [LB847]

SENATOR COUNCIL: Yes. [LB847]

SENATOR LAUTENBAUGH: So, arguably, that must be becoming more important as

the dollar amounts involved can become more important as well. [LB847]

SENATOR COUNCIL: Exactly. As those limits increase, litigants who, unfortunately, are the subject of a default judgment really would want to have an opportunity to have that set aside. [LB847]

SENATOR LAUTENBAUGH: I've had to remove things from small claims before and handle them and whatnot, and I realize that there may be a lot of things we need to address in small claims, and this is one of them. And I applaud you for bringing it. [LB847]

SENATOR COUNCIL: Thank you. [LB847]

SENATOR ASHFORD: Thank you, Senator Council. Proponents of this bill, LB847. [LB847]

ANGELA BURMEISTER: Angela Burmeister, A-n-g-e-l-a B-u-r-m-e-i-s-t-e-r. I'm an attorney practicing primarily in Omaha. I'm here testifying on behalf of the Nebraska State Bar Association. We would like to thank Senator Council for bringing this bill to the Legislature to address this problem. As the senator pointed out, prior to 1-1-09, the appeal to a district court for a small claims litigant was a review of de novo which means they get a whole new trial at that level, and so the statutes that are in place now that would allow a litigant from Small Claims Court to have an undoing or a vacating of a default judgment, they prohibit the Small Claims Court litigant from utilizing them, conceivably because they had the right to a whole new trial. Now that that change has been made and the review is error on the record, so they don't get a whole new trial. Those other statutes that are in place that afford that protection when a default judgment is entered are still prohibiting a Small Claims Court litigant from having that ability, and the result of that is, is that you cannot undo a default judgment right now in Small Claims Court. My particular client's issue...the reason that she failed to appear at her Small Claims Court trial was there was a death in her family, and we were unable to undo it because the statutes prohibit it, so this bill would allow a means for undoing a default judgment that is consistent with the way that we do it in the other courts. It also has judicial economy and efficiency in mind, and we're trying to have a means that makes some sense for the Small Claims Court without taxing all the courts with a lot of extras. With regard to the issue of the attorney's appearance, it allows the attorneys to appear for the sole purpose, or I guess broadens the attorney's appearance for the sole purpose of assisting with that vacating of a default judgment which can be a complicated procedure if you have to go beyond the ten-day time limit, so it only broadens it for that sole purpose. [LB847]

SENATOR ASHFORD: Thank you, Angela. Any questions of Angela? Thank you. Any other proponents of this bill? Any opponents? Neutral testifiers? Senator Council.

[LB847]

SENATOR COUNCIL: Waive closing. [LB847]

SENATOR ASHFORD: Senator Council waives closing. Senator Lautenbaugh, LB1043. [LB847]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman and members of the committee. LB1043, I believe, I put in to address sort of an inconsistency between some of the district courts and county courts as to how we're handling medical bills. I think there's a difference between how it's done in Douglas County versus how it may be done elsewhere. In a nutshell, what LB1043 does is provides for evidence to be issued of not what the face value of the bill says, but also what was actually paid on the bill as a means of rebutting the actual expenses that a plaintiff may have incurred. It changes evidentiary roles to allow such an inquiry, still preserves the long-held rule, if you will, that evidence of insurance coverage does not come in, that it would just be a mechanism for handling it whether it be a presentation of evidence after discovery on the issue of what was actually incurred. I'd be happy to take any questions you may have. I know there's some proponents coming as well, but I'd be happy to take them as well. [LB1043]

SENATOR ASHFORD: Thank you. Any questions of Scott? Seeing none, thank you. Proponents of LB1043? Korby. [LB1043]

KORBY GILBERTSON: Good afternoon, Chairman Ashford, members of the committee. For the record, my name is Korby Gilbertson. It's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as a registered lobbyist on behalf of the Property Casualty Insurers Association of America in support of LB1043. The language that we're dealing with in LB1043 was the result of a floor amendment done, I believe, in 2008, and I think it was a bill on Select File, and I remember standing out in the Rotunda, and someone ran out and said, did you see what got filed? And the argument was, well, this is the way all of the courts do it, so we should put this in statute and, obviously, it was adopted in advance before any of us could rally the troops and do anything. And so I think that this serves as a good time for there to actually be some debate on the issue of what we feel is a commonsense approach to actually give people their damages, their actual damages rather than to provide for a windfall for a plaintiff in these types of cases because it does create a double standard for general healthcare liability claims versus personal injury claims, and we think that this is a more fair approach. I'd be happy to take any questions. [LB1043]

SENATOR ASHFORD: Senator Lathrop. [LB1043]

SENATOR LATHROP: You know, Korby, I don't want to overreact to your comments,

but there were three people...three insurance people in the lobby. That bill...that amendment got run by all three of them. They all said, that's the law? Yeah, sure, it doesn't do anything. So I'm a little concerned that you'd come in and represent that somehow there was some kind of a sleight of hand on Select File and misrepresent it. Here's the question, though, ultimately. And that is, whether insurance companies who insure, for example, drunk drivers that cause people to get hurt should have the benefit of a discount on a health insurance policy I bought and paid for myself or whether I should. And you would change the rule of this bill, so that property and casualty insurance companies get the benefit of a discount on my medical bills that I secured because I bought health insurance, and that would be the effect of this. [LB1043]

KORBY GILBERTSON: I think the argument would be, you would buy that health insurance regardless of that, and why should you be getting a windfall because of that type of case instead of paying for the actual damages? [LB1043]

SENATOR LATHROP: Well, somebody is going to realize the difference between the amount of the medical bills sent out by the hospital and the amount my health insurance pays. Is that true? [LB1043]

KORBY GILBERTSON: The difference between that? [LB1043]

SENATOR LATHROP: There is a discount. If I have health insurance, my health insurance company that I've paid is going to get a discount... [LB1043]

KORBY GILBERTSON: That's right. [LB1043]

SENATOR LATHROP: ...for me on my care. And the question is whether that should go to you, the insurance company, the company that insures the drunk driver, or whether it should go to me, the guy that bought the policy. [LB1043]

KORBY GILBERTSON: I think our argument is that the insurance company or whoever is paying the claim should have to pay the actual amount that is paid regardless of whether or not it's private pay or an insurance coverage. If, for some reason, you don't have insurance coverage, and you're able to cut a deal with the provider, so then should they not be able, if you don't have insurance? I went to a doctor and said, you know, I don't have insurance. Could I pay this amount of money? Should then the insurance company still have to pay the rack rate for whatever that service was? [LB1043]

SENATOR LATHROP: Well,... [LB1043]

KORBY GILBERTSON: I think that it's not just an insurance issue. You can look at it for any type of deal you would make. [LB1043]

SENATOR LATHROP: Without...without going into the long division and taking up a lot of people's time today, this would be a repeal of the collateral source rule, though, would you agree? [LB1043]

KORBY GILBERTSON: I think that was the argument made when the amendment was presented to those of us who were in the Rotunda and we...I trust that we can bring... [LB1043]

SENATOR LATHROP: And, incidentally, it represented the latest pronouncement by the Supreme Court on the subject matter as well. [LB1043]

KORBY GILBERTSON: And that's what the argument was made. That's the argument that was made there, and that's why we did not do anything at the time. [LB1043]

SENATOR LATHROP: Well, do you disagree with that, Korby? [LB1043]

KORBY GILBERTSON: I would not. [LB1043]

SENATOR LATHROP: Okay. Thank you. [LB1043]

SENATOR ASHFORD: Senator Lautenbaugh, do you have a question? [LB1043]

SENATOR LAUTENBAUGH: Yes, I do, Senator Ashford. Thank you. Now, Korby, it's not always the case that the defendant has insurance, is it? [LB1043]

KORBY GILBERTSON: That's...I think...I was trying to make that point when I said, so if the person didn't have insurance and they were able to get a different rate, how do you determine that then? This would just allow other evidence to come in and look at the actual cost of the claim. [LB1043]

SENATOR LAUTENBAUGH: It's possible that neither party has insurance. Is that the case? [LB1043]

KORBY GILBERTSON: Absolutely. [LB1043]

SENATOR LAUTENBAUGH: So you could have a plaintiff whose bills are paid by the government. Now if there's a full recovery of the face value of the bills, the government doesn't get that money back, does it, under current law? If you have a defendant who has a $25,000 policy and $100,000 comes down as the award or the jury verdict, they don't have insurance for the $75,000 do they? [LB1043]

KORBY GILBERTSON: No. [LB1043]

SENATOR LAUTENBAUGH: So this doesn't necessarily represent a windfall just to an insurance carrier who's defending someone. [LB1043]

KORBY GILBERTSON: No. [LB1043]

SENATOR LAUTENBAUGH: Those defendants are actually people, not necessarily insurance companies. [LB1043]

KORBY GILBERTSON: Yes. I would agree. [LB1043]

SENATOR LAUTENBAUGH: Thank you. [LB1043]

SENATOR ASHFORD: Thank you, Korby. [LB1043]

KORBY GILBERTSON: Thank you. [LB1043]

SENATOR ASHFORD: Tad, how are you? [LB1043]

TAD FRAIZER: Thank you, Senator. Good afternoon, Senator, Senators. My name is Tad Fraizer, T-a-d F-r-a-i-z-e-r, representing the American Insurance Association, a national trade association of property and casualty insurers. And just in the interest of time, I'd simply like to echo the thrust of Ms. Gilbertson's comments on the bill. With respect to Senator Lathrop, I was not involved in the discussions at the time of the prior legislation, so our support is more on just the thrust of the bill as currently written. And I'd be pleased to attempt to answer any questions you might have. [LB1043]

SENATOR ASHFORD: Any questions of Tad? Thank you. [LB1043]

TAD FRAIZER: Thank you. [LB1043]

SENATOR ASHFORD: Any other proponents? [LB1043]

CATHY TRENT-VILIM: Good morning, Senator Ashford, members of the Judiciary Committee. My name is Cathy Trent-Vilim, C-a-t-h-y T-r-e-n-t-V-i-l-i-m. I'm an attorney at Lamson, Dugan, and Murray in Omaha, Nebraska, and I'm here on behalf of the Nebraska Defense Counsel Association. I would like to thank Senator Lautenbaugh for bringing the bill. For those of you who are not practicing attorneys, you may not understand necessarily the issue in this case, and essentially what happens is a lot of times when you have somebody who is injured, they receive medical treatment; they receive a bill, and then if they have private health insurance or if they have some type of governmental insurance, they receive a discount. And sometimes that discount can be very significant. It can be anywhere from 10 percent to 60 percent or more, and so, for example, in a situation where you have $100,000 in billed medical expenses, in some

cases, it may be only $40,000 of that bill is actually paid, and that satisfies the complete payment for those medical bills. And so we're talking about a significant amount of money, especially when you start looking at it from the macro level. And as previously discussed, the way that the current statute came into effect, it didn't come through committee. There wasn't an opportunity to have a debate on the topic, and so we wanted to have an opportunity to kind of point out some of the issues that are raised by the current version of the statute. And essentially, with deference to Senator Lathrop, I don't think that this does do away with the collateral source rule. Historically, the collateral source rule prevented a tortfeasor from getting the benefits of the third party payment, and that's really not what this bill does. We're not looking to deduct from a plaintiff's damages the amount of medical bills that are paid by their insurer. All we're looking to do is actually make the plaintiff whole and in this particular case, making the plaintiff whole means compensating him in accordance with what amount was paid. And in addition, this bill goes one step further because what it also allows the plaintiff to do is to put on evidence of how much they paid in procuring their health insurance policy. So in your situation, Senator Lathrop, you would actually be able to put on evidence of how much you paid to procure that health insurance policy that led to those contractual discounts. And so in this particular case, what this bill does, it actually prevents anybody from getting a windfall because the plaintiff is made whole because they are paid the amount that the medical bills are paid; they're also compensated for the amount that they had to pay out of pocket for the health insurance that led to the contractual benefit, and the defendant is not required to pay any more above and beyond what was actually paid to satisfy the medical bills. You know, one thing that having the amount come in that is billed versus paid is it causes an increase in insurance for liability carriers because instead of paying the $40,000 that was used to satisfy a medical bill, instead they have to pay $100,000. And, obviously, that cost is going to get passed along to the people who are purchasing the insurance, and so, ultimately, what this does is it limits the cost; it makes the plaintiff whole, and allows the plaintiff to recover for any expenses that they've incurred as a result of obtaining that contractual benefit. [LB1043]

SENATOR ASHFORD: Okay. Good. Thank you. [LB1043]

CATHY TRENT-VILIM: Any questions? [LB1043]

SENATOR ASHFORD: I don't see any questions. You clearly explained your position. [LB1043]

CATHY TRENT-VILIM: Thank you. [LB1043]

SENATOR ASHFORD: Next...next proponent. Opponent? [LB1043]

ROBERT MOODIE: I'm not sure who I give this to anymore. [LB1043]

SENATOR ASHFORD: Sarah. [LB1043]

ROBERT MOODIE: Mr. Chairman, members of the committee, my name is Robert R. Moodie, M-o-o-d-i-e, testifying on behalf of the Nebraska Association of Trial Attorneys in opposition to LB1043. As sometimes happens when I appear before this committee, several of my points have already been made by Senator Lathrop and his questions. But the essential message that I would give is that this bill is going to provide an advantage for the bad drivers at the expense of the good drivers. And if I had been paying for health insurance and thereby secured a reduction and negotiated a reduction because my health insurance company has made that contract, then I should receive the benefit of the reduction that I paid for. Now, I've looked in the statute, and I saw that a previous testifier referring to the costs of procuring that, and I'm not sure what that means. I'm 51 years old, and I've been paying for health insurance for, you know, by myself for 30 years. Am I going to recover 30 years' worth of health insurance payments? Am I going to recover the health insurance payment that is prorated to the day that I had my accident? I think the way the law is at this point, the benefit...and it's not a windfall, but the benefit of what has been negotiated with medical providers should fall to the policyholder who paid the premium and was responsible enough to put himself in that position, not to the benefit of the driver who was irresponsible enough to cause an accident which has resulted in injuries. [LB1043]

SENATOR ASHFORD: Any questions of Robert? Yes, Senator Lautenbaugh. [LB1043]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thanks for coming today, Mr. Moodie. You're speaking of plaintiffs as if they all had private health insurance. What if it's Medicare or Medicaid that pays the bills? Does your argument still hold up that it's not fair to take into account the discount because they paid for insurance all the years that they haven't? [LB1043]

ROBERT MOODIE: Well, the Medicare or Medicaid...well, I'm not sure I'd throw Medicare and Medicaid into the same category because Medicare deals with its issues on subrogation in a completely different manner than Medicaid does. The point that I guess I would make is that once these settlements come into play, Medicaid is generally the people are going to end up being off Medicaid because, at that point, they no longer qualify for the threshold requirements that entitled them in the first place. The argument does make a certain amount of...does make a certain amount of difference, but I'm not sure how you can abolish the rule for one and deal with Medicaid recipients in a completely different issue. [LB1043]

SENATOR LAUTENBAUGH: Okay. We just make a different rule for private insurance that the plaintiff has paid for versus everything else if that would address your concern? [LB1043]

ROBERT MOODIE: I don't know. [LB1043]

SENATOR LAUTENBAUGH: How about the circumstance where there's no insurance at all, but the plaintiff has been savvy and negotiated 50 cents on the dollar? [LB1043]

ROBERT MOODIE: I think that one...I think that example points out my argument even better because in that situation where the patient...the plaintiff patient has negotiated a better deal, that then is providing the benefit directly to the bad driver. Okay? Where if I can and I will and I deal with my providers to negotiate a better deal, why should the benefit of my efforts to negotiate a better deal not benefit me? [LB1043]

SENATOR LAUTENBAUGH: Well, if you're seeking damages from someone, shouldn't you actually seek what you've actually paid? [LB1043]

ROBERT MOODIE: Well, the way the law is written, the damages should be for the reasonable and necessary medical bills. [LB1043]

SENATOR LAUTENBAUGH: I agree that's what the current law says. I'm saying if he's negotiated a better deal, this plaintiff has, why is he entitled to recover more from the other driver? [LB1043]

ROBERT MOODIE: Well, and I...nobody is going to negotiate a better deal if they can't make a better deal for themselves. I'm certainly not going to negotiate a better deal that benefits the drunk driver who ran into me. [LB1043]

SENATOR LAUTENBAUGH: Well, I don't know if that's the case, and every defendant isn't drunk. I think that was the hypothetical that was thrown out first, but... [LB1043]

ROBERT MOODIE: Well, every...I mean, and you're right...shouldn't use that, but I can and suggest that we should use the word bad driver for the defendant. If the defendant is paying...if there was...if he was negligent and he caused the accident for whatever reason, my negotiations with my medical provider should not benefit the bad driver. They should benefit me. [LB1043]

SENATOR LAUTENBAUGH: Okay, thank you. [LB1043]

SENATOR ASHFORD: Thanks, Bob. Any other proponents? Or opponents, I'm sorry. Any neutral testifiers? I believe that completes the testimony. Do you wish to close, Senator Lautenbaugh? [LB1043]

SENATOR LAUTENBAUGH: Just briefly. Of course, I'm happy to discuss any resolution of this with anyone who might have different ideas, and... [LB1043]

SENATOR ASHFORD: Probably won't be this afternoon, but (laughter)... [LB1043]

SENATOR LAUTENBAUGH: Probably not. We have other things on our plate today. [LB1043]

SENATOR ASHFORD: Okay. That concludes the hearings on the three bills that...and I appreciate everybody that came at 12:30. Thank you for coming. Thank you to the committee. And okay, we're going to turn to LB1103, but we're going to do that at 1:30, so we're at halftime here. We have a little break. I want to...told everybody 1:30 would be the starting time, so we will start at 1:30. [LB1043]

BREAK

SENATOR ASHFORD: (Recorder malfunction)...will be coming in the next few minutes and we will begin. We are here today, we have one bill only and...LB1103, which is Speaker Flood's bill. Let me...we're going to try to complete the hearing at around 4:00. I've discussed with the potential testifiers the...kind of the guidelines and how we would like to proceed with the testimony and I do have a list, and I appreciate receiving it, a list of testifiers on either side of LB1103. And there...okay, and there may be, obviously, neutral testifiers that would come in and testify after the opponents. But I do have a list of proponents and opponents, and we will try to stick as closely as possible with the agreed upon time frames. Let me introduce my colleagues who are here. My name is Brad Ashford. I am from Omaha. My colleagues to my right are Senator Kent Rogert from Tekamah, Nebraska; Steve Lathrop, the Vice Chair of the committee, is from Ralston; Brenda...I'm sorry, Amanda McGill, (laugh)...

SENATOR McGILL: Hello.

SENATOR ASHFORD: ...Senator Amanda McGill from Lincoln; Senator Brenda Council from Omaha; and Senator Colby Coash from Lincoln. Stacey Trout is the legal counsel. Christina Case is committee clerk. And Sarah and Jamie are here, Sarah McCallister and Jamie Myers who are with us at every hearing and do a wonderful job as the pages. Senator Mark Christensen from Imperial has just come in and Senator Scott Lautenbaugh from Blair and Omaha, both. So there are a few basic rules. One is, and you hear this at all these hearings, but we'd ask you to turn off your cell phones, if you would. There are pages that can...obviously Sarah and Jamie, and if you have exhibits that you would like us to reference and take a look at, you can submit those to the pages. If you are here and have a position on the bill, LB1103, and are not able to testify or do not wish to testify, there are sheets in the back where you can indicate your support or your opposition to these bills. Before you come up and testify, there is a sign-up sheet at the desk and we'd ask you to give us your information. I think that pretty well starts...we can now start the hearing with Speaker Flood.

SENATOR FLOOD: (Exhibits 1, 2, 3, and 4) Good afternoon, Chairman Ashford, members of the Judiciary Committee. For the record, my name is Mike Flood, F-l-o-o-d, and I represent Legislative District 19, which includes the city of Norfolk and all of Madison County. I recognize at the outset that there is probably no more divisive political issue than abortion, but I hope to set us on a track for an honest, civil, and thoughtful discussion of this bill, both this afternoon and throughout the legislative process. In the wake of Dr. Tiller's murder in Kansas, Dr. Carhart, a Bellevue physician, commented to the press that he was considering expanding his late-term abortion practice. His comments at the time highlighted an issue I have given much consideration. While I believe all innocent human life should be given protections by the state, as a lawyer I recognize that a law that bans all abortions would be quickly struck down by the U.S. Supreme Court. I believe that this bill, LB1103, presents a middle ground on which folks on both sides of the abortion divide might agree. LB1103 doesn't prohibit all abortions. It doesn't prohibit most abortions. It only prohibits, with certain exceptions, late-term abortions after 20 weeks, after a point in which the unborn baby can feel pain. The Supreme Court has recognized that the state has a duty to define its interest in the abortion debate, and what I hope in today's hearing to establish is that there is a legitimate legal argument to allow for some regulation of abortions that are late term but a couple of weeks prior to viability. LB1103 is premised on several significant factual findings and these findings are contained in Section 3 of the bill: (1) At least by 20 weeks gestation the unborn child has the physical structures necessary to experience pain; (2) There is substantial evidence that by 20 weeks gestation unborn children seed to evade certain stimuli in a manner which in an infant or an adult would be interpreted as a response to pain; (3) Anesthesia is routinely administered to unborn children 20 weeks of age who undergo prenatal surgery; (4) There is substantial evidence that abortion methods used at and after 20 weeks would cause substantial pain to an unborn child; and finally (5) An unborn child is capable of experiencing pain even if the pregnant woman has received local analgesic or general anesthesia. For these factual findings I am relying on the testimony of four doctors who will follow me. Additionally, I'm relying on the testimony of three medical doctors who have done research in the area of fetal pain. At this time, I would like to submit for the record a copy of the congressional testimony of Dr. Robert White and Dr. Curtis Cook, and the testimony of Dr. "Sunny" Anand for the U.S. Department of Justice in the partial-birth abortion litigation. Justice Anthony Kennedy, who is widely regarded as the swing vote on the abortion issue, has emphasized that it is, "inappropriate for the judicial branch to provide an exhaustive list of state interest implicated by abortion." That's found in the dissent in the Stenberg case, 530 U.S. at 961. He also said, "Casey is premised on the states having an important constitutional role in defining their interests in the abortion debate." That's found also in the dissent in Stenberg, 530 U.S. at 961. In other words, as a recent Law Review article in the Journal of Law and Public Policy points out, Gonzales v. Carhart, "shifts the weight of analysis to an outright balancing of state and private interest, ultimately guided by the crucial facts supplied by the Legislature." That's found at 17 J.L. & Pol'y 57,61. It seems reasonable to me that if an unborn child

reaches 20 weeks and has an ability to feel pain, he or she is worthy of the state's protection. Taking a position on the infliction of pain on sentient beings is not something new for the state. Nebraska rightly sets public policy for the proper treatment of animals, and Chapter 28 of our Criminal Code, for example, spells out the offenses against animals for abandonment, neglect, torture, etcetera. Last week, in fact, I read in the Omaha World-Herald that an Omaha woman has been charged with felony animal cruelty for the mistreatment of a German shepherd. We rightly have laws against leaving animals out in the cold without food or water. Abortions after 20 weeks gestation are rare in Nebraska. In the most recent data available from the Department of Health and Human Services in Nebraska, none of the abortions reported were 20 weeks gestation or older. I realize most of the abortions reported did not specify the age of the unborn child, but the national data confirms that abortions after 20 weeks are unusual. One point three percent of abortions performed in 2006 were at or more than 21 weeks gestation, according to CDC data. With these facts in mind, I think LB1103 is a modest and reasonable proposal which fairly balances the privacy rights of a woman with the interest of the state in protecting and promoting fetal life. While the bill does not impact a majority of situations, it will provide a needed protection for the unborn child who is 20 weeks of age from the painful procedures of an abortion. I think an analysis of the constitutionality of LB1103 centers on three main points, and I would refer the committee, in its deliberations, to a memo that was prepared by Matt Boever, a lawyer in my office, which more fully discusses the constitutionality of LB1103. I would like to submit a copy of this memo for the record as well. One objection to LB1103 is that, as discussed in the memo, is that LB1103 would prohibit pre-viability abortions. As you know, Nebraska currently has a post-viability ban on abortions. Viability has been defined by the U.S. Supreme Court as 23 to 24 weeks gestation or perhaps earlier. LB1103, with certain exceptions, draws a bright line at 20 weeks. Thus, it would prohibit abortions at a point in the development of the unborn child three to four weeks earlier than the current law. In the analysis I have done, I think there are several good reasons to think the U.S. Supreme Court would uphold this bill if it had the opportunity. Another constitutional question is the scope of the medical emergency exception language. There are exceptions to the 20-week prohibition for medical emergencies, which the bill defines. The memo that I have submitted discusses this aspect as well, and I am also pleased that regarding these constitutional questions Professor Teresa Stanton Collett from the University of Saint Thomas Law School, and Mary Spaulding Balch with National Right to Life Committee are also able to testify and will be here today following me. With that, I'd like to thank the committee for its consideration of LB1103. I'd be happy to try and answer any questions. [LB1103]

SENATOR ASHFORD: Any questions of Speaker Flood? [LB1103]

SENATOR McGILL: Well, I just have one real quick, and I'm just trying to wrap my mind around everything. I am not an attorney, like you are, so people have been coming to me with some of these constitutionality arguments that I'm trying to wrap my mind

around. Twenty weeks for me, as an individual, I don't have really a moral problem with that. I'm on board generally. But people have said to me, and I'm not seeing in the memo yet and I've just got this, but there's a case that's been brought to me from, looks like 1979 with the United States Supreme Court, that says that a legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability whether it be weeks of gestation or fetal weight or a single factor as the determination when a state has a compelling interest in the life or health of a fetus. Do you know any...do you have any thoughts or, you know, according to this case, they're saying a week limit might not be constitutional. [LB1103]

SENATOR FLOOD: Well, I think the controlling case in this matter is obviously Gonzales v. Carhart, a recent...the most recent abortion law decision from the U.S. Supreme Court, and I wrestled with that issue when I drafted the bill. Two things: Justice Kennedy, in his opinion written for the majority, states very clearly that states have wide discretion when it comes to matters of scientific uncertainty, which opened one door for me, but what really caught my attention in Gonzales v. Carhart was Justice Ginsburg's dissent. She's obviously a supporter of Roe v. Wade, believes it is good law, and she clearly said in her dissent that the Supreme Court in Gonzales walked away from, in her opinion, pre- and post-viability abortions, and went on to state in her dissent that the Gonzales v. Carhart case blurs the line between pre- and post-viability abortions. And that is discussed, I believe, in my memo in the midsection of it, so I would offer that to the committee as a response to what I think is a very good question. [LB1103]

SENATOR McGILL: Okay. Thank you, Mr. Speaker. [LB1103]

SENATOR ASHFORD: Thanks. Yes, Senator Council. [LB1103]

SENATOR COUNCIL: Yes, thank you, Senator Ashford and Senator Flood. My concerns also revolve around issues of constitutionality. And admittedly this, your memorandum, was just handed to me, but in terms of, and I will confess limited study of these cases, the issue in the Franklin case in 1979, my reading of that case was that the Supreme Court definitively rejected as unconstitutional fixed gestational limits for determining viability. Do you agree that that's what the ruling was in '79? [LB1103]

SENATOR FLOOD: I have reason to believe that is what the ruling is. I, without the case in front of me and without any specific quotations, I defer to Professor Collett from Saint Thomas to address that issue with you. [LB1103]

SENATOR COUNCIL: Okay. Well, and maybe I'll defer the questions to that time because then your next statement is that Gonzales, the decision in Gonzales blurred the lines on that issue. Now my reading of Gonzales, while it did deal with the issue of late-term abortions, as I read Gonzales, what was being addressed there and what the

court stated that the federal legislation was constitutional had to do with the actual, what do I want to...how do I want to...procedure that was employed. And I've got the...I have it somewhere, specifically the ban prohibits deliberately and intentionally vaginally delivering a living fetus past certain anatomical landmarks for the purpose of performing an overt act that the person knows will kill the partially delivered, living fetus. And my reading and certainly others who come after you can certainly disagree with, is that that is the basis of the decision in Gonzales, that it dealt with the actual procedure itself at that point in the pregnancy, not so much the point in the pregnancy. And like I say, if you don't feel comfortable responding to that, I'll certainly ask that question to later testifiers. But the bottom line is if I'm correct in my reading of Gonzales and if I am correct in my analysis of Supreme Court decisions, that when the Supreme Court has an opportunity to expressly reverse a prior holding, they do that. And in my reading of Gonzales, I don't see any expressed reversal of its decision in the Franklin case. [LB1103]

SENATOR FLOOD: You know...if I may respond, Senator Council? [LB1103]

SENATOR COUNCIL: Yes. It is a question, although it sounds like it isn't. (Laughter) [LB1103]

SENATOR FLOOD: I read, you know, I read Gonzales very carefully to see whether I felt there was a basis for the bill that I introduced, and what I saw the court doing in Gonzales was, for the first time, referring to the unborn child as a baby. I saw the court stating Justice Kennedy's statement where he says, "The court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." The traditional rule is consistent with Casey, which confirmed the state's interest in promoting respect for human life at all stages in the pregnancy. Obviously, we see the ruling in Gonzales differently, but I think what you have to acknowledge is the court opened several doors to what my bill proposes. My bill does not center around the issue of viability. It creates a new standard and it connects that standard with legitimate and substantial interests of the state, and that interest is different than viability. That interest is protecting an unborn child from feeling pain during an abortion. So we may disagree on that point. Professor Collett I think will do a very good job of distinguishing some of the cases for you, and I'd be happy to come back in my closing and answer any additional questions you have. [LB1103]

SENATOR COUNCIL: Okay. So in that regard, it's your position, Senator Flood, that LB1103 does not fix the gestational limits for determining viability. [LB1103]

SENATOR FLOOD: Well, there is a bright line, but that bright line is connected to a new standard, that being fetal pain, and the standard is at 20 weeks, science, compelling science, medical research, which you'll hear more about today, identifies or suggests and believes and states that babies feel pain at 20 weeks. And for that reason, the state

has the ability to put a bright line rule in effect. [LB1103]

SENATOR COUNCIL: Would you agree that if LB1103 is passed in its current state that the likelihood of a constitutional challenge to this legislation would be forthcoming? [LB1103]

SENATOR FLOOD: I would have to agree with you based solely on the comments that I've seen from the state's abortion physician, Dr. Carhart, in his interest in challenging any ban that goes into effect, but other than that I would have no basis to predict a challenge. [LB1103]

SENATOR COUNCIL: And one other question: As the sponsor of the legislation, I have some difficulty understanding why it's your belief that no condition shall..."no such condition shall be deemed to exist if it is based on a claim or a diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function." I read that to say that the intent of this legislation is to ignore any medical evidence that the mother would be likely to commit suicide or some other serious bodily harm to themselves, that that factor is to be ignored, that the mental health issues associated with continuing the pregnancy is to be ignored. [LB1103]

SENATOR FLOOD: Where do you...what page and line number are you on? [LB1103]

SENATOR COUNCIL: Page 5, Section 5 says, "No person shall perform... [LB1103]

SENATOR FLOOD: Okay. [LB1103]

SENATOR COUNCIL: ...or induce or attempt to perform or induce an abortion upon a woman when the probable gestational age of the woman's unborn child is 20 or more weeks unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment." The next sentence, "No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function." So as I read that, the intent of this is it doesn't matter what the mental state of the mother would be as a result of this, and it wouldn't even matter if there was a clear diagnosis of suicidal ideations and...doesn't matter. If the mother would commit suicide if required to continue the pregnancy, that doesn't matter. [LB1103]

SENATOR FLOOD: Senator Council, if I may, you misrepresent the intent of my bill. I believe that a physician that encounters a patient that is exhibiting suicidal behavior, thoughts, or tendencies also has a duty to ensure that, and in any emergency situation,

the individual is placed in emergency protective custody so that the behavioral health system in the state of Nebraska can take steps to ensure her safety and the safety of others. You're assuming, if I may, that the only option is to perform an abortion if someone exhibits suicidal behavior. I think the first and the most reasonable option under our law, under the Mental Health Commitment Act and the emergency protective custody statutes, is to notify law enforcement or an emergency room and have this patient treated for a mental health condition, if that is the behavior that is being exhibited by the patient. If there are suicidal thoughts or tendencies, that clearly would be consistent...that clearly would fall under the Mental Health Commitment Act, which we have passed and most recently revised in LB1083 in 2004. [LB1103]

SENATOR COUNCIL: Well, aren't you assuming, Senator Flood, that the treatment of that condition would not require medication that would potentially place both the fetus and the mother at risk? [LB1103]

SENATOR FLOOD: I think when those thoughts are presented to a physician that's engaged in the practice of providing abortions, that the most reasonable next step for the physician would be to refer that individual to a specialist that handles behavioral healthcare matters, a psychiatrist licensed in the state of Nebraska, to make an evaluation and then make a determination as to what the best possible course of treatment is. As to the potential drugs that would be given to the patient, I believe that assumes two steps down the road that we haven't gotten to yet. I'm sure that psychiatrists treat patients every day that are pregnant and that they are...they have treatment protocols consistent with good medical practice that protect the life of the baby and allow the mother to receive needed healthcare. [LB1103]

SENATOR COUNCIL: So in your opinion, it would never arise that the best course of treatment under that hypothetical may be to terminate that pregnancy. [LB1103]

SENATOR FLOOD: I believe the intent of my bill, in Section 5, page 5, line 10, would suggest that, given the fact that I do believe that the behavioral health community has options to treat women with mental illness during pregnancy. [LB1103]

SENATOR COUNCIL: But that doesn't answer my question, Senator Flood. My question is if the mental health community says that it's in that mother's best interest, under her mental incapacity, to terminate that pregnancy, wouldn't your bill prevent that? [LB1103]

SENATOR FLOOD: You are asking a legal question that's connected to a medical issue and I have four credentialed physicians following me and I would ask them to answer that, with their medical judgment and the training they have in the laws, they deal with patients, to give you a very clear answer. I'm not attempting to evade your question. I want you to have the best information on the record because I haven't...I haven't fully

considered all of the scenarios that you've presented. I do believe the bill speaks for itself. My intent is not to prohibit or...women from getting healthcare for a behavioral health issue. I don't feel that an unborn child should suffer because an abortion provider believes that that's the only method to address the behavioral health concern. [LB1103]

SENATOR COUNCIL: Okay. And I will, with all due respect, your last statement assumed that it would be the abortion provider. I was basing my question on your scenario that the abortion provider is under a duty to refer that patient to a mental healthcare provider and if that mental healthcare provider, under his or her best professional judgment, believes that the pregnancy should be terminated, and that's in the best interests of the mother's mental health, the question was doesn't that language on page 5 prohibit that from occurring? [LB1103]

SENATOR FLOOD: I think the answer is yes, and I think you raise a medical ethics question that will be addressed by physicians that follow me. [LB1103]

SENATOR ASHFORD: Thank you, Speaker Flood. [LB1103]

SENATOR McGILL: I just have a quick comment. [LB1103]

SENATOR ASHFORD: Oh, Senator McGill. [LB1103]

SENATOR McGILL: And this isn't even so much for Speaker Flood as it is for other people in the room, but I just want to draw attention to, very briefly, the other hearing that's going on at HHS right now dealing with prenatal care, and we as senators have received e-mails from women who were scared that they would no longer have coverage, who said in their e-mails that they were considering abortion, and I just want to make sure everyone here recognizes the impact that our state laws and our other policies have on a woman's state of mind and her mental health when she's in a situation like that and scared about not having proper healthcare or the economics to care for a child. So I hope that as all of you are here looking at this legislation, you're also thinking about the other end of things and the tough situations that women are put in sometimes due to us. So thank you. [LB1103]

SENATOR ASHFORD: Thank you, Senator McGill. Senator Lautenbaugh. You're not done yet, Speaker Flood, apparently. [LB1103]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thank you, Mr. Speaker. I want to make sure I understand some of your prior testimony. In your opinion, your bill really doesn't turn on the issue of viability but when the fetus can feel pain. [LB1103]

SENATOR FLOOD: That's true. [LB1103]

SENATOR LAUTENBAUGH: And is it your belief that since technology marches on and we've made such strides that it's at least possible that opinions from 20-30 years ago might not hold a lot of validity anymore based upon what we know now? [LB1103]

SENATOR FLOOD: Absolutely, that's a great point. I do believe that. [LB1103]

SENATOR LAUTENBAUGH: Thank you. [LB1103]

SENATOR ASHFORD: Not that 20 or 30 years ago is a long time ago. (Laughter) [LB1103]

SENATOR LAUTENBAUGH: It's a lifetime. [LB1103]

SENATOR ASHFORD: Okay. [LB1103]

SENATOR McGILL: I wasn't born yet, Senator Ashford. (Laugh) [LB1103]

SENATOR ASHFORD: Thank you. Thank you. Thank you, Speaker Flood. [LB1103]

SENATOR FLOOD: I will close. Thank you. [LB1103]

SENATOR ASHFORD: We have...here's what we're going to do. I'm going to...we have...and I'm going to get, hopefully, not get the pronunciation wrong, but Salvacion, is that correct? Dr. Salvacion and Dr. Grissom is also here. Normally, we ask the testifiers to limit their testimony to around three minutes and we have a light system that tells you that when it's time to sum up the yellow light comes on. It's been requested that Dr. Salvacion and Dr. Grissom would have more time and so I'm going to allocate seven minutes for your introductory comments and try to keep it to that, and then there, I'm certain, will probably be some questions. So with that, and then Dr. Grissom as well, seven minutes, and then we'll decide where we are, go from there. Go ahead. [LB1103]

FERDINAND SALVACION: (Exhibit 5) Thank you. Chairperson Ashford and members of the Judiciary Committee, my name is Ferdinand Salvacion, M.D. I am the medical director of the pain management program at Memorial Medical Center in Springfield, Illinois. I have an appointment to clinical faculty as associate professor of anesthesiology at Southern Illinois School of Medicine. I am board certified in anesthesiology and pain medicine. I have been practicing exclusively in the specialty of pain medicine since 1996. I appreciate the invitation to testify before the Nebraska Legislature Judiciary Committee on the topic of fetal pain. I understand the committee is considering Nebraska LB1103, the Abortion Pain Prevention Act. I will focus my testimony on our understanding of pain, the anatomy and physiology required for pain perception, and the capacity of a fetus to experience pain. In the interest of time, I will summarize the most important points of my written testimony. First, what is pain? The

International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Note: The inability to communicate verbally does not negate the possibility that an individual is experiencing pain." Pain can be expressed nonverbally by movement in responses to a stimulus or physiological changes, such as changes in heart rate or blood pressure. Despite discrete physiological changes that occur in response to pain, its measurement and expression is always subjective. Because of this subjectivity we cannot "know" what the feeling of pain is like for another person. Anatomy and Physiology: The sequence of events by which a painful stimulus is perceived involves four processes: (1) transduction, (2) transmission, (3) modulation, and (4) perception. Transduction is the initiation of the pain response. Specialized sensory nerve cells are found in the tissues of the skin, muscles, bones, and organs. They respond to different forms of energy, such as mechanical, heat, or cold, and convert this information into electrical activity. Transmission is the process by which this electrical activity is conducted through the nervous system. Signals travel from the peripheral nerves to second order neurons in the spinal cord, to structures in the brainstem and diencephalon. Finally, neurons in the brainstem and diencephalon send projections to the various cortex structures in the highest area of the brain. Modulation is the process whereby neural activity may be altered along the pain transmission pathway. Tracks descend from exons in the brain and spinal cord, which can reduce the transmission of painful signals. Perception is the final stage of the process where we become aware of pain. It results presumably from activation of the various cortical structures of the brain. The capacity of the fetus to experience pain: There are several. First, anatomical development. It has been well established in the scientific literature that all the neural components required for processing perception of pain are present in the fetus by 20 weeks gestational age. The neurotransmitters in the spinal cord that mediate pain transmission appear early in development and are abundant. In contrast, the neurotransmitters used in modulation of pain transmission are not expressed fully until after birth. As a result, the pain pathways and the ability to perceive painful stimuli are developed in the fetus, while the ability to ameliorate pain through descending pathways and endogenous opioids is not. Electroencephalography: This is the most objective way of assessing general cortical function. Electroencephalograms, also known as EEGs, identify and measure discrete electrical activity from cortical neurons. EEG activity is seen by 19 to 20 weeks gestational age, and sustained patterns can be recorded from fetuses of 23 weeks gestational age. Somatosensory evoked potentials test the entire path of nerve transmission from peripheral sensory fibers all the way to the somatosensory cortex in the brain. SEPs can be recorded in the fetus after 24 weeks gestational age. SEPs and EEGs are evidence of pain processing and perception of pain in the fetus. Stress responses: Pain and surgical stress are demonstrated by a coordinated outpouring of hormones from the pancreas, pituitary, and adrenal glands. Cardiovascular responses, such as elevation in blood pressure and heart rate, may signal pain. Fetuses have been observed to exhibit hormonal stress responses to painful stimuli as early as 16 weeks gestational age. In addition, these

responses were reduced when pain medication was administered directly to the fetus, demonstrating pain processing and the ability to ameliorate pain pharmacologically is present in the fetus. Behavior: ultrasonographic findings report specific fetal movements in response to punctures in utero. Preterm neonates born at 23 weeks gestational age show highly specific and well-coordinated physiologic and behavioral responses to pain similar to those seen in full-term neonates, older infants, and small children. Fetal anesthesia: Fetal surgery is an area of rapid growth. Surgical intervention is considered for the fetus with a congenital condition that can compromise or disturb cardiovascular function or cause severe postnatal morbidity. The medical community has recognized, given that fetal pain pathways are developed and functional in the fetus, that anesthesia for such surgeries is necessary not only for the mother but the infant as well. Hysterotomy based fetal surgery is best provided by general anesthesia with inhalational agents. While general anesthetic agents can cross the placental barrier and fetal blood/brain barrier, the fetus receives only 50 to 70 percent of maternal levels, and that occurs only after an hour of anesthesia. Prior to fetal incision, the fetus is routinely given additional doses of an opioid to supplement anesthesia and provide postoperative pain relief. Conclusion: A frame of reference does not currently exist for the prenatal condition. We must, therefore, rely on our understanding of the nervous system as well as our interpretations of neurophysiologic data and behavioral responses to develop contemporary interpretation that allow appreciation of fetal experience. Neurophysiologic findings taken together with the observed painful responses of premature infants appear to confirm pain occurs in the fetus. Opioid analgesics administered to the fetus are routinely used to supplement general anesthesia for fetal surgery to minimize procedural pain. Local anesthetics are used to prevent pain from minor procedures in preterm neonates in the ICU setting. Based on the scientific evidence, it is my opinion that human fetuses possess the capacity to experience pain as early as 20 weeks gestational age, and the pain perceived is possibly more intense than that perceived by mature newborns. It is also my opinion that the fetus would be subjected to intense, excruciating pain, occurring prior to fetal demise, from abortion procedures used in the second and third trimesters. That concludes my testimony. I'd be happy to answer questions. [LB1103]

SENATOR ASHFORD: Thank you, Dr. Salvacion. Yes, Senator Lautenbaugh. [LB1103]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thank you for coming today, Doctor. And if you're not the proper person to address this to, just feel free to say so and I'll try again later on. Do you have any knowledge regarding the drugs that a person who is having some sort of mental disability or mental defect or possible suicide risk would be administered and how they might interact with a fetus? [LB1103]

FERDINAND SALVACION: I would not be able to answer that question. Sorry. [LB1103]

SENATOR LAUTENBAUGH: Okay. Thank you. [LB1103]

SENATOR ASHFORD: Just one question, then I'll...could the sensation of pain occur earlier than 20 weeks? [LB1103]

FERDINAND SALVACION: Yes. [LB1103]

SENATOR ASHFORD: How much earlier do you think? [LB1103]

FERDINAND SALVACION: I'm not able to answer that. [LB1103]

SENATOR ASHFORD: Or you have an opinion on 20 weeks but is it possible that it could be 15 weeks? [LB1103]

FERDINAND SALVACION: In some of the studies that we've looked at, there's coordinated pain behavior demonstrated as early as 16 weeks. [LB1103]

SENATOR ASHFORD: Okay. [LB1103]

SENATOR McGILL: So... [LB1103]

SENATOR ASHFORD: Senator McGill. [LB1103]

SENATOR McGILL: ...is your experience directly with fetal issues or in your pain research and business that you do on a day-to-day basis? What is your expertise? [LB1103]

FERDINAND SALVACION: My expertise is in pain management. [LB1103]

SENATOR McGILL: Okay. [LB1103]

FERDINAND SALVACION: I devote my practice entirely to that. [LB1103]

SENATOR McGILL: Okay. [LB1103]

FERDINAND SALVACION: And in my practice I do take care of pediatric patients. [LB1103]

SENATOR McGILL: Okay. [LB1103]

SENATOR ASHFORD: Thank you. [LB1103]

SENATOR COUNCIL: And can I ask? [LB1103]

SENATOR ASHFORD: Yes, Senator Council. [LB1103]

SENATOR COUNCIL: I'm just going to say Doctor because I don't want to massacre you. It's Salvacion? [LB1103]

FERDINAND SALVACION: Yes. [LB1103]

SENATOR COUNCIL: Close. On page 2, under anatomical development, after your discussion of the cerebral cortex and the cortical neurons and thalamus, you say "the structures required for pain perception are present in the fetus by 20 weeks gestational age," and I think I read later that then the assumption is drawn that, since the structures required for pain perception are present, that subjectively the belief is that pain can be experienced because the structures are present. [LB1103]

FERDINAND SALVACION: Yes. [LB1103]

SENATOR COUNCIL: And that's what I'm saying. That's the basis of your theory, and it says the structures are present, ergo, pain could be experienced. [LB1103]

FERDINAND SALVACION: Well, that is one of the components of the argument. The physical structures necessary are already present in the fetus. However, we have these other marker surrogates for pain perception that we can observe as well besides just the anatomy that has been studied. [LB1103]

SENATOR COUNCIL: Okay. And the pain perceptions that you can observe are what through ultrasound or... [LB1103]

FERDINAND SALVACION: Yes. Well, we can measure electrical activity in the brain of the fetus. We can look at these neuro endocrine markers which is the hormones that are released by a fetus under stress. We look at behavior issues, withdrawal from painful stimulus, and we can infer some of that from the behavior of preterm neonates, premature babies that are born as early as 23 weeks. They clearly display pain behavior from the numerous painful procedures they undergo that are necessary for their treatment. [LB1103]

SENATOR COUNCIL: Okay, now and in that regard then what you are...your opinion is, is that the same kind of stimulus and reaction after birth is experienced in the womb. [LB1103]

FERDINAND SALVACION: I'm sorry, could you rephrase that question? [LB1103]

SENATOR COUNCIL: That the same pain that is experienced after birth is experienced in the womb. [LB1103]

FERDINAND SALVACION: Well, Senator, I'm not sure what can be experienced. I'm not sure that we can know what the experience is because of the subjective nature, first, of pain. We can only infer the perception of it based on these surrogate markers, but these are the same markers that we use in our field of anesthesia. When we're anesthetizing an adult or pediatric patient, we observe change, the same physiological changes that are markers for pain--increase in blood pressure, heart rate, movement, alterations in electrical activity, and because of that observation we realize that the patient is experiencing pain and so it alters our medical care of the patient in that state. And an adult anesthetized individual is rendered nonverbal, just the way as a fetus is nonverbal, and so because a patient who is under anesthesia is not able to tell us, or maybe isn't capable of telling us because they're paralyzed as part of their anesthetic, that they're experiencing pain, we go by that to guide our medical care of them. [LB1103]

SENATOR COUNCIL: And can you give me an idea of what type of procedure would necessitate your administration of anesthesia to a fetus? [LB1103]

FERDINAND SALVACION: Well, fetal surgery is frequently done to correct different congenital anomalies that are occurring and that have been identified by ultrasound early in labor, and so when the determination has been made that to do nothing would be...would risk a likely fatal outcome at the time of birth, and the risks of that outweigh the risk to the mother and the fetus to do surgery in midgestation, that's when those surgeries would take place, and they take place in a very highly specialized center. I personally have not been involved in a fetal surgery case so I'm not able to provide any additional details to that. [LB1103]

SENATOR COUNCIL: Okay, so and in terms of your opinion, in terms of the reaction to anesthesia by a fetus, that's based upon not your personal observation or experience but based upon research you've reviewed and considered? [LB1103]

FERDINAND SALVACION: Yes, ma'am. [LB1103]

SENATOR COUNCIL: Thank you. [LB1103]

SENATOR ASHFORD: Thank you, Doctor. Whoops, no, Senator Lautenbaugh. [LB1103]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thank you again, Doctor. So I'm trying to unpack what you just said. It's not that your opinions and observations are based merely upon the fact that at 20 weeks the mechanical structures are in place. What you're saying is you observe the same reactions, if you will, as you would with a postnatal patient under anesthesia to determine if pain is likely present. [LB1103]

FERDINAND SALVACION: Yes. [LB1103]

SENATOR LAUTENBAUGH: Okay. Thank you. [LB1103]

SENATOR ASHFORD: Thank you, sir. [LB1103]

FERDINAND SALVACION: Thank you. [LB1103]

SENATOR ASHFORD: Dr. Grissom. And then Teresa Stanton Collett would be next. Good afternoon. [LB1103]

THOMAS GRISSOM: (Exhibit 6) Senator Ashford and distinguished members of the committee, my name is Tom Grissom, M.D. I'm a physician and medical director of Advanced Pain Centers of Alaska. I'm also a clinical instructor at the University of Washington's pain fellowship program in Seattle and have been practicing pain medicine since 1995. And I may be able to answer some of the questions oriented earlier towards clinical experience with fetal surgery, since I was doing anesthesia up until just a year ago. I appreciate the opportunity to testify before the committee on the topic of fetal pain and I will try to keep my focus, my testimony, on our current understanding of fetal and neonatal physiology and the relationship to pain, and I will be reiterating some of the same things that Dr. Salvacion mentioned. Pain can be defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. This is the definition of pain by the American...sorry, by the International Association for the Study of Pain. Both science and experience show us that the fetus and the preterm infant or neonate are capable of feeling unpleasant sensory impulses and experience actual pain sensation. Pain transmission in the neonate: Study of the preterm infant has helped us to understand pain in fetal development. These preterm infants have the same anatomy and physiology with regards to the nervous system and pain signal transmission. Since the fetus is incapable of verbal communication, other markers for fetal response to pain must be utilized. Specialized nerve endings involved in pain transmission are seen as early as 7 weeks and are found throughout all organs of the body by 20 weeks. These neurons are first order neurons, i.e., they travel from the skin or an organ innervated to the spinal cord. Second order neurons located in the spinal cord develop before 13 weeks and send projections up to the midbrain, thalamus, and eventually to the cortex. All of these structures are present in the fetus by 20 weeks. This means that all the elements for the perception of pain are present by this period of time. Our ability to study the perception of pain focuses on measuring the physiologic responses to painful stimuli. The fetus shows increased levels of circulating hormones, like cortisol and catecholamines in response to painful stimulation. These levels will actually increase in relationship to the level of stimulation. Studies of electrical activity, including EEGs and SEPs, show that the fetus responds to painful stimuli in the same way that infants do by 24 weeks gestation. In fact, the responses are exaggerated

because the fetus does not have the inhibitory descending pathways that develop later on from the brain down to the periphery to blunt these sensations. Anesthesia and the neonate: Up until the late 1980s, preterm infants were not given anesthesia or analgesia with surgical procedures. In 1987, Anand and colleagues showed that preterm infants who are operated on without anesthesia or analgesia had hormonal responses consistent with pain seen in term infants and adults. This and other studies have showed that these hormonal responses could be blunted or eliminated with the administration of anesthesia and analgesic agents. The administration of anesthesia to preterm infants with surgical procedures was also correlated with better outcomes. Today it is routine to provide anesthesia not only to preterm infants as early as 23 weeks but also to the fetus in utero with surgical procedures done prior to 20 weeks gestation. I come before you not on my...based not on my position of pro-life or pro-choice, but because I'm a physician, an anesthesiologist and a pain management physician, and I swore an oath to basically treat patients and to, first, do no harm. As a physician, I cannot sit by in silence on a bill that addresses the topic of fetal pain. LB1103 recognizes that a fetus has an intact nervous system capable of experiencing pain by 20 weeks. This concept of fetal pain has big implications that require objective scientific appraisal of the current literature, independent of the controversy regarding abortion and women's rights. These implications include pain perception in preterm infants, anesthesia for fetal surgery, as well as long-term consequences of perinatal anesthesia and analgesia in brain development. The scientific evidence to support the concept of fetal pain is overwhelming. The knowledge and proof of an intact nervous system, including functional cortex cells at 20 weeks is irrefutable. The response of preterm infants in the fetus in utero to noxious stimuli is quantifiable and directly related to the level of the stimulation. This observation by healthcare providers to the preterm infant exposed to painful stimulation supports the fact, not the concept, of fetal pain. As an anesthesiologist and a pain management physician, I have personally witnessed not only pain response but pain-focused behaviors in the neonatal intensive care unit in infants as early as 23 weeks, and some of my colleagues have seen this same type of behavior in utero with surgical procedures prior to 23 weeks. The medical schools of this country teach physicians and anesthesiologists to provide anesthesia and analgesia to the fetus in utero and to the preterm infant. The medical community is bound by an obligation to treat pain and suffering. An abortive procedure at 20 weeks gestation or later causes pain that is experienced by the fetus and of this there is no doubt. I will take questions. Thank you. [LB1103]

SENATOR ASHFORD: Thank you, Dr. Grissom. Any questions? Senator McGill. [LB1103]

SENATOR McGILL: I certainly won't argue with any of the scientific findings that either of you have presented, but since you brought it up, are you pro-life or pro-choice? [LB1103]

THOMAS GRISSOM: I am pro-life from the perception that I do not know when life begins and I have chosen that it begins at fertilization because, from my religious viewpoint, that does not put me at odds with my maker. [LB1103]

SENATOR McGILL: And I understand that and I wasn't...I just... [LB1103]

THOMAS GRISSOM: But it does not...but it does not... [LB1103]

SENATOR McGILL: I noticed that both of you are from far away from Nebraska... [LB1103]

THOMAS GRISSOM: Okay. [LB1103]

SENATOR McGILL: ...and so I was wondering what the connection is, if you guys go...are you pushing for something like this in either of your states? [LB1103]

THOMAS GRISSOM: In Alaska, there are several bills that are addressing similar issues, yes. [LB1103]

SENATOR McGILL: Okay. Thank you. [LB1103]

SENATOR ASHFORD: Senator Lautenbaugh first and then...did you... [LB1103]

SENATOR LAUTENBAUGH: No, I didn't. [LB1103]

SENATOR ASHFORD: Oh. Senator Council. [LB1103]

SENATOR COUNCIL: Yes, thank you, Dr. Grissom. I don't profess to be a physician or understand medical procedures, so you'll have to help me understand what a hormonal marker is. Give me some examples. [LB1103]

THOMAS GRISSOM: Hormonal markers are chemicals made by the body in response to...oh, they're involved in growth and normal function of the human body but some of them are stress markers. For instance, cortisol, which is a steroid produced by the body, is elevated under stress or in a situation where pain is applied, for instance. [LB1103]

SENATOR COUNCIL: Can cortisol be present under any other circumstance? [LB1103]

THOMAS GRISSOM: It can be present with disease states, yes. [LB1103]

SENATOR COUNCIL: So it's not confined to stress. It can be present during disease states. [LB1103]

THOMAS GRISSOM: No, but during the studies that looked at that, these other entities were not...were not involved. This was purely a response to a painful stimulus. [LB1103]

SENATOR COUNCIL: And you're saying that that's with regard to all of the studies that you have considered as a part of your presentation. [LB1103]

THOMAS GRISSOM: Uh-huh. [LB1103]

SENATOR COUNCIL: And the definition of pain can be defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Vaginal birth, could that result in actual or potential tissue damage? [LB1103]

THOMAS GRISSOM: Yes, of course. [LB1103]

SENATOR COUNCIL: No further questions. [LB1103]

THOMAS GRISSOM: Can I add something quickly that was... [LB1103]

SENATOR ASHFORD: You may. You may. [LB1103]

THOMAS GRISSOM: ...a couple of questions that were aimed at Dr. Salvacion that I had a chance to think about. It was a very good question earlier about the administration of medication for mental health during a pregnancy that was 20 weeks or beyond. There are medications that are used routinely in the treatment of severe depression, including electroconvulsive therapy for people who have mental health issues that put themselves at risk from the standpoint of depression. I do not believe that the termination of a pregnancy is a situation that outweighs the concern of the infant at times, because you can treat effectively mental health during pregnancy. [LB1103]

SENATOR ASHFORD: Okay. [LB1103]

SENATOR COUNCIL: I have question. [LB1103]

SENATOR ASHFORD: Okay. We got into another area there. (Laugh) [LB1103]

THOMAS GRISSOM: Yeah. [LB1103]

SENATOR ASHFORD: That's all right though. You've already...Senator Council. [LB1103]

SENATOR COUNCIL: Now again, I don't know what it is but it sounds painful. What is

electroconvulsive therapy? [LB1103]

THOMAS GRISSOM: ECT? [LB1103]

SENATOR COUNCIL: Yeah, what is that? [LB1103]

THOMAS GRISSOM: It's essentially applying electrical current to a patient that is temporarily anesthetized that excites the brain or neurons to essentially have a grand mal seizure. The liberation of chemicals, specifically norepinephrine and serotonin, during a grand mal seizure are the same types of medications that are elevated with antidepressant medications, like Paxil, Prozac, etcetera. And so it's an effective therapy for patients who have depression. [LB1103]

SENATOR COUNCIL: If I could simplify that, you invoke a seizure. [LB1103]

THOMAS GRISSOM: Yes, ma'am. [LB1103]

SENATOR ASHFORD: Senator Lathrop. [LB1103]

SENATOR LATHROP: I just want to clarify your testimony in this respect. You were talking about at what point in the development does an unborn child experience pain. You said that you've seen it in 23 weeks and today we are, if the bill passes, changing the legal standard, putting it at 20 weeks, and that's based upon the notion that...or the...yeah, the notion that these unborn children experience pain at 20 weeks. Is that universally true? Is 20 weeks the date at which all of them do, some of them do, a few of them experience pain? [LB1103]

THOMAS GRISSOM: The specific answer to your question is nobody knows. The components present for the ability to perceive pain are present at 20 weeks and may be present even before that, but the ability to say with 100 percent certainty at what point specific that occurs, I don't know. I don't think anyone can tell you that. [LB1103]

SENATOR LATHROP: Okay. It might...does it depend from one to the next or science doesn't know the answer to the question at what point the... [LB1103]

THOMAS GRISSOM: No, development, from the science standpoint, development occurs fairly uniformly across the board and so within a small window of time, plus or minus a small standard deviation of maybe a few days or so, all of those structures are present at 20 weeks. [LB1103]

SENATOR LATHROP: So 20 weeks, 20 weeks represents the point at which, in development, the wiring is in place for an unborn child to experience pain. [LB1103]

THOMAS GRISSOM: It is. It is the point at which all of the hardware, as you would put it, is in place, and it is the point at which the studies would tend to correlate the response from a physiologic standpoint to painful stimuli are present. So...and some of those responses are even before then. [LB1103]

SENATOR LATHROP: You sound a little unsure of yourself. [LB1103]

THOMAS GRISSOM: No. [LB1103]

SENATOR LATHROP: Okay. I just wanted to clarify because you talked about 23 weeks. I didn't know if you were getting off of the 20 weeks or... [LB1103]

THOMAS GRISSOM: So, the 23 weeks are from personal observations, being in a neonatal intentive care unit, working with neonates,... [LB1103]

SENATOR LATHROP: Okay. [LB1103]

THOMAS GRISSOM: ...providing anesthesia to those neonates, etcetera. And at 23 weeks, you actually see pain-focused behaviors, pain behaviors, within a learned response. [LB1103]

SENATOR LATHROP: Okay. You've answered my question. Thank you, Doctor. [LB1103]

SENATOR ASHFORD: Yes, Senator Lautenbaugh. [LB1103]

SENATOR LAUTENBAUGH: You were correct, Senator Ashford. I did have a question. [LB1103]

SENATOR ASHFORD: Yeah. I had one but maybe you'll ask it and then I won't need to ask it. [LB1103]

SENATOR LAUTENBAUGH: Thank you for coming today, Doctor. So if all of the wiring to experience pain is present at 20 weeks fairly uniformly, is there any reason to suggest that pain would not be experienced at 20 weeks? [LB1103]

THOMAS GRISSOM: No, there's none. [LB1103]

SENATOR LAUTENBAUGH: Thank you. [LB1103]

SENATOR ASHFORD: Thank you, Doctor. That was the question I was going to ask sort of. Thank you, Dr. Grissom. [LB1103]

THOMAS GRISSOM: Yeah. Thanks. [LB1103]

SENATOR ASHFORD: Teresa is next. Teresa, we're going to give you seven minutes, but then we're going to go to the lights after that because we're going to... [LB1103]

TERESA STANTON COLLETT: (Exhibit 7) Good afternoon, Senator Ashford, members of the committee, other esteemed guests. I appreciate the opportunity to address the questions surrounding LB1103. My name is Teresa Collett. I'm a professor of law at the University of St. Thomas in Minneapolis. The testimony I'm about to give arises from my study for over a decade on constitutional law and bioethics, both courses I teach at the law school. It also reflects my experience as assisting attorneys general throughout the country in defending various laws. I'm currently serving as special attorney general for the state of Oklahoma in defending two of their laws, one based on sex selection abortion, it's a prohibition, and the second regarding mandatory ultrasounds related to abortion. However, the testimony I'm giving reflects only my own personal professional views and does not reflect the views of any organization or any other individual. I believe that this legislation has a very strong chance of provoking a constitutional challenge, as Senator Council suggests, but also of prevailing in that constitutional challenge. The simple fact is that the question of fetal pain has been around for well over ten years. Recall that dramatic picture on the cover of LIFE magazine where little Samuel Armas, at 21 weeks, reached out of the womb to wrap his finger around the surgeon's heart when he was correcting his spina bifida. Just a few months later, The New York Times reported that there had been a replacement of a heart valve in an infant in utero at 23 weeks. Perinatal surgery is no longer rare or even particularly exotic. It's something that is occurring throughout the country. And as a part of that perinatal surgery, they are using fetal anesthetic. They use the fetal anesthetic because they have found that it promotes quicker healing and better recovery of the fetus within the womb, not external to the womb. It's an important aspect of healthcare now for the child that is within the womb. President Reagan, in 1980, anticipated this sort of debate when he said that the lives of the unborn are snuffed out and they often feel pain, pain is long and agonizing. Since that time we now have the medical evidence that the doctors presented to you. That medical evidence has moved medical associations in Great Britain as well as in Canada to determine that in fact fetal pain exists at 20 weeks, and some reports, even like the Rawlinson report, suggests that it occurs even earlier. So can you constitutionally base a prohibition on the existence of that fetal pain? Well, I think some of the lower court opinions regarding the state and federal partial-birth abortion bans, give us some insight into whether it's a legally significant factor. Judge Casey, the district court judge in New York, in ruling upon the federal partial-birth abortion ban called the procedure "gruesome, brutal, barbaric, and uncivilized" and specifically found that those abortion procedures "subject fetuses to severe pain." In contrast, Judge Hamilton, in the federal district court in California, arrived at a different conclusion. She wrote, "much of the debate on this issue is based on speculation and inference," and "the issue of whether fetuses feel pain is unsettled in the scientific

community." Now of course those opinions were entered into well over five years ago, but nonetheless they do reflect that the debate has entered the legal arena before. While these opinions arrive at divergent factual conclusions regarding the evidence that was presented in their individual courtrooms about it, what they do not diverge on is whether or not fetal pain would be legally significant. Both judges acknowledge that it would be of legal significance, and so I will focus my testimony on what that significance might be in the constitutional context. The simple fact is that Roe v. Wade was issued in 1973, more than 35 years ago. In fact, Roe v. Wade was issued at a time when we hadn't even had the first in vitro fertilization baby and we certainly didn't have perinatal surgery. We didn't have the wonderful sonograms that we have of the unborn child within the womb now. We didn't have a great deal of the medical knowledge that we've acquired. And even at that time, the court recognized that in finding a right to abortion within its privacy jurisprudence that it was something unusual, something different than its previous decisions in the area of marriage or family or even contraception. The court specifically stated the woman, pregnant woman cannot be isolated in her privacy. She carries an embryo and later a fetus, if one accepts the medical definitions of the developing young in the human uterus. The situation, therefore, is inherently different from marital intimacy or bedroom possession of obscene material or marriage or procreation or education, in which Eisenstadt and Griswold, Stanley, Loving, Skinner, Pierce, and Meyer were respectively concerned. As we have intimated above, it is reasonable and appropriate for a state to decide that at some point in time another interest, that of the health of the mother or that of potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly. So even in 1973, the Supreme Court anticipated that changes in medical knowledge would effectuate a change in constitutional standards, as Senator Lautenbaugh suggested in one of the questions to a prior witness. In this instance, what we see is the development of over 35 years of medical knowledge. The Abortion Pain Prevention Act is a reasonable response to this new knowledge and such legislation has not been directly addressed by the United States Supreme Court. It is correct, as Senator Council suggested, that the current standard is viability to allow prohibition of abortion, but the court has never said that's the exclusive standard and the court has never been presented with the question of fetal pain. I would suggest that given the legal significance that has already been acknowledged by federal district courts of the existence or nonexistence of fetal pain, and given the wide array of laws in which pain--pain of animals, pain of children, pain of the elderly--are all considered sufficient grounds to impose criminal sanctions, that it would be an adequate justification in order to support the constitutionality of LB1103. I would be happy to answer any questions of members of the panel. [LB1103]

SENATOR ASHFORD: Any questions of Teresa? Senator Council. [LB1103]

SENATOR COUNCIL: Yes, thank you, Professor Collett, and I respect and appreciate the acknowledgement that certainly reasonable minds differ on what the current

unequivocal state of the law is on viability. And I guess just in terms of my position, all I can do is go back to Franklin where that issue was squarely addressed as to whether a state could fix gestational limits, and the decisions since then have not addressed that specific issue. The Carhart decision and, well, under the Gonzales, since they were heard together, dealt with the procedure and the fact that there was a vaginal delivery of a living fetus with the anatomical landmarks, and then there had to be some action taken to effect that. The gestational period is a completely different issue, and is it your opinion that that was...that issue was squarely addressed in any decision since Franklin? [LB1103]

TERESA STANTON COLLETT: Mr. Chairman, may I answer the question? [LB1103]

SENATOR COUNCIL: Absolutely. That's what... [LB1103]

SENATOR ASHFORD: Oh no. Oh no, I'm sorry. No, I... [LB1103]

TERESA STANTON COLLETT: Oh, I'm sorry. I'm unfamiliar with the etiquette of this Legislature. [LB1103]

SENATOR ASHFORD: No, no, no, you may answer the question... [LB1103]

TERESA STANTON COLLETT: Thank you. [LB1103]

SENATOR ASHFORD: ...and I assumed that you would. [LB1103]

SENATOR COUNCIL: I don't simply get to pontificate. You get to answer. [LB1103]

SENATOR ASHFORD: Well, and that assumes a question is actually over yet. No, I think the question has been asked and you may answer. [LB1103]

TERESA STANTON COLLETT: Yes, Mr. Chairman. Senator Council, in fact, a few years before the Franklin opinion, the Danforth opinion came before the United States Supreme Court. And as you're familiar with the Colautti opinion, Colautti v. Franklin, I'm sure you're also familiar with the Danforth opinion. The issue in the Danforth opinion was whether or not medical judgment was the proper method by which to determine viability. The issue in Colautti was whether you could restrict the medical judgment in such a way that it would be...that it would not be determinative. As I read LB1103, this bill absolutely relies on the medical judgment as to the gestational age in order to trigger the prohibition and so fall squarely within Danforth's approval of that method of determining medically significant facts. [LB1103]

SENATOR COUNCIL: You know, you're a good lawyer because you completely avoided my question. (Laughter) And my question was any decision since Colautti that

has specifically addressed the ability of a state to fix the gestational limits for determining viability. [LB1103]

TERESA STANTON COLLETT: Senator Council, my answer is Colautti did not determine language similar to this and that Danforth is a relevant precedent which proceeded Colautti and was not overruled in Colautti and, therefore, Colautti is not the determinative constitutional standard but the Danforth opinion is. [LB1103]

SENATOR COUNCIL: Okay, so it's your opinion that LB1103 does not establish viability. That's the basis of your argument,... [LB1103]

TERESA STANTON COLLETT: That is correct. [LB1103]

SENATOR COUNCIL: ...that LB1103 does not establish... [LB1103]

TERESA STANTON COLLETT: LB1103 is not concerned with viability. That's correct, Senator Council. [LB1103]

SENATOR COUNCIL: ...doesn't...right, And so...and on that basis your point, you're arguing that Danforth is closer. [LB1103]

TERESA STANTON COLLETT: That is correct, Senator Council. [LB1103]

SENATOR COUNCIL: Okay. Okay. So for those who are of the opinion that LB1103 addresses establishing gestational limits, in your opinion, is there a decision since Colautti that has indicated that a state can do that? [LB1103]

TERESA STANTON COLLETT: Senator Council, Colautti doesn't determine gestational limits. It was determining viability, which was the question I answered. [LB1103]

SENATOR COUNCIL: Well, gestational limits for determining viability. [LB1103]

TERESA STANTON COLLETT: And Colautti was simply a time that did not have the medical judgment application that this particular bill has. Danforth had... [LB1103]

SENATOR COUNCIL: And I don't mean to interrupt you and I'm not disagreeing. I'm saying if someone takes the position that LB1103 sets forth...fixes a gestational limit for determining viability, assuming that to be true, hypothetically that's what it is, is there a case, in your opinion, since Colautti that would state that it would be constitutional for a state to do that? [LB1103]

TERESA STANTON COLLETT: There was a case subsequent to Colautti that dealt with viability but it did not have the strict date limitation that Colautti did. [LB1103]

SENATOR COUNCIL: Okay. Okay. And my last question for you is we've heard from the medical community and I've reviewed the basis. There was a statement, and I don't want to put words in a mouth and I don't want to...and correct me if I'm wrong, is this question of whether or not pain can be felt by the fetus prior to 20 weeks, is that a universally accepted medical position? [LB1103]

TERESA STANTON COLLETT: It is reflected in the Royal College of Obstetricians and Gynecologists standards, it is reflected in the Medical College of Alberta Province in Canada, and the medical...and the practice as described by the prior witness of the training and medical education in this country would confirm it as well. [LB1103]

SENATOR COUNCIL: Okay. So let me ask it this way. Are there people who disagree with those opinions, medical professionals who have some degree of credibility and respectability, to your knowledge? [LB1103]

TERESA STANTON COLLETT: To my knowledge, Senator Council, there are physicians who define pain differently and, therefore, disagree. But if they use a similar definition of pain, I believe there is a strong consensus. [LB1103]

SENATOR COUNCIL: Okay. Then I'm going to ask you the question on vaginal birth. Using that definition of pain, more likely than not pain is suffered during vaginal birth? [LB1103]

TERESA STANTON COLLETT: Which definition? Are we talking about the American... [LB1103]

SENATOR COUNCIL: Well, what I understood as a universal... [LB1103]

TERESA STANTON COLLETT: ...the institute of pain that was used by the prior witness? [LB1103]

SENATOR COUNCIL: Yes, by the prior witness. [LB1103]

TERESA STANTON COLLETT: Yes. [LB1103]

SENATOR COUNCIL: Okay. Thank you. [LB1103]

SENATOR ASHFORD: I think you had your hand up. [LB1103]

SENATOR LAUTENBAUGH: Yes, I did, Senator. Mr. Chairman, thank you. [LB1103]

SENATOR ASHFORD: Yeah. [LB1103]

SENATOR LAUTENBAUGH: And thank you for coming today, Professor. So I understand your testimony, you believe this could be subject to a constitutional challenge. [LB1103]

TERESA STANTON COLLETT: My experience is almost any legislation in the abortion area is subject to a constitutional challenge. (Laugh) [LB1103]

SENATOR LAUTENBAUGH: Couldn't you really say the same of any advancements in civil rights law and any other legal advancement we've made over the past couple hundred years? [LB1103]

TERESA STANTON COLLETT: Just this week we got a new Supreme Court Opinion on the Miranda rights, Senator. [LB1103]

SENATOR LAUTENBAUGH: So the fact that something might be subject to challenge isn't necessarily a reason not to do it, in your opinion. [LB1103]

TERESA STANTON COLLETT: Nor is it evidence that they will prevail in that constitutional challenge. [LB1103]

SENATOR LAUTENBAUGH: Thank you. [LB1103]

SENATOR ASHFORD: Senator Lathrop. [LB1103]

SENATOR LATHROP: I do have a question for you and that is you have...your focus today so far, at least to this point in time, has been on the movement from viability to pain as a measure for moving this to 20 weeks. And I have a question about your thoughts in Section 5, to this part of Section 5 which says "the physician shall terminate the pregnancy in a manner which...in the reasonable...in reasonable medical judgment provides the best opportunity for the unborn child to survive." First, have you seen that language before? [LB1103]

TERESA STANTON COLLETT: Actually, the Thornburgh opinion, which was subsequently overturned on this matter, looked at the issue of the second physician present in order to sustain the life of a child who might emerge alive from an intended abortion, and the court has subsequently sustained a second physician requirement, so yes. [LB1103]

SENATOR LATHROP: That isn't a subsequent...that isn't a second physician requirement. It just says... [LB1103]

TERESA STANTON COLLETT: No, but it's similar. [LB1103]

SENATOR LATHROP: ...the doctor shall perform it in a way that's most likely to... [LB1103]

TERESA STANTON COLLETT: Yes. [LB1103]

SENATOR LATHROP: ...result in the unborn child surviving. [LB1103]

TERESA STANTON COLLETT: Correct. [LB1103]

SENATOR LATHROP: Here's my question about that. And you say you've seen it before? [LB1103]

TERESA STANTON COLLETT: We have...in the Thornburgh opinion or in the cases which have upheld a second physician requirement, it was for the purpose of sustaining the child's life. In fact, you even had to have a second physician present. I have not seen the language where the sole physician has it, but if we can impose the requirement of having a second physician present, it certainly seems reasonable that we could require that. [LB1103]

SENATOR LATHROP: But this is...this is about the manner in which it is performed. [LB1103]

TERESA STANTON COLLETT: Yes. [LB1103]

SENATOR LATHROP: And I'm...you're the constitutional scholar here today... [LB1103]

TERESA STANTON COLLETT: I understand, Senator. [LB1103]

SENATOR LATHROP: ...so I'm just going to ask you to talk about that because whether or not...is this requirement going to require physicians that do these kind of procedures to do C-sections? [LB1103]

TERESA STANTON COLLETT: No, Senator, at least it appears to me that, based on the medical circumstances, that certainly would not be the mandate in every instance. It may require an induction so that a vaginal delivery could occur, but that depends on the medical circumstances and what's medically indicated. [LB1103]

SENATOR LATHROP: Well, do you think there's some circumstances under which a C-section would be required with that language? [LB1103]

TERESA STANTON COLLETT: In all honesty, Senator, that is not a question I'd anticipated. I'd be happy to prepare a letter or brief on it for you. [LB1103]

SENATOR LATHROP: I'd be interested in that because... [LB1103]

TERESA STANTON COLLETT: I'd be happy to do that. [LB1103]

SENATOR LATHROP: ...and I appreciate your...the information you've given us on the constitutional implications of this bill but that hasn't been addressed and I'm curious about whether that will withstand, in your judgment,... [LB1103]

TERESA STANTON COLLETT: I understand and I'll be happy to prepare that. [LB1103]

SENATOR LATHROP: ...constitutional scrutiny. [LB1103]

TERESA STANTON COLLETT: Mr. Chairman, when would you like that? [LB1103]

SENATOR ASHFORD: Oh, that's a...I've never been asked that question before. (Laughter) [LB1103]

TERESA STANTON COLLETT: Within...or shall I just send it to your chambers? [LB1103]

SENATOR ASHFORD: When would you...what do you feel comfortable? How about seven days? Could we do that? [LB1103]

TERESA STANTON COLLETT: I'm happy to do that, sir. [LB1103]

SENATOR ASHFORD: Okay. [LB1103]

TERESA STANTON COLLETT: And in addressing that, actually the earlier question about the medical exception I found quite interesting, because in my bioethics class I teach about body identity disorder, which is where the patient has a great psychological concern that they have a healthy limb and so they seek to have a surgeon remove them. Now obviously that's not the correct response, which sort of reinforces the idea that the treatment of a psychiatric illness is not to disfigure or disable an individual or necessarily to kill an unborn child. [LB1103]

SENATOR ASHFORD: Yeah, I... [LB1103]

SENATOR LATHROP: And maybe one more thing, if I can,... [LB1103]

SENATOR ASHFORD: Yes, Senator Lathrop. [LB1103]

SENATOR LATHROP: ...Mr. Chair, and that is you've also not addressed the medical

exception here and can you take just a second and tell us your judgment about the language for the medical exception, whether you believe it to be constitutional and why,... [LB1103]

TERESA STANTON COLLETT: Certainly. [LB1103]

SENATOR LATHROP: ...and briefly so that we... [LB1103]

TERESA STANTON COLLETT: Absolutely. [LB1103]

SENATOR LATHROP: ...I don't want to monopolize the... [LB1103]

TERESA STANTON COLLETT: I've gone over my time and I apologize. It's quite clear that it's patterned after the medical exception in the Pennsylvania statute that was sustained by the United States Supreme Court in the Planned Parenthood v. Casey. It uses...it limits it to the life of the mother or substantial physical impairment. I believe, based on Casey, there is no question that this is constitutional. [LB1103]

SENATOR LATHROP: Okay. Thank you very much for your answer. [LB1103]

SENATOR ASHFORD: I do have one just question. In Gonzales and the discussion about the medical judgment discussion,... [LB1103]

TERESA STANTON COLLETT: Right. [LB1103]

SENATOR ASHFORD: ...is it...by putting 20 weeks in the statute, in some sense it's restrictive, isn't it? I mean because one could argue that if feeling pain is the standard, as Dr. Grissom suggests, I believe it was Dr. Grissom or prior, that pain could be felt prior to 20 weeks, so I mean under...if pain is a legitimate standard then 20 weeks would not necessarily...I mean you could simply have that be the standard without...theoretically without putting a 20-week restriction on... [LB1103]

TERESA STANTON COLLETT: It is possible. There is...there are a couple of studies out of Europe that suggest that because of the physiological reactions that a child would feel pain, the unborn child could feel pain as early as 12 weeks. But because of the developmental arguments that Dr. Grissom made, that's not...there's not a consensus on that point. It seems to me then quite sensible for this Legislature to take the point at which we see other medical communities answering that. [LB1103]

SENATOR ASHFORD: But...and I get that, but to...but to Senator...I think some of the other questioning was has a gestational age specific been determined to be constitutional or not, and was one of the just conversations we were having. If by removing the 20 weeks and putting in "feeling pain," does that make it more infirm or

does that... [LB1103]

TERESA STANTON COLLETT: I would be concerned, I would be much more concerned about a vagueness challenge under those circumstances simply because of the competing definitions of pain. Must the...is the pain simply physical? And so we see it by the withdrawal response from the needling. [LB1103]

SENATOR ASHFORD: Right. [LB1103]

TERESA STANTON COLLETT: Or is it...or is it...or is there a requirement of the thalamus? [LB1103]

SENATOR ASHFORD: Then let me ask this. Then is it...then is it the...is it the subjective...it's not...and I understand the testimony regarding the development of the unborn child. I understand the development issue. But is it...let's see if I can phrase this correctly, so by putting the 20 weeks, it is...some would view pain as more subjective than objective, let's say, theoretically, and even though scientifically we can find it. By putting 20 weeks, that gives certainty to what might otherwise be a vague standard? [LB1103]

TERESA STANTON COLLETT: I believe that to be correct, Mr. Chairman. [LB1103]

SENATOR ASHFORD: And does that...and does that make it more constitutionally acceptable in your view? [LB1103]

TERESA STANTON COLLETT: In light of its reliance upon the physician's judgment as to the gestational age, which is why it falls more within Danforth than it does Colautti. [LB1103]

SENATOR ASHFORD: Okay. So that's why Danforth would be more... [LB1103]

TERESA STANTON COLLETT: The relevant precedent. [LB1103]

SENATOR ASHFORD: ...applicable. Okay. I think I understand your point. Senator Council. [LB1103]

SENATOR COUNCIL: Just one other question, Professor Collett, and it was prompted by a question Senator Lathrop asked. And I'll preface, I don't know the answer so that's why I'm asking the question. In response to the section that Senator Lathrop referenced in the bill that deals with the health of the mother, and correct me if I'm wrong, your response was that that...the language in LB1103 is consistent with the language in the Casey decision. Was that your... [LB1103]

TERESA STANTON COLLETT: Yes, Senator. [LB1103]

SENATOR COUNCIL: Okay. When was Casey decided? [LB1103]

TERESA STANTON COLLETT: Nineteen ninety-eight. I have it on my computer if you'd like me to check it. [LB1103]

SENATOR COUNCIL: Okay. [LB1103]

SENATOR ASHFORD: I think you're right. I think it was 1998. [LB1103]

SENATOR COASH: Ninety-two. [LB1103]

TERESA STANTON COLLETT: Ninety-two, I beg your pardon. [LB1103]

SENATOR ASHFORD: Or '92. We have it here. [LB1103]

TERESA STANTON COLLETT: It's in my footnotes. (Laugh) I should check my own footnotes. [LB1103]

SENATOR COUNCIL: Thank you. [LB1103]

SENATOR ASHFORD: Thank you. Thanks for your comments. [LB1103]

TERESA STANTON COLLETT: Thank you, Mr. Chairman. [LB1103]

SENATOR ASHFORD: And thanks for asking me what your time constraints were. (Laughter) [LB1103]

TERESA STANTON COLLETT: One week, sir. [LB1103]

SENATOR ASHFORD: Okay. Now we'll move to is it Sean? Sean has five minutes. [LB1103]

SEAN PATRICK KENNEY: (Exhibit 8) Okay. Good afternoon. Thank you for allowing me to discuss the medical concerns associated with this bill. I'm a board certified, maternal-fetal medicine specialist who specializes in the care of high-risk pregnancies in Lincoln, Nebraska. I serve as a major referral center for most of everything west of here. From a medical standpoint, the bill requires a reasonable attempt to be made to establish the estimated gestational age. This can easily be determined based on the patient's last menstrual period, a history of her previous cycles, and a physical exam. By 20 weeks, the uterus is about the size of the umbilicus, so as long as the baby is smaller than that, you're going to be okay. If your baby is larger than that, you probably

need to consider doing an ultrasound. If someone is going to do a, safely, second trimester termination, they will want to know the gestational age specifically for their own benefit because you don't want to think you're terminating an 18-week baby and get in there and find a 26-week baby, because you need different instruments, different equipment. So this should not be a ban or a difficult thing to do and most abortion doctors that I have talked to, when they said they got really good at feeling the size of the uterus. Ultrasound is readily available at all...all, qualified abortion clinic would have an ultrasound available and that would be plus or minus seven to ten days based at this gestational age. The bill does have a medical emergency exception which is commonly used now for beyond 22 weeks, and so that would not place an undue physical burden on the mothers. If the mother has such medical conditions that require that she is at significant risk to herself or to her form, then she will need to be managed in a hospital that's capable of taking care of her conditions, so this is something that is currently done today without difficulty and very important. When we deal with these medical complications that might warrant termination or interruption of pregnancy at this gestational age, I think it's important to know that this is a rare occurrence. Even in the whole state of Nebraska, I would suspect it happens less than one to two times per month. It's interesting with Senator Flood talking that there weren't any reported abortions between 20 and 22 weeks, and yet I know that I have delivered patients in that range but it was considered delivery, it wasn't considered abortion, and so it never...I never was told to fill out the right form, I assume. Let me discuss the different medical conditions that might be considered emergencies. First off, we have premature rupture of membranes, when the membranes rupture before viability or before term. The biggest risk to doing this is sepsis. If there is no signs of infection at the time of ruptured membranes, a lot of patients, after appropriate counseling, will decide to continue the pregnancy because there's about a 25 percent chance of taking a baby home if they go with conservative management. However, if there is ever evidence of chorioamnionitis or infection around the uterus, all of us would agree that at that time we need to warrant delivery of the baby and administer IV antibiotics. Again, this is not the type of delivery you're going to want to do in a clinic. You're going to want to do it in a hospital. The second condition would be preeclampsia and eclampsia, which is a condition where the mother develops hypertension and possibly seizures in the view of eclampsia. There are different levels, mild versus severe, but severe preeclampsia and conditions such as HELLP syndrome, where the liver is starting to swell and platelets are falling, would warrant delivery at early gestational age. And we'll talk a little about that later. Third condition would be uncontrollable hemorrhage. We have some people that are pregnant, they come in, they're bleeding real bad and mom is getting "shocky," mom's life is at threat, we need to stop the bleeding by whatever means; again, nothing that you would do in the clinic but something you would do in here. All three of these conditions, again, should be managed in the hospital where you can take good care of the mother. Even at my hospital, which is considered a very pro-life and strict hospital, these three conditions, when we're treating the condition, the removal of the placenta, we will stand by. With respect to your concerns over maternal psychiatric conditions,

there are numerous medications, ECT is used. I take care of several patients with mental conditions. Some people would argue other conditions, but by the time someone reaches 20 weeks gestational age their heart is 50 percent cardiac output increased plasma volume. It is not easy to terminate a pregnancy after 20 weeks as it is previous to that. And again, as our hospital benefits, we routinely resuscitate 23-week babies and neonatal advanced life support recommends all babies at 24 weeks be resuscitated. In my 12 years of experience as a maternal-fetal medicine specialist, I can only think about four patients in that 12 years that would have fallen into where this bill would have had any effect on, and all the times she would have warranted delivery and the appropriate care would be (inaudible). I'd like to thank everyone, thank you for allowing me the opportunity to share my medical facts with you. Be happy to answer any questions. [LB1103]

SENATOR ASHFORD: Senator Lathrop. [LB1103]

SENATOR LATHROP: I do have kind of a question for you. Did you just say that before 23 weeks typically you wouldn't try to resuscitate a child? [LB1103]

SEAN PATRICK KENNEY: I used to say that, but one time I had a patient came in, in delivery, and I took care of the whole pregnancy so I knew she was 22 weeks. And I said, well, we're not going to be able to resuscitate her baby and when it came out it was crying so I ran it to the nursery and right now it's a healthy little five-year-old boy. So I think there's...you have to be close to 23 weeks, but we are individualizing those times. [LB1103]

SENATOR LATHROP: But at 20 weeks say... [LB1103]

SEAN PATRICK KENNEY: We would not resuscitate. [LB1103]

SENATOR LATHROP: You wouldn't resuscitate. And then...and maybe our Doctor or Professor Collett can address this in terms of constitutionality because the bill does seem to require that we deliver a baby in the manner most likely to result in a live birth. And you're saying even with a new deadline or a new bright line at 20 weeks the first 2 weeks of our new bright line period aren't times when you resuscitate the child even if you did a C-section, for example. [LB1103]

SEAN PATRICK KENNEY: Correct. A lot of people are not experienced in doing terminations or D&Es at that advanced gestational age. So my patient I would choose to induce that patient with that same condition. [LB1103]

SENATOR LATHROP: I don't know and I'm talking to Doctor Collett or Professor Collett maybe, but I don't know how that works into the constitutionality of the bill later. [LB1103]

SEAN PATRICK KENNEY: I guess, and again I would think that's kind of the intent. She kept questioning about vaginal birth. Yes, vaginal birth is painful to a baby. We squeeze the head. At no point in life would I go up to a baby and squeeze his head, but I know when it comes through the birth canal that's what happens. We put forceps on. Even when I do a C-section, I have to put a lot of traction on babies to get them delivered. This is again, the intent is to deliver the baby. It helps the baby cry, and that's where I think they're going with that route. [LB1103]

SENATOR ASHFORD: Thank you, Doctor. [LB1103]

SEAN PATRICK KENNEY: Thank you. [LB1103]

SENATOR ASHFORD: Next testifier is Anita. Anita, I'm going to ask you to try to give us your testimony in five minutes if you would. [LB1103]

ANITA SHOWALTER: (Exhibit 9) Thank you for allowing me to testify before the committee today. I'm submitting written testimony that has more detail in regard to what I'm going to be explaining today. I'm a board certified obstetrician/gynecologist, the head of the division of obstetrics and gynecology at Pacific Northwest University of Health Sciences, and I have an active clinical practice. I'm a proponent of safe, compassionate healthcare for women. My opinions are my own. I'm not representing any group. I reviewed the legislation that is proposed. Section 4 requires the accurate dating of a pregnancy before performing an abortion. With today's availability of ultrasound, accurate dating of a pregnancy is routinely performed. When a patient presents for prenatal care in the first trimester, the accuracy of ultrasound is 4.7 to 7 days. Up to 20 weeks gestation the accuracy is about 7 days. After this time, the accuracy begins to wane. For the purposes of this legislation, the fetus at 20 weeks gestational age, which would be 22 weeks from the last menstrual period, can be accurately dated within 1 week. Obstetricians and physicians providing obstetrical care are routinely trained in obtaining these measurements, and ultrasound units are readily available in our hospitals and clinics for those presenting without prior care. Exception is provided in the bill for immediate life-threatening emergencies that may require an abortion to save the life of the mother in Section 2(5). Hemorrhage, heart disease, and some renal diseases and preeclampsia are diseases that may fall into this category. Examples of medical emergencies that may require immediate termination are outlined in my written testimony and in the appendixes. The bill adequately makes provision for the patient and physician to freely make medical decisions to save the patient's life in whatever manner is medically indicated in these situations. Other medical conditions can present that may not be immediately life threatening, but may cause irreversible impairment if not treated promptly. There are some cancers in which the treatment may terminate the pregnancy. There are other cancers that can be adequately treated despite the pregnancy. The bill also makes satisfactory provision for the physician to

make these judgments for the health and well-being of his patient. Most medical conditions are compatible with pregnancy and can be adequately treated. When a medical condition occurs that requires termination of the pregnancy after 20 weeks, Section 5 of the bill requires that the fetus be delivered in a manner that provides the best opportunity for the unborn child to survive unless it would pose a greater risk to the mother. Some methods of abortion may not deliver an intact fetus but may be a safer option in very limited medical conditions. But the bill gives provision for the physician to make that judgment in those cases. The procedure that's used to save the life of the mother after 24 weeks is called a delivery, not an abortion. It is not necessary to take the life of the child to terminate the pregnancy in these situations. Therefore, it's possible for physicians to compassionately care for their patients within the parameters of this bill. I am not aware of any studies that indicate any psychological conditions that actually benefit from abortion. In fact, the contrary is true. There have been studies that show that the rate of mortality for a woman after an abortion is higher for all causes in the first year after the abortion and specifically in the area of suicide. Most women experience remorse, regret, abandonment, a feeling like the system let them down, like their support groups let them down, and that they felt forced to submit themselves to an abortion. Therefore, it would be a rare circumstance where somebody would actually be helped psychologically by that procedure. [LB1103]

SENATOR ASHFORD: Thank you. Any questions? Senator Council. [LB1103]

SENATOR COUNCIL: Yes. Thank you. But the fact that the rare case that a person would be helped psychologically, is it your opinion that if the psychological well-being of the mother would be damaged or her condition worsened that the ability to terminate should not be an option in terms of the health and welfare of that mother? [LB1103]

ANITA SHOWALTER: When a mother is in an extreme emotional state, that is not a really good time to make a decision that's going to affect your entire life. And so the patient should be treated and that decision postponed until the patient is more stable. And I am not aware of any type of circumstance where terminating the pregnancy would have been shown to be generally beneficial to a woman in that kind of situation. [LB1103]

SENATOR COUNCIL: But if...well, we're not going to be able to address every possible scenario. But the issue, the concern is if there is a mother who is established to be suicidal and it is connected to the pregnancy and her mental health provider says it's in that mother's best interest healthwise, mental healthwise, for the pregnancy to be terminated, it's your opinion that the physical healthcare provider should somehow overrule the mental healthcare provider and require that that mother continue to carry when her mental health is connected to the pregnancy, her condition? [LB1103]

ANITA SHOWALTER: Like I said, I'm not aware of any medical studies that establish

that as a reasonable treatment in those situations. And as a physician, I am obligated not just to treat patients according to my opinion, but according to the evidence of the medical literature, which may contradict my personal opinion. So we need...currently the evidence would suggest that a woman is much more likely to be subject to emotional trauma after a termination than be benefited because of one. [LB1103]

SENATOR COUNCIL: But that does not exclude the possibility that there would be women who would be mentally damaged before the termination or because of the pregnancy. [LB1103]

ANITA SHOWALTER: We would have to have studies that would indicate that that is indeed the case. And to my knowledge, there is no such data out there. [LB1103]

SENATOR ASHFORD: Senator Christensen and then Senator McGill. [LB1103]

SENATOR CHRISTENSEN: Thank you, Mr. Chairman. Thank you, Doctor. Just a little bit further on Senator Council's question. After 20 weeks, we could deliver that baby if it come down to the rare situation of not being...that we're talking about the case of mental health. It would be better for the mother not to have the baby, we could deliver that, correct? [LB1103]

ANITA SHOWALTER: Under the terms of the bill you could, yes. [LB1103]

SENATOR CHRISTENSEN: And so it really comes down at this point if it's better for the woman then you literally could deliver it and wouldn't have to kill it. [LB1103]

ANITA SHOWALTER: Well, that would be part of the point of the bill is that when there is a medical situation that requires a delivery it doesn't have to be with intent to kill the living fetus. I believe the bill does make exception to...now I don't remember the exact wording of the bill. But that it's physical, not emotional damage. Emotional damage is very difficult to prove. And in the type of scenario that's being presented, it would be very dangerous to act in a manner that's already been shown to be likely to actually exacerbate the situation instead of help as a solution for that particular woman's condition. [LB1103]

SENATOR CHRISTENSEN: Okay. Thank you. [LB1103]

SENATOR ASHFORD: Senator McGill and then Senator Lautenbaugh and then Senator Council. [LB1103]

SENATOR McGILL: Two things and this is more of a comment. Both of them are about the mental health issue, but my concern, and I generally don't have a problem with most of what's in this bill, but my concern is that if a woman thinks that her only option is to

have the baby, I'm afraid that instead of pondering suicide and going and talking to people about it she'll just commit suicide in the first place. And so that's my concern over that. You know, I'd rather have a system where she would feel open going and talking to someone. And we're talking about a very low percentage of abortions, you know, dealing with this bill anyway so we are kind of theoretically dealing with extreme cases. And that's just something that I want to throw out there as far as a discussion. And second, I mean you even said in this discussion that emotional damage is very hard to prove. And I just want to throw out there and remind people that even once a woman gets pregnant she has emotional damage. If she's 18 years old, her life is changed forever. I know women who willingly got married at 21 and 22 and have little kids and now they're 30 and they're like, "my whole 20s are gone." And they are happy they had their kids, but there's still that "I was an adult way too soon" mentality. And so I just want to add to the discussion that there are emotional impacts and damages regardless of if a woman decides to keep the baby or abort the baby. Those are just two comments I guess. [LB1103]

SENATOR ASHFORD: Thank you, Senator McGill. Senator Lautenbaugh. [LB1103]

SENATOR LAUTENBAUGH: Thank you, Mr. Chairman. Thank you for coming today. I do want to follow up on something Senator Council was asking because I think it was maybe confusing two things. You were asked to presuppose that there could be a mental health issue that's specifically caused by the pregnancy. [LB1103]

ANITA SHOWALTER: Um-hum. [LB1103]

SENATOR LAUTENBAUGH: And is that in your experience likely? [LB1103]

ANITA SHOWALTER: No. [LB1103]

SENATOR LAUTENBAUGH: And your actual response was more to the point that even if that were the case, which we're being asked to presuppose, the treatment of terminating the child is not the proper treatment for that condition. [LB1103]

ANITA SHOWALTER: And in fact may make it worse. [LB1103]

SENATOR LAUTENBAUGH: Thank you. [LB1103]

SENATOR ASHFORD: Senator Council. [LB1103]

SENATOR COUNCIL: Doctor,...I got to get the names right here, Showalter, you are the head of obstetrics and gynecology, correct? [LB1103]

ANITA SHOWALTER: At our medical school in Yakima, Washington. [LB1103]

SENATOR COUNCIL: Right. Are you a psychiatrist? [LB1103]

ANITA SHOWALTER: No. [LB1103]

SENATOR COUNCIL: Do you ordinarily treat women with mental health conditions? [LB1103]

ANITA SHOWALTER: I treat women in pregnancy with mental health conditions. If it's significant, it is in conjunction with a psychiatrist. [LB1103]

SENATOR COUNCIL: And just a comment. The question that Senator Christensen raised is the point that I'm making. Under LB1103, Senator Christensen, a medical provider can terminate the pregnancy because of a medical condition to avert the death or to avert the serious risk of substantial and irreversible physical impairment of a major bodily function of the mother. And in that case, they must terminate it in a way that provides the best opportunity for the unborn child to survive. So that's even if the mother is at risk of death or impairment of a major bodily function. But if she has a mental health condition that could result in her death or in a substantial irreversible physical impairment, termination is not even an option. Termination under this condition, "providing the best opportunity for the unborn child to survive," that's the problem I have with this. It's okay to do it if the mother's at risk of immediate death and immediate physical harm. But her mental condition that could lead to that does not trigger the ability for the pregnancy to be terminated under these conditions. And under these conditions is in a way that provides the best opportunity for the unborn child to survive. And that's what creates a problem. We ignore the effects, the mental health effects on the mother in these situations and allow for this opportunity only to avert her death or the, you know, it appears to be an immediate risk of substantial and irreversible physical impairment. And that's what's problematic for me. The mother's mental health, if it's such that there's a real concern that she take her own life or physically impair herself, we're going to say you're going to have to continue that pregnancy. [LB1103]

SENATOR ASHFORD: Okay. Thank you, Doctor, for your testimony. We have four more testifiers, Mary who is here, I see, and Ann Marie Bowen, Al Riskowski, and Greg Schleppenbach. And I would ask you to confine...we're going to go to three minutes because in fairness to the...both sides here, I'd ask that we confine our testimony to the three minutes and then we'll move on to the opponents. No reflection... [LB1103]

MARY SPAULDING BALCH: No problem. Mine is less than three minutes. Thank you, Mr. Chairman, members of the committee. [LB1103]

SENATOR ASHFORD: ...on the importance of your testimony. Just to try to keep everybody...get a chance while the day is still young. [LB1103]

MARY SPAULDING BALCH: (Exhibit 10) Good afternoon. My name is Mary Spaulding Balch, and I'm the director of the department of state legislation for the National Right to Life Committee. I am speaking on behalf of Nebraska Right to Life and the National Right to Life Committee in support of this bill. Combining the written and oral testimony presented in support of this bill to this committee, you have five expert physicians, two anesthesiologists who specialize in pain management, one specialist in pediatric critical care medicine, one maternal/fetal medicine expert, and one neurologist, all of whom independently conclude that the unborn child at 20 weeks is capable of feeling pain. I'm attaching to my testimony nine peer review medical journals that support the same conclusion. There are many more but I figured nine would be enough for you. You have heard from two highly qualified obstetricians, one an expert in high-risk pregnancies, who agree that the language in the bill which permits post 20-week abortions to prevent death of the mother or to avert substantial and irreversible physical impairment of a major bodily function is fully sufficient to cover the situations where there is a genuine medical need for an abortion at that stage. This expert testimony and medical literature gives Nebraska a clear, factual basis for asserting a compelling interest in protecting the lives of unborn children who are capable of feeling pain and for enacting a law preventing abortions of such children in the absence of a genuine physical threat to the maternal health. We ask that you support the bill and vote this bill to the floor. Thank you. [LB1103]

SENATOR ASHFORD: Thank you, Mary. Are there any questions of Mary? Thank you. And we will certainly accept the information you've given us. Ann Marie. Good afternoon. [LB1103]

ANN MARIE BOWEN: (Exhibit 11) Same to you all. Good afternoon. Ann Marie Bowen, I used to have to spell my name so I'll do it just because I'm used to that for thirty-seven years. It's Ann without an E, Marie Bowen B-o-w-e-n. I am pleased, Senator Ashford, Chairman of this committee, and this committee, that you will allow us citizens to come and speak before you. I am also speaking on behalf of Nebraskans United for Life, a pro-life organization, statewide pro-life organization. And before I begin, I will tell you that I don't know how you get up every morning at 5:00 and do all you do and drive here. I'm very tempted, the next time, to start an initiative not only giving you all a raise, but it will say that you get an hour nap after your lunch. (Laughter) This is a killer. (Laughter) All right, with that in mind, in a recent article, in the Omaha World-Herald, the unborn child was called a family member. This article went on to say that for purposes of healthcare needs, which by the way was speaking about LB1110, which Nebraskans United for Life does support, for purposes of healthcare needs, an unborn child is a family member. So my question to you, senators, is, is it okay to dismember a family member, even if the mother of the child gives permission to the abortionist to do so any time but especially if the said child feels pain? You have heard from expert testimony and from medical journal articles that it is a matter of fact that an unborn child at least at

the age of 20 weeks of gestation feels pain. Nebraskans United for Life is convinced by simple biology the unborn child with human DNA should expect the same humane medical care as any other family member. I quote Mr. John Lillis, board of directors and PAC chairman of NUL, "this bill will put the viability question to rest by acknowledging fetal pain at 20 weeks and effectively banning post-viability abortion codifying an underlying fact: the unborn feel pain when they are carved up or they are burned in the womb." NUL joins all people of right-reason and goodwill in seeking the end of the barbarism of abortion by any nonviolent means across the board. We urge you to pass at this time LB1103. [LB1103]

SENATOR ASHFORD: Thank you, Ann Marie. Any questions of Ann Marie? Seeing none, thanks for the plug. [LB1103]

ANN MARIE BOWEN: All right. [LB1103]

SENATOR ASHFORD: Al. [LB1103]

AL RISKOWSKI: (Exhibit 12) Thank you, senators. It was a little hard to get up after sitting that long, not because I'm older, of course. Al Riskowski, Nebraska Family Council. And I am here in support of this bill and with the belief that the reason that we are here today is because of the baby, not choice. We're looking at a situation that has changed since we had children. At that time we didn't have ultrasound, neither did we have little children, and I'll use my pastoral terminology, testifying to the fact that this is a baby who does feel pain. Little Trey was born at St. E. Hospital at 24 weeks. Trey functioned in Jessica's arms just the same as a full term baby. There was no difference between Trey and any other child other than the size of that child. And because of medical advances, that little 24-week-old baby not only survived but the other article talks about the one year anniversary and how that child is functioning today. Our encouragement then is as we look at the new technologies and the evidences that are before us to consider the baby once again, and that in fact when we see these little babies being born, at 24 weeks, we realize that they do feel pain even earlier than that you have a functional baby before us. So I just appreciate the Judiciary Committee's willingness to move on this important piece of legislation. And hope you'll move it on to the full Legislature. [LB1103]

SENATOR ASHFORD: Thank you, Al. Thanks for your comments. Seeing no questions, Greg. And then we'll move on the opponents of the bill. [LB1103]

GREG SCHLEPPENBACH: I just want to go on the record saying that Ann Bowen has always been a brown-noser. (Laughter) With all due charity... [LB1103]

SENATOR ASHFORD: Thank you. I thought everything she...I thought her comments were very well taken. (Laughter) [LB1103]

GREG SCHLEPPENBACH: With all due charity. Mr. Chairman, members of the committee, my name is Greg Schleppenbach, I'm here on behalf of the Nebraska Catholic Conference to urge you to support LB1103. The Conference represents the mutual interests of the Catholic bishops of Nebraska. In 2005, Edward Lazarus, former clerk to Justice Blackmun who authored Roe, said that, "As a matter of constitutional interpretation and judicial method, Roe borders on the indefensible. It is one of the most intellectually suspect constitutional decisions of the modern era." Laurence Tribe, a Harvard Law School professor, said that, "One of the most curious things about Roe is that behind its own verbal smokescreen, the substantive judgment on which it rests is nowhere to be found." These candid admissions by proponents of legal abortion illustrate why Roe and its companion, Doe v. Bolton, did not settle the abortion debate in our nation. Instead, seven unelected justices substituted their flawed reasoning for the judgments of elected legislatures around the country, including ours. In the declaration section of Nebraska's abortion law, 28-325, our Legislature refers to Roe and Doe as "the legislative intrusion of the United States Supreme Court that removed the protection afforded the unborn." They go on to say that, "The members of the Legislature expressly deplore the destruction of unborn human lives which has and will occur in Nebraska as a consequence of the court's ruling." Far from a reasonable compromise, Roe and Doe unleashed abortion on demand in our nation during all nine months of pregnancy and for virtually any reason. The result, more than 50 million abortions nationwide and more than 170,000 here in Nebraska. Even Roe's seemingly reasonable provision allowing states to ban third trimester abortions except when a mother's health or life are in danger, was eviscerated by Doe's exceedingly broad definition of health, an exception that swallows the rule. Nebraska's current ban on post-viability abortions is similarly rendered meaningless by its inclusion of this broad health exception. So here we are again with another bill to try to restore some level of recognition and protection for unborn human life. And the pro-life movement will not cease coming before you until the justice of recognizing and protecting preborn human beings in law is achieved. Certainly, we will always work tirelessly to reduce abortions by addressing the underlying injustices that drive women to the desperate and violent act of having their own offspring destroyed. And, Senator McGill, I thank you for bringing up LB1110. If I weren't here, I'd be testifying over there. In fact, the Catholic Conference is and in fact all of the pro-life groups have gone on record, at least the majority of them, of the major groups, in support of that bill. And we are strongly working hard with our grass roots to support that effort. [LB1103]

SENATOR McGILL: And I knew that and I thank you for that. [LB1103]

GREG SCHLEPPENBACH: Our goal is not merely to make abortion illegal but to make it unthinkable. Women deserve better than abortion and our society can do better. But make no mistake, reducing the incidence of abortion alone is not sufficient. True justice will only be achieved when every human being, no matter how small, vulnerable or

marginalized is recognized and protected in law. Please vote to advance this bill. Thank you. [LB1103]

SENATOR ASHFORD: Thank you, Greg. Thank you. We're now going to go to the opponents. The first testifier is Leslie Griffin. And, Leslie, I gave the first group eight minutes, I said seven, that was a trick, they actually got eight. So you have eight minutes. I would also mention that in about a half hour or so Senator Lathrop will be taking over as...to chair the remainder of the session as I have to leave. But with that, good afternoon. [LB1103]

LESLIE GRIFFIN: Good afternoon, Senator Ashford and members of the committee. Thank you for allowing me to testify before you today. My name is Leslie Griffin. I hold the Larry and Joanne Doherty chair in legal ethics at the University of Houston Law Center, where I teach constitutional law and bioethics. And in that capacity, I want to explain why the bill is unconstitutional for two reasons. And the first reason is that it bans pre-viability abortions by setting the 20-week definition into the text of the bill. And the second reason that it's unconstitutional is that even if you read it to ban post-viability abortions, the exception provision is not an adequate health exception provision. And I base these two conclusions on the current law as explained by Justice Kennedy in the Carhart decision, where he made very clear at the beginning that he still abides by the principles of Casey. And so he said, principle one, which is unchanged after the Carhart II case is that you...before viability the state's interests are not strong enough to support a prohibition of abortion. And he says, "the state may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." And so that viability line still stands according to the language of Justice Kennedy. And this bill interferes with that by, as we heard earlier, by setting the 20-week stage and saying, well, instead of using the legal standard which is viability, it sets the 20-week standard, which is not the viability standard. Now on my second point is even if you were to say, well, it's really a post-viability standard, I think that you have to remember that, as Justice Kennedy said, the standard post-viability is that the state's power to restrict abortions post-viability, you have to have exceptions for the woman's life or health. And if you look at the language that you've discussed so often today in the earlier testimony, and that language in Section 5 where it says the exception is "to avert serious risk of substantial and irreversible physical impairment of a major bodily function." Now see, that type of exception is inadequate under the case law because it limits physical conditions, right? It's not physical health, it's very severe physical health. And so it's a very restrictive physical health exception. And then the next language where it says, "no such conditions shall be deemed to exist based on a claim about the woman's emotional status." I mean, those are the questions that Senator Council raised over and over again. That second provision doesn't allow the woman's mental health to be taken care of at all. And so you have this exception provision which doesn't define physical health broadly enough and which doesn't allow mental health to be considered at all. And I think the standard there is very clear. The standard was set by the companion

case to Roe v. Wade, Doe v. Bolton, in which there was a woman who did have mental illness. And in that opinion the court said very clearly that physical, emotional, psychological, familial, the woman's age, all these factors relate to health. And so...and that has been the law since then. Now I know there was earlier testimony that the medical exception, the emergency exception in the Casey case, in 1992 changed that. But I think it's very important to say that that's a completely different context that's irrelevant to the issue here. The medical emergency exception in Casey is just that, it says, you know, if we allow the states to impose some kind of waiting limit so that the woman can get more information, in a medical emergency we'll let some limitations be overridden to protect the woman in the midst of a medical emergency. But the medical emergency circumstances do not set the rule of a woman's health. So the medical emergency situation is one context where you can override state attempts to delay the abortion decision in order to protect the woman's health. The general rule on the woman's health exception, post-viability, is that you have to take into account the woman's full physical health. And this bill is unconstitutional because it allows the exception only for very narrow physical health and then not at all for mental health. And so I think that that part is unconstitutional as well. And if you consider that this is the exception in the post-viability setting, then you have to follow the language of Carhart I , which said, you know, if something is unconstitutional in the post-viability setting, right, if this exception is unconstitutional in the post-viability setting then it clearly has to be unconstitutional in the pre-viability setting, which is still involved in the legislation. That was my first point. So I hope that's addressed some of the points you're interested in. I'm happy to answer your questions. [LB1103]

SENATOR ASHFORD: Any questions of Leslie? Seeing none, thank you. [LB1103]

LESLIE GRIFFIN: Thank you. [LB1103]

SENATOR ASHFORD: Caitlin, Caitlin, I'm sorry. I should know that, figured that out. [LB1103]

CAITLIN BORGMANN: Good afternoon. Thank you for the opportunity to testify today in opposition to LB1103. My name is Caitlin Borgmann and I'm a professor of law at the City University of New York School of Law, where I teach and write in the areas of constitutional law, family law and reproductive rights. I've published numerous articles on abortion and other constitutional law issues in scholarly journals. And although I'm from New York, I grew up in Montana and spend as much time there as possible. So I'm always glad to come to a place with wide open spaces. My testimony today is going to focus on the constitutional flaws in LB1103. And first, I just want to say a little bit about the constitutional framework that governs this particular bill. As some of the witnesses have already testified, Justice Kennedy coauthored the controlling opinion in Planned Parenthood v. Casey, which upheld the constitutional right to abortion declared in Roe v. Wade. And while the underburden standard established by Casey is somewhat

complex in that it allows for certain abortion restrictions in the pre-viability period and not others, Casey's bottom line as it applies to LB1103 is simple and straightforward. Before viability the state may not ban abortions. And after viability the state may ban abortions but only as long as it makes exceptions for the woman's life and health. Viability is the key to the Casey framework. In Casey the court strongly and repeatedly reaffirmed Roe's emphasis on viability as "the earliest point at which the state's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." Before viability the Casey standard is the underburden standard. It certainly allows no abortion bans. And it also allows no restrictions that have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion. The woman's right to terminate her pregnancy before viability, said the court in Casey, is the most central principle of Roe v. Wade, it is a rule of law and a component of liberty we cannot renounce. In addition, the court made clear in Casey that health exceptions also apply in the pre-viability period. After viability, Casey retained the Roe framework, it made no change to the Roe framework. So as before, post-viability bans on abortion are prohibited where necessary to protect a woman's life or health. Nothing in the court's opinion, in Gonzales v. Carhart, in 2007, changes this. In Gonzales the court explicitly stated that it was applying Casey, again Gonzales v. Carhart was authored by Justice Kennedy who was a coauthor of the controlling opinion in Casey. In Gonzales the court said that before viability a state may not prohibit any woman from making the ultimate decision to terminate her pregnancy. And furthermore, Gonzales v. Carhart is not relevant here in the sense that it was the addressing something that was completely different, which was a ban on abortion procedures. And the way the Supreme Court interpreted that ban in Gonzales v. Carhart was to prohibit only a particular abortion procedure and not to reach the most commonly used method of abortion in the second trimester of pregnancy. And therefore, the court could conclude that the ban did not impose an undue burden before...on previable abortions. Gonzales v. Carhart said nothing about fetal pain or acknowledging it as a state interest that could justify a pre-viability abortion ban. LB1103 is an undue burden then because it unconstitutionally bans pre-viability abortions. The bill doesn't purport to ban abortions at the point of viability. In fact, of course, the bill's sponsor admits that it pushes the line to earlier than fetal viability. But even if it purported to hinge on viability, the court is clear that viability cannot be fixed at a particular point in pregnancy by statute. And many cases have established this, including Roe v. Wade, Planned Parenthood v. Danforth, Colautti v. Franklin, Webster v. Reproductive Health Services, in 1989, and significantly in a Tenth Circuit case in 1996, the court, in a case called Jane L. v. Bangerter, addressed a ban similar to this one which banned abortion in the same period from 20 weeks on and found that the ban was unconstitutional under those precedents that I just cited. The reason for this is that viability varies with each pregnancy. Some fetuses never become viable. A fetus that has no brain will never become viable and cannot survive outside of pregnancy, regardless of the stage of pregnancy. And in general, fetuses are not generally understood to have achieved viability until at least two weeks after the period specified in this bill. LB1103 also unconstitutionally endangers women's health.

Although a state may prohibit abortions entirely after viability, it must always include exceptions to protect women's health. And the court has not put any qualifiers on health in this context. So as Professor Griffin testified, the medical exception that was at issue in Casey was a medical emergency exception that applied to pre-viability restrictions that by definition didn't prohibit abortion but it merely imposed burdens on the abortion decision. And so the medical emergency exception in those circumstances made it possible for women with medical emergencies to get an abortion sooner where there was no question of women not getting abortions at all under Casey. In the post-viability period women must have the opportunity to get an abortion to protect their health. And again the state, in Casey and in no other decision has the court ever pulled back from defining health in a way that would encompass mental health as well as physical health. Finally, I want to point out that there is nothing in Gonzales v. Carhart that would change any of this. In order for the current Supreme Court to uphold a restriction such as this they would need to have Justice Kennedy in the majority. And in order to do that Justice Kennedy would have to overrule his own precedent in Planned Parenthood v. Casey, which I think is extremely unlikely. I think the committee should not pass this bill on the assumption that Justice Kennedy will reverse himself on the underburden standard that he helped to establish. Again, LB1103 is not like the procedure ban in Carhart II, it is a game-changer, it bans all abortions at a fixed time in pregnancy that occurs before viability. That is a slippery slope. If we start to ban abortions before viability that has no end. Kennedy and Justice Casey's joint opinion said that "liberty must not be extinguished for want of a line that is clear." The clear lines that the court has established time and time again are viability and the woman's health. And both of those lines are clearly crossed in LB1103. And I would now be happy to answer any questions that the committee might have. [LB1103]

SENATOR ASHFORD: Yes, Senator Christensen. [LB1103]

SENATOR CHRISTENSEN: Thank you, Mr. Chairman. Thank you for attending. You mentioned that the exception for the health of the mother, what is the difference of trying to deliver that baby and killing the baby? What's the difference? If you tried to deliver it and it lives, great, if it dies, same result as intent to kill. Why...I don't understand why you think you have to have the abortion side of this because we have had kids this young live. So why do we have to have the side that we have to kill versus just trying to deliver for the health of the mother? [LB1103]

CAITLIN BORGMANN: Thanks for your question. First of all, I think that even the sponsor acknowledges that this bill applies pre-viability, which means that it will at least in some cases address fetuses that are not viable and will not survive. And in those circumstances I think it's undisputable that women should have the safest procedure possible and that there would be no reason to make a woman go through labor or have a cesarean section, which at that stage of pregnancy is really a much more invasive and dangerous procedure called a hysterotomy. But even in later stages of pregnancy

where the fetus may be viable, there are vast differences between childbirth procedures and abortion procedures. And the Supreme Court has upheld time and time again the principle that doctors must be able to perform procedures in a way that is safest for their patients. And this bill prevents them from doing that. [LB1103]

SENATOR ASHFORD: I just have one question on the health issue because, to be honest, that's an issue that's bothered me over the years. If we have shifts in medical evidence that would suggest that, and there's been much discussion today about...from physicians about what's really going on in these various time frames of the gestation of an infant. As we know more about the viability or just the stage of gestation, the feeling of pain, all these things that go into the development of an infant, is it your sense...I guess, it is, you've said it, that the health definition in Doe continues to be the "must" definition? I mean, to me the more we know about what's going on there and the more we know from medical science what's going on and we certainly know more today than we did in 1972, 1973, you don't think there's any room on the definition of a woman's health for change? I mean, just... [LB1103]

CAITLIN BORGMANN: Well, I think that the question of a health exception is separate from the question of scientific evidence on fetal pain. [LB1103]

SENATOR ASHFORD: It is separate, but it's separate legally. But I don't...from a...it may be separate legally. But from just a common sense perspective the more you, and I'm not suggesting that...from a common sense perspective you have advancements in medical science. You have an early 1970s case that defined health as X. We have many...there have been many changes in that since that time as far as awareness of medical issues. So doesn't that to you seem... [LB1103]

CAITLIN BORGMANN: Well, I think...I mean, to me the question is not whether you contract the definition of health. Because I think that if...I'm not sure whether you're suggesting completely... [LB1103]

SENATOR ASHFORD: Well, I'm just suggesting, I mean, I think that's a very...that's a definition that to some extent would permit abortion at any time, whether it's post or pre-viability. If we're going to...theoretically, if we're going to, the health of the mother being the standard and the health being defined as it was in Doe, that what we're really kind of saying is that abortion at any time is going to happen or be permissible. It's going to be difficult to prove that a physician acted in a way that was violative of that standard. [LB1103]

CAITLIN BORGMANN: Well, I think that the question of whether to contract the definition of health, right, so I take it you're not suggesting that we should not have a health exception but that perhaps it should be narrower. [LB1103]

SENATOR ASHFORD: Well, I'm just say, I...I'm not suggesting, I'm just trying to understand because this is an issue that I've dealt with legislatively for 20-some years. And it seems to me that we know more today than we did 20 years ago when we first discussed this issue in the Legislature. [LB1103]

CAITLIN BORGMANN: Well, I...so when you talk about knowing more you're talking about the scientific research on fetal pain, right? So... [LB1103]

SENATOR ASHFORD: Or not just that, just on the development of the... [LB1103]

CAITLIN BORGMANN: ...of the fetus in general. So the viability standard, I think, is specifically designed to accommodate advances in medical...in medicine, right, on the issue of viability. And that's why it isn't fixed to a particular period of pregnancy. So that can evolve under the Casey standard, with no change to the Casey standard in terms of... [LB1103]

SENATOR ASHFORD: It can evolve to...from 24 to 23 to 22 weeks. [LB1103]

CAITLIN BORGMANN: Well, it isn't fixed presently as a matter of weeks. It is what the physician determined based on individual characteristics of that fetus and that pregnancy and all the factors involved in that particular pregnancy whether or not the fetus is viable. So that varies with every single pregnancy. And...but in terms of fetal pain, I think that good information about fetal pain should be developed and that women have a right to all information on fetal pain that is developed without a political agenda. But whether that supports... [LB1103]

SENATOR ASHFORD: No, I don't think this is a political agenda question. I think it's just a question of trying to do the right thing and trying to preserve human life wherever you can do it. I mean... [LB1103]

CAITLIN BORGMANN: Well, but that's why I just want to again say that I think not just as a legal matter but just as a logical matter to me, the issue of fetal pain is separate from the health restriction in the sense that you have to think about whether you think that fetal pain justifies an all out ban on all abortions in all circumstances or not. Right? But this...so bans like this, to me, are not about preventing all abortions, they're about preventing some. They don't really seem to me to be about fetal pain, they're about banning some abortions in a period prior to viability with some exceptions... [LB1103]

SENATOR ASHFORD: I understand, I understand. And I understand your point, I understand your point. [LB1103]

CAITLIN BORGMANN: So I think that there may be a different kind of bill that would address fetal pain in a different sort of way that would be about information or...yeah.

[LB1103]

SENATOR ASHFORD: Well, in the context of this bill I under...right, in the context of this bill I understand what you're saying. What I'm saying, I guess, is asking something that maybe is something for just general conversation. But it seems to me that the more you know about whether...the more you know about the unborn infant the more you have to question the health definition, the more you know at the different stages. That's all I'm saying. And that the burden, having a heavier burden or more of a burden as that development occurs is not illogical. I mean, because it...and just because viability or just because the health definition is in a particular case, I agree, that is an important criteria when we look at a bill. But you can't ignore either the fact that these...that we know so much more about the development of the infant. [LB1103]

CAITLIN BORGMANN: Yes. And I think that... [LB1103]

SENATOR ASHFORD: And what would have happened in Roe, had we known what we know now. I mean that's always a question that troubles me, would the decision have come out the same? These are just...these are things that come to my mind. [LB1103]

CAITLIN BORGMANN: Yeah, yes. And I think that, you know, in terms of a health exception, what I find to be important is that mental health not be excluded as a category, you know, as a categorical matter because I think there are clearly, you know, people, including some of the senators have already raised scenarios that provide compelling justifications for abortion, as compelling if not more than some physical circumstances that we might imagine. [LB1103]

SENATOR ASHFORD: Right. How serious a health problem does it have to be? [LB1103]

CAITLIN BORGMANN: Right, right, right. [LB1103]

SENATOR ASHFORD: What is the answer to that? How serious a health problem does it have to be to fit that? [LB1103]

CAITLIN BORGMANN: Well, I don't know if you're asking me as a matter of precedent or as a matter of my personal opinion. Obviously,... [LB1103]

SENATOR ASHFORD: Well, how about a matter of precedent? [LB1103]

CAITLIN BORGMANN: As a matter of precedent, the court has not addressed that question. I mean, I think, you know, in practical terms there are so few abortions that are performed after viability that this is not a huge universe of cases that ends up being litigated commonly. But I think that, you know, the precedents that we have don't

address that question. [LB1103]

SENATOR ASHFORD: I agree there aren't many cases. But it goes to who we are as a people. It isn't necessarily the number of cases, it's who we are and how do we define ourselves, it seems. So I agree, there are not a lot of cases, not a lot of precedent but it does get to some of that issue. I'm sorry. [LB1103]

CAITLIN BORGMANN: Right. Yeah, and I think whether to add qualifiers like "serious" and so on are very different questions from what's presented here, right? If you had...if you included mental health circumstances but you had some other qualifiers that made it clear that they were serious health concerns, then I think you'd have a much better...you'd be in a much better position under the current Supreme Court... [LB1103]

SENATOR ASHFORD: Precedentially, serious health concerns are acceptable. [LB1103]

CAITLIN BORGMANN: Yes, right. Yes, absolutely. [LB1103]

SENATOR ASHFORD: Senator Council. [LB1103]

SENATOR COUNCIL: Yes. Thank you, Chairman Ashford. And, Professor Borgmann, I guess, first of all I want to be sure that I understand your position from a constitutional perspective. It is your position that, despite the suggestion that LB1103 doesn't deal with viability, that that is the constitutional standard that would be applied in reviewing whether or not LB1103 is constitutional... [LB1103]

CAITLIN BORGMANN: That's correct. [LB1103]

SENATOR COUNCIL: ...under the current state of the law and how the law has evolved. [LB1103]

CAITLIN BORGMANN: That is correct. [LB1103]

SENATOR COUNCIL: And while Professor Collett, on the other hand, was of the opinion, and I guess basically her position is that this LB1103, I think, in her opinion presents a case of first impression. What is your thought about that? [LB1103]

CAITLIN BORGMANN: Well, it presents a case of first impression in the sense that the Supreme Court hasn't addressed this particular kind of restriction and it hasn't addressed this particular type of ban. And it hasn't addressed a ban that's premised on fetal pain as the asserted state interest. But, I mean, that's always true when you have, you know, a new piece of legislation that hasn't been tested in court. I think what the proponents of this bill are hoping is that the Supreme Court will change the standard.

And they are speculating that the Supreme Court would change the standard. What my analysis is based on is what the Supreme Court has said and what it has ruled on. And there is no indication based on the existing precedence that the court would go out on a limb and uphold this. And I think it could not do so consistently with the current precedent. So it would require the court to overrule Roe v. Wade because viability is the line after which bans are justified. And this is a ban. No one denies, even the supporters of this, that it is an abortion ban and that it applies in the pre-viability period. And that's simply not permissible under the existing precedence. [LB1103]

SENATOR COUNCIL: Okay. And then your opinion on Professor Collett's position that the Gonzales case shows...it is an indication of the court's movement away from viability being the standard and looking at the timing of the abortion and the procedure used. I'd be curious as to your response to that. [LB1103]

CAITLIN BORGMANN: I see nothing in Gonzales v. Carhart that indicates a move away from viability or that blurs the pre- and post-viability periods. The court...there was no reason for the court to address that because the restriction that was at issue in Gonzales v. Carhart clearly applied in the pre-viability period throughout the second trimester of pregnancy. And in fact, the court interpreted the ban very narrowly to ban only one procedure and not the most commonly used procedure. So there was no question that abortions were still permitted and they were still permitted using the most commonly used method. So there isn't anything in the opinion that I can see that has anything to do with viability or changing the line that the court drew at viability. [LB1103]

SENATOR COUNCIL: And then with regard to the health issue and the risk of a serious health event with the mother, the question was asked about the language of LB1103 that deals with the medical exception and the fact that the medical exception makes no reference to mental health and, in fact, goes to the length of specifically stating that a suicidal condition is not grounds for...does not fall within the definition of a medical emergency. I mean it goes to great length to carve that out. Dr...Professor Collett stated that that language comes out of the Casey decision, that is consistent with the medical emergency language... [LB1103]

CAITLIN BORGMANN: Right. [LB1103]

SENATOR COUNCIL: ...in the Casey decision. What is your understanding of the medical emergency language in the Casey decision? [LB1103]

CAITLIN BORGMANN: I disagree with her interpretation. The language is different than the language in Casey. First of all, the language in Casey doesn't include the addition of the word "physical" and the expressed exclusion of mental conditions, for example, the suicide scenario that you presented. In addition, the medical emergency exception in Casey was not a health exception in the context of an abortion ban, but rather an

exception that would be invoked when a woman needed to get an abortion without complying with the state mandated counseling requirements and the parental involvement requirements and so on that were imposed by that law. So they weren't...they were just...it was an emergency designed to allow women to get an abortion sooner and without complying with those restrictions, if a medical emergency required that. That's a very different circumstance from when you were banning all abortions and then you were saying that women can't get an abortion at all. So what this bill does is take a medical emergency exception, narrower than the one that was in Casey, in fact, and then putting it in the context of a post-viability or actually pre-viability ban on all abortions. [LB1103]

SENATOR COUNCIL: Okay. So, I mean, to maybe state that in a little more clear layman fashion, the medical exception in Casey was not a medical exception to the performance of an abortion, the act of, it was a medical exception from the requirements in order to proceed to an abortion. [LB1103]

CAITLIN BORGMANN: That's right, that's right. [LB1103]

SENATOR COUNCIL: So like a 24-hour waiting period or parental consent... [LB1103]

CAITLIN BORGMANN: Correct, right, those were the two. [LB1103]

SENATOR COUNCIL: And in order not to have to comply with those requirements you had to fall within a specified medical exception. [LB1103]

CAITLIN BORGMANN: That's right, that's right. And not only that, but the court actually discusses in Casey that the counseling requirement in fact had essentially a mental health exception in it. That providers did not have to comply with the counseling requirements if the evidence showed that it would be...that it would harm the mental health of their patients. So separate and apart from the medical emergency exception, the counseling provision itself had, effectively, a mental health exception embedded within it. [LB1103]

SENATOR COUNCIL: Well, and, I mean, just as a comment to those who have been present during the course of this hearing, I just think that it is interesting, and that may be a mild way to put it, that another committee is in hearing right now addressing the issue of provision of prenatal care. And when we talk about...in LB1103 we set out all of these legislative intent and what, you know, the interest of the state. And in that hearing our Department of Health and Human Services is testifying against extending prenatal care coverage. I just think that's rather ironic. [LB1103]

SENATOR LATHROP: Thank you. Oh, I'm sorry, you've got one more. I'm asleep at the switch. Senator Lautenbaugh has a question for you. [LB1103]

SENATOR LAUTENBAUGH: Thank you, Mr. Chair. And this may be improperly directed to you, but maybe you can tell me if it is. We've had some discussion about suicidal treatments or suicidal mental states. Do you know or have any reason to know, are there treatments for that that would not involve aborting the unborn child? [LB1103]

CAITLIN BORGMANN: I'm not an expert in mental health conditions. But I think there are many, many situations that one could imagine beyond even suicide that are not encompassed by this bill, for example, a young victim of rape who doesn't even realize that she's pregnant until after the 20th week of pregnancy, a victim of incest, a woman with a wanted pregnancy who discovers that her fetus is utterly incompatible with life and has to then otherwise go through the remainder of her pregnancy knowing that this fetus will not survive. So, I think that there are a number of mental health circumstances that I can envision arising and that I know have arisen in pregnancies that are not covered by the bill. As to what other potential treatments there might be, I can't testify to that. [LB1103]

SENATOR LAUTENBAUGH: Can you envision a scenario where the court presented with the first time of evidence of suffering of an unborn child in the womb might recoil from the mental health exception and actually adopt this bill as constitutional? [LB1103]

CAITLIN BORGMANN: I don't. I think that the problem with this bill is that it is not tied to fetal pain specifically. So it still allows some abortions. And why you would draw the line at mental health again is not clear to me since there are many compelling mental health circumstances that I think should not be distinguished from physical because they're equally of compelling concern. And I think that we'd be in a different scenario entirely if we had some sort of solid scientific evidence on fetal pain and this bill addressed that in some way, provided information to women or in some other way addressed fetal pain. But this is an incomplete ban, right? And then it's a pre-viability ban. It's not logically connected, to me it doesn't appear logically connected to its stated intent. [LB1103]

SENATOR LAUTENBAUGH: What information would you need to conclude that fetal pain exists at 20 weeks that we don't already have? [LB1103]

CAITLIN BORGMANN: Well, I'm not an expert in fetal pain. But my understanding is that the weight of the scientific evidence is that fetuses generally do not experience pain before viability. And Nebraska already has a post-viability ban in place. So I think that the majority of the cases that are represented by medical evidence, scientific evidence are already banned in Nebraska. As to that earlier period, I think, you know, the same evidence that we would require for anything else, which would be solid scientific evidence. And at this point my understanding is, although I'm not an expert in the area, is that it's still quite hotly disputed as to at what point and whether fetuses can experience pain. [LB1103]

SENATOR LAUTENBAUGH: Okay, thank you. [LB1103]

CAITLIN BORGMANN: Thank you very much. [LB1103]

SENATOR LATHROP: I think that's it. Thank you for your testimony. [LB1103]

CAITLIN BORGMANN: Thank you. [LB1103]

SENATOR LATHROP: Looks like next is Kyle Carlson. Well, Senator Ashford left me with a note that you have 5 minutes. [LB1103]

KYLE CARLSON: It won't take me that long. [LB1103]

SENATOR LATHROP: Okay. [LB1103]

KYLE CARLSON: Practice, I had it to 3:15, so we'll see. (Laughter) [LB1103]

SENATOR LATHROP: Perfect. Well, we won't interrupt you. (Laughter) [LB1103]

KYLE CARLSON: (Exhibit 13) Good afternoon. My name is Kyle Carlson and I am in-house counsel for Planned Parenthood of the Heartland. I'd like to thank you for the opportunity to speak today on LB1103. In addition to my written testimony, I've also attached a memo from former Acting Solicitor General, Walter Dellinger, regarding the constitutionality of LB1103. And I'll touch on some of those points as well. Planned Parenthood of the Heartland opposes LB1103 because it's unconstitutional in several ways but I want to point out three ways in particular. Number one, it bans pre-viability abortions. Number two, it fails to state a constitutionally recognized state interest. And three, it fails to adequately protect a woman's health. On the first point, according to Planned Parenthood v. Casey, the U.S. Constitution prohibits a state from enacting a law that bans abortion prior to the point in pregnancy when the fetus is viable. Furthermore, in Planned Parenthood of Central Missouri v. Danforth, the Supreme Court held that "Determination of whether a fetus is viable is and must be a matter for the judgment of the responsible attending physician." Also in Danforth, the court specifically rejected as unconstitutional laws which provide for a fixed gestational limit on when abortions can be performed. In Colautti v. Franklin, the court explained that decision saying, "Because viability may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability, be it weeks of gestation or fetal weight or any other single factor, as the determinant of when the state has a compelling interest in the life or health of a fetus." So because this bill sets a gestational age when abortions are to be banned and does not permit the responsible attending physician to determine whether or not the fetus is viable, LB1103 is unconstitutional. Secondly, the bill fails to state a

constitutionally recognized state interest. To date, the United States Supreme Court has only ever recognized two state interests that are compelling in the context of an abortion ban. Those two state interests are either (1) the preservation of the potential life represented by a viable fetus, or (2) regulation necessary to protect the health of the women undergoing the medical procedure. The interest asserted by the state of Nebraska in this bill is neither of these. And finally, LB1103 is unconstitutional because it fails to adequately protect a woman's health with an appropriate exception. The Supreme Court has long held that even after viability, when a state may prohibit abortion, the prohibition must make exception for where the abortion is necessary, in the appropriate medical judgment, for the preservation of the life or health of the woman. The exception in LB1103 only applies when the abortion is necessary to "avert serious risk of substantial and irreversible physical impairment of a major bodily function." This exception language is too narrow to pass constitutional muster and threatens the health and safety of pregnant women in Nebraska. So to repeat, this bill is unconstitutional for several reasons that we've talked about. But I've pointed out three in particular, in that it bans pre-viability abortions, it fails to state a constitutionally recognized state interest, and it fails to adequately protect a woman's health. So for these reasons, I would request that the committee not approve this piece of legislation as drafted. And I would certainly entertain any questions that you may have. [LB1103]

SENATOR LATHROP: Thank you, Kyle. Senator Council. [LB1103]

SENATOR COUNCIL: Yes. Thank you, Mr. Carlson. On the first page of your testimony, in your analysis of the Danforth case and the Colautti case, and you read the statement from the Colautti decision where the court explained that, "Because viability may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability, be it weeks of gestation or fetal weight or any other single factor, as a determinant of when the state has a compelling interest in the life or health of the fetus." There has been testimony today that LB1103 doesn't address viability, although it's tied to 20 weeks being the point, some determining point in this analysis of pain. In your mind is that...you know that... accepting that the pain is the triggering event here and not viability. Under the Colautti, the court's decision in Colautti, doesn't that statement suggest that that's not a compelling interest? [LB1103]

KYLE CARLSON: I think the clear constitutional principles set out that viability is the standard. And that the section that I've quoted from Colautti explains that even if the considerations in this bill were not just stand-alone but were in conjunction with trying to determine viability, it still wouldn't be enough. The viability is the clear line. And then you cannot pick and choose any one single factor that may go into viability as rationalization to set a fixed gestational week period where you can ban abortions entirely. [LB1103]

SENATOR COUNCIL: That's all I have, Mr. Chair. [LB1103]

SENATOR LATHROP: Any other questions? Senator Coash. [LB1103]

SENATOR COASH: Thank you, Senator Lathrop. Thank you, Kyle. Just reading your testimony, Planned Parenthood doesn't perform any abortions 20 weeks or after? [LB1103]

KYLE CARLSON: Correct. [LB1103]

SENATOR COASH: Does Planned Parenthood have a position on whether or not a fetus can feel pain at 20 weeks or before? [LB1103]

KYLE CARLSON: I'm really...from a legal perspective I can't really answer that question. It's not...my understanding of the medical...of the research that's been done out there is that there's conflict on that. And I don't think we've got a particular position on that point or have made a determination on that point. [LB1103]

SENATOR COASH: Okay, thank you. [LB1103]

SENATOR LATHROP: I see no other questions. Thank you, Mr. Carlson. [LB1103]

KYLE CARLSON: Thank you very much, I appreciate it. [LB1103]

SENATOR LATHROP: Next up would be Dr. Darla Eisenhauer. Doctor, we have you down for five minutes. Is that going to give you enough time? [LB1103]

DARLA EISENHAUER: Plenty, thank you. [LB1103]

SENATOR LATHROP: Okay. Would you spell your last name for us too. [LB1103]

DARLA EISENHAUER: Sure. My last name is Eisenhauer, it's E-i-s-e-n-h-a-u-e-r. And I am an obstetrician and gynecologist here in the Lincoln area, practicing in private practice. And I'm here just as my own representative today and regarding concerns regarding LB1103 and how it could potentially impact some of my patients. Sorry, I'm...(laugh). So some of the general areas that I wanted to talk to you about today starting off where...is the fact that they are...in this bill there is a specific gestational age as a cutoff for termination regardless of the mode of termination or ending of a pregnancy, the only exception being medical emergency of a mother when there are other factors that can play a role in this decision. In my experience with late-term abortions, these are extremely difficult decisions for families and mothers to make. And most of them at this point in pregnancy are based on new findings, either regarding the mother's well-being or the findings regarding the baby's well-being. When looking at options and things with mothers with a medical condition, I have had cases where

people have been diagnosed with cervical cancer in the early second trimester of her pregnancy. And that is an overwhelming diagnosis, as you can imagine, particularly in pregnancy. And it takes time to make sure that patient gets the appropriate counseling by specialists, potentially second opinions, and that can approach that 20-week line before that patient feels she has adequate information to decide what is best for her overall well-being and potentially how that will impact her baby. Treatment of cervical cancer is hysterectomy or radiation and neither of those is compatible with continuing a pregnancy. I have had patients that have chose both options: to continue on with the pregnancy, and I've had others that have chosen to forgo the pregnancy and move on with treatment of their cancer. Those patients that choose to continue on with the pregnancy, they do run some risk of that cancer potentially progressing and that changing their survival rate. Now as a general rule in medicine, we consider an otherwise healthy fetus to be potentially viable at around 24 weeks gestation, and that's based on last menstrual period, so based on this bill that would be 22 weeks. However, early pregnancy situations, there is the possibility down to 21 weeks based on the definition in this bill. And that sometimes is determined based on the baby's physical size, our ability to intubate a baby, the airway being large enough, and then enough lung development in that child to actually oxygenate the body to continue bodily functions. So obviously, women have a very difficult decision when it comes to these. The other thing...the other area that this bill does not necessarily address is lethal and potentially life-threatening anomalies found in babies. There are some babies, during the developmental stage, that we determine are not going to be compatible with life following delivery or delivery from the uterus. We do offer screening tests throughout pregnancy so we can find out this information as soon as possible to limit the risk to the mother if these anomalies are found. However, there again, some of them are not found until approximately that same 20-week gestational cutoff that would be set down by this bill. So not only are these women facing this very difficult devastating decision on how to proceed with a known lethal anomaly, they also now are being put under a deadline to make this decision, and there's going to be a few women that are going to miss the deadline. And as a practitioner, my main concern with that are for those women that are unable to make that decision or miss the cutoff of the 20 weeks to make that decision. Then I, essentially, will end up abandoning them and their care at the most difficult point in their pregnancy by telling them they have to go to another state in order to get their care away from their family network and support system. Again, I have had cases of pregnant women who have continued on with pregnancies with lethal anomalies, and fortunately I was in a location where there was perinatal hospice to provide support for these women because that, too, is a difficult decision to make. And as opposed...in the section of the mental health exception, as a practitioner we focus or I focus on the complete woman's health. We look at both physical, mental, and social health when we are treating women. We don't exclude any particular area because they all are interlaced in how that woman and how that baby will be impacted for the rest of their lives. These women with mental health, there has been shown that there is impact on the baby's growth, increased risk of preterm labor and delivery and higher risk...rates of

preeclampsia. And the medications, there are medications and treatments for these women. But again, some of those also carry risk to the baby and so there is no clear answer with these types of restrictions. [LB1103]

SENATOR LATHROP: Very good. Thank you, Doctor. Are there any questions? I see none. Thank you, Dr. Eisenhauer, appreciate your testimony today. Next up, Rosemary Esseks. And, Ms. Esseks, we have you and the remaining witnesses at 3 minutes. [LB1103]

ROSEMARY ESSEKS: Okay. I wonder if I could have an extra 30 seconds to correct some information that was presented previously that was not correct? [LB1103]

SENATOR LATHROP: Okay, we'll give you 3 minutes and 30 seconds. [LB1103]

ROSEMARY ESSEKS: (Exhibit 14) Thank you. I'll see if I can do that. Yes, again, my name is Dr. Rosemary Esseks. I'm a licensed psychologist in Lincoln, specializing in child and family issues and trauma treatment. Today I represent the Nebraska Psychological Association in stating opposition to LB1103 due to the lack of a mental health exemption. Correcting the previous information, it was mentioned before that most women experience significant negative mental health effects from an abortion. That is not actually correct. The report of the Joint Task Force of the American Psychological Association, which was published in, I believe, August in 2008, looked at, very carefully at the research that's available. It included an examination of the quality of that research and concluded that there's no compelling evidence of a postabortion syndrome. Most women do not have negative effects after an abortion, particularly a first trimester abortion. There is somewhat of an increased risk of a negative mental health effect after a later abortion, in part due to some of the circumstances that would lead a woman to have an abortion at that point. That information again is available at apa.org or I can provide that for you. To get into my prepared testimony, the concern that the Abortion Pain Prevention Act has a significant potential to cause mental as well as physical pain to women and girls at a particularly vulnerable moment in their lives. As was mentioned previously, women considering an abortion at 20-plus weeks are often in situations involving a previously wanted pregnancy that developed severe complications, such as a recently discovered major fetal abnormality or an emerging maternal health problem that, while not eminently life-threatening, is still very grave. These are women facing very serious and often traumatic situations and this bill, far from supporting such women, has the potential to make their lives even more miserable. For some women and girls major mental health issues may contribute to their failure to detect a pregnancy until 20 weeks or later. Based on national estimates, about 9,000 Nebraska women suffer from bipolar disorder. A woman in a severe depressive or manic phase may not be sufficiently competent to detect or take appropriate action regarding a pregnancy. The psychotropic medications necessary for the treatment of bipolar disorder carry a significant risk to fetal development. However, if she stops

treatment, the woman's bipolar disorder places her at risk for impulsive behavior, including attempting suicide. However, the bill specifically states that an intention to commit suicide would not grant her a mental health exception; there's no mental health exception. It's odd that this obviously life-threatening condition is excluded, that this mental health does not affect or rank in importance with physical health. Again, using national estimates, about 9,000 women in Nebraska suffer from schizophrenia. People with schizophrenia are also treated by psychotropic medications that are not safe in pregnancy either, giving her the same choice then, continue with the pregnancy, possibly harming the fetus. Women with schizophrenia also tend to be impulsive. Another situation of concern is sexual victimization. According to Nebraska Health and Human Services, in 2008 there were 498 substantiated cases of child sexual assault. Five percent of female victims become pregnant after a sexual assault, thus an adolescent being repeatedly abused would be at very high risk of an eventual pregnancy. She may not be aware of the significance of missing a period, and may not detect a pregnancy until late. Very young girls are more likely than older mothers to experience severe and even fatal pregnancy complications for themselves and their offspring and are at increased risk of dropping out of school, contracting sexually transmitted infections and living in poverty. Victims of sexual assault, both children and adults, have very high rates of posttraumatic stress disorder, a condition that would likely be exacerbated by the constant reminder of a pregnancy. But this would also not grant them an exemption. In such situations, decision-making powers should rest with the individual affected in consultation with her support network and her medical and mental health providers. These vulnerable women and girls should not be subjected to arbitrary restrictions that do not address their individual circumstances. Thank you. [LB1103]

SENATOR LATHROP: You got through it. Thank you. Are there any questions for the Doctor? Yes, Senator Council. [LB1103]

SENATOR COUNCIL: Yes. Thank you very much, Dr. Esseks. I don't know if you were in the room when I was asking some of the questions about mental health conditions and various treatments. [LB1103]

ROSEMARY ESSEKS: Um-hum. [LB1103]

SENATOR COUNCIL: Electroconvulsive therapy...and as I understand that, that causes seizures or it's imposed seizures. What does that do to a person? I mean,... [LB1103]

ROSEMARY ESSEKS: As a psychologist, I don't conduct electroconvulsive therapy. My understanding is that it changes electrical activity in the brain, which can be useful in cases of severe depression that don't respond to medications. I've only worked with a couple of people who have been through it. My understanding is it's done very rarely, rarely, I should say. [LB1103]

SENATOR COUNCIL: Okay. So when you say and you stated by saying they don't respond to medications, so the first level of treatment would be medication. [LB1103]

ROSEMARY ESSEKS: Certainly would be medication and psychological treatments. [LB1103]

SENATOR COUNCIL: And in terms of medications, I mean you're not an ob-gyn, but I would imagine that you would, as the treating psychologist, if the individual was pregnant, that would determine what kind of medication you would prescribe. [LB1103]

ROSEMARY ESSEKS: Yeah, I'm not a prescriber. That would be done by their prescriber, their medical prescriber. But I've had input into those decisions. But again, I do not prescribe. [LB1103]

SENATOR COUNCIL: Okay. And in terms of and in fact, the Speaker, when he introduced the bill and was responding to my questions about mental health and the treatment, suggested that an individual could be placed in a treatment facility and monitored and supervised for the remainder of the term of their pregnancy. As a medical professional in the mental health area, what kind of effect long term could that have on that individual? [LB1103]

ROSEMARY ESSEKS: Well, I would imagine that would be...a lot of individuals would object to being confined against their will. [LB1103]

SENATOR COUNCIL: Okay. Because the decision is being taken away from them with regard to whether they complete the term. The freedom is being taken away from them in terms of confinement. And then, you know, one of the issues that really hasn't been discussed here is in the situation where you may have someone with a diagnosed condition that could lead to them harming...either committing suicide or causing serious bodily harm to themselves. The intent of LB1103 is to force that person to carry to term, give birth and do what? [LB1103]

ROSEMARY ESSEKS: That's a good question. I don't know. [LB1103]

SENATOR COUNCIL: I mean, in that situation would it be healthy for that child to be...remain with that mother? [LB1103]

ROSEMARY ESSEKS: The decision, obviously, would be made on a case-by-case basis. But you do, as you say, wonder long term how that would affect the woman involved and her relationship with the child, if she continued to have one. [LB1103]

SENATOR COUNCIL: It concerns me because we obviously don't have a compelling

interest on prenatal care. I doubt we'll have a compelling state interest on taking care of children who the mother chooses not to take care of. [LB1103]

ROSEMARY ESSEKS: And there is concern, too, would there be...there's something of a shortage of psychiatric beds as it is. [LB1103]

SENATOR COUNCIL: Thank you. [LB1103]

SENATOR LATHROP: I see no other questions. Thank you, Doctor, we appreciate your testimony and your care with the time. Next will be Tim Mosher, please. Good afternoon, welcome to the committee. [LB1103]

TIMOTHY MOSHER: Good afternoon. I have some handouts. Ladies and gentlemen, this is my full testimony. [LB1103]

SENATOR LATHROP: Why don't we have you give your name and spell your last name for us too. [LB1103]

TIMOTHY MOSHER: (Exhibit 15) Sure, thank you. My name is Timothy Mosher, M-o-s-h-e-r. I originally prepared this testimony for ten minutes worth of response time. But I realize that that's not going to be possible today, so I also prepared a shortened version. Before I get started, I would like to offer each one of you respect. Regardless of whether or not you are personally pro-choice or personally pro-life, I want you to know that I respect each one of you even though I've never met you. I am a husband and father of three boys. My wife, Dawn, and my sons, Justin, Brenden and Ryan, who are 20, 7 and 3, they mean the world to me. I consider myself a devoted person with a deep capacity to love. My family of origin has been and is currently in the field of education. I, however, am a career firefighter and an emergency medical technician, with 24 years of experience. I've been blessed to be witness to many of life's miracles, from assisting in the home birth of a child that was so eager to be born that he could not wait to be delivered at a hospital, to performing CPR on a 50-year-old man, offering him a second chance to live. I've also been witness to the negative side of the fire service, the suicides, the car wrecks and fatal home fires. It is hard for anyone to understand both sides of the fire service unless they themselves have walked a mile in my fire boots. In addition to my sons, I know that I also have a daughter. Her name is Karalyn Grace Mosher. She is here with me right now, not physically but spiritually. Dawn and I wanted one last child to complete our family and we both hoped to have a daughter. We conceived a child on January 2004, and in May of 2004 we went to our doctor for our comprehensive ultrasound and learned that we were in fact expecting a baby girl. We also learned that our baby girl had unfortunately been diagnosed with the worst level of spina bifida. We met with a genetic counselor in a prominent hospital in St. Louis and, with the assistance of a perinatal specialist who specialized in fetal abnormalities, we began all testing needed to clarify our daughter's true condition. Our daughter suffered

from the most severe level of spina bifida. The pressure within her skull from the fluid buildup forced her brain to develop at the base of the cranium and her skull was shaped like a lemon. All treatable options became no options at all. The damage was beyond repair. Dawn and I spent days researching our options, assessing our options. We both wanted to base any and all decisions on real, proper and factual information, not solely upon opinion or feelings. We also relied heavily upon prayer and personal faith to show us the way, help us to make the best possible decision for our daughter. We wanted to base any decisions upon love, respect, dignity and devotion, not hatred or resentment for how our life cards had been dealt to us to manage. We looked hard within our hearts and asked one terribly simple yet terribly complicated question: What did we want for our daughter that was facing a quality of life surrounded around pain and suffering with the conclusion that it would ultimately have led to a premature death? Dawn and I did not want our daughter to suffer. The decision was filled with much sorrow. And unless any of you have had to walk through this type of experience, you will never truly in your own hearts and souls understand the magnitude of my pain. Dawn and I never thought we'd be included in statistics, like neural tube defects or have to make a decision to go through a late-term abortion. But then again, who said that life was fair and that Dawn and I along with any of you would ever be exempt from becoming a statistic for others to dissect, criticize or offer misunderstanding, especially from a political entity? I've learned some tough lessons through our painful experiences. I should hold off on my opinions of others and not cast stones unless I, myself, have to walk a mile in someone else's painful shoes. I have learned that life is not always black or white but gray as well. I have also learned that I ultimately do not have the right to decide for another human being how they, themselves, handle their own black and white issues or within gray what needs to become black and white based upon my belief system. [LB1103]

SENATOR LATHROP: Hey, Tim, we're going to have you sum up, if you would. [LB1103]

TIM MOSHER: Okay, I'm... [LB1103]

SENATOR LATHROP: We do have your testimony and we'll have an opportunity to read the balance of it. [LB1103]

TIM MOSHER: Okay. All right. Our last son, Ryan Timothy Mosher was born January 2007. His birth represents the miracles, despite the tragic times endured along with my family's journey through life. Ryan Timothy has red hair and green eyes and is a completely healthy boy. Ryan was born one day early and arrived on Martin Luther King's birthday. The irony of that is as Martin Luther King left behind a message of freedom, just as too my story represents freedom. From one public servant to another, thank you for allowing me just for today to share my story with you. Thank you for hearing my voice and the voice of all others that have had the unfortunate opportunity to walk a mile in my painful shoes. Thank you. [LB1103]

SENATOR LATHROP: Thanks, Tim. Are there any questions? I see none. Thank you for coming down. We appreciate it when folks share their personal stories, as you have. [LB1103]

TIM MOSHER: Thank you. [LB1103]

SENATOR LATHROP: Tiffany Campbell. [LB1103]

TIFFANY CAMPBELL: (Exhibit 16) Good afternoon. My name is Tiffany Campbell, T-i-f-f-a-n-y C-a-m-p-b-e-l-l. I'm a mother of three and a native daughter of Nebraska, testifying in opposition of LB1103. My husband, Chris, and I, in consultation with our doctors, made the difficult decision to have an abortion in 2006. We did it so we could bring our youngest son into this world rather than burying two babies. Here is what happened. Chris and I were happily married with two children and looking to add to our family when we became pregnant. We were thrilled. Then at 19-weeks gestation I landed in the hospital with a severe kidney infection and received my very first ultrasound for that pregnancy. We were overjoyed to see that we were expecting identical twin boys. But then we learned that our sons were suffering from a severe case of twin-to-twin transfusion syndrome, a condition where twins unequally share blood circulation. One baby was receiving too much blood, resulting in a strained heart and acute risk of heart failure. Meanwhile, his brother was clinging to life but his blood supply was insufficient to sustain normal development. This is an affliction where if one twin dies in utero, the other faces a significant risk of death. In fact, severe TTTS has a 60 to 100 percent fatal or neonatal mortality rate if left untreated. My husband and I were sent to one of the premiere fetal care centers in the world and told our only hope for saving this pregnancy was to have a selective termination of one of the babies and hope that the other twin would survive. So we were faced with an awful situation that forced us to examine our most fundamental moral and spiritual beliefs. At first we just didn't want to believe the doctor's prognosis. We wanted so badly for our boys to win the fight, but we couldn't stay on the sidelines forever. Against all of our hopes and prayers, the twins' conditions continued to deteriorate quickly. This was the most difficult decision of our lives. We could let nature run its course and pray that by the grace of God our boys would miraculously survive or we could abort the sicker of the two, giving his brother a legitimate shot at life. We decided to abort one of our sons at 22 weeks. Our decision was predicated on consultation with experts in the field of fetal medicine, excuse me, our personal beliefs, prayers and a mother's intuition. This was an excruciating decision for us to make, but it would have been unimaginably worse if our decision had been criminalized. Under LB1103, the lifesaving procedure that we underwent would have been illegal and unavailable in Nebraska. Under LB1103, we would have been forced to go against our doctors' judgment and our better judgment as a family. We would have buried two babies instead of one. If LB1103 is passed, every other woman and family in America would be stripped of their decision to make this

private medical decision in consultation with their doctor and clergy. Instead, the government would be dictating a family's personal choices. Today we have a healthy 3-year-old boy who is a treasure of his older brother and sister. He's the family jester, the optimist, the one with a quick smile and contagious giggle. It's like he made a pact with his twin brother to live passionately, to live for both of them in honor of the spirit of his fallen brother. Every day our youngest son's contagious giggle reminds us that we made the right decision for our family. Please vote no on LB1103 and let God be our judge. Are there any questions? [LB1103]

SENATOR LATHROP: Thanks, Tiffany. [LB1103]

SENATOR McGILL: Thanks very much. [LB1103]

TIFFANY CAMPBELL: Thank you. [LB1103]

SENATOR LATHROP: I am told, Tiffany, your testimony I appreciate. The written copy will be incorporated into the...into our record. We are having difficulty with the recording. And so before we call up the next witness...have we rectified that? Okay, we're going to have to take a brief break while we...we want to make sure we have a transcript and a good record of this. [LB1103]

EASE []

SENATOR LATHROP: We are going to listen to or take testimony from two more opponents, they will be Sue Ellen Wall and Fritz Hudson. We will listen to neutral testimony and then have Senator Flood close. I would invite you, if you have not testified and wanted to or if you have written testimony and you would like us to read it, if you want to provide us with a written copy of testimony, as others have done, you can provide it to the pages and the pages will give that and distribute it among the committee members so we can have an opportunity to read the views of those who have not had an opportunity to testify. Okay. So that's kind of how this is going to work. And, hopefully, we're pretty close to out of here by 5:00. Next up is Sue Ellen Wall. [LB1103]

SUE ELLEN WALL: (Exhibit 17) Good afternoon, members of the committee. My name is Sue Ellen Wall. I live here in Lincoln, Nebraska, and I'm testifying today on behalf of myself as a longtime advocate of women and children and also as a member of the Pro-Choice Coalition. When...if you pass this bill as it's written with a fixed date attached to viability in the statute, it will be unconstitutional. And the A bill needs to include, I'm estimating, $300,000 to $1 million in legal fees to defend it because someone will challenge it. It is not constitutional. That money could be spent to feed the hungry children we have in Nebraska. Here's a novel idea, give their mothers birth control, a living wage, preschool expenses, child care, many, many other things. And you can't

call yourselves fiscal conservatives if you spend it passing a bill that you know will be found unconstitutional and you know will be challenged. We have...the other thing that I'm deeply concerned about is the government mandated childbirth. It is the right of a woman in this country to determine which children she will have and which children she will not. And if you start mandating how physicians have to do the work that they need to do and the choices that women must make, that is just simply not legal, it's not acceptable and it is, frankly, a terrifying thought. And that's what this bill does as it is currently written. I think we heard earlier...the thing I didn't hear today anything about, and I went to law school, not to medical school, is pain memory. What makes it hurt is not the autonomic electrical connections you heard about, described earlier by the physicians. It's the memory of the pain. And that happens when all the electrical fixtures are done and hooked up and then plugged in, and plugged in happens at birth and that's what makes it painful and, I believe, that's a red herring to try and begin to do what the Supreme Court has said you may not do. You may not set viability by legislative fiat. And that's what is wrong with this bill. And we strongly suggest that you leave it in committee and let it die a natural death. Thank you. [LB1103]

SENATOR LATHROP: Thanks, Sue Ellen. Are there any questions? I see none. Thank you for your testimony. And batting cleanup will be Fritz Hudson. [LB1103]

FRITZ HUDSON: Good afternoon, Senators. My name is Fritz Hudson. I'm the minister of the Unitarian Church here in Lincoln. I'm also a member of the Nebraska Bar. And I tell you those two things because I think I have some expertise in drawing distinctions between something you can consider morally wrong, even often so, and something which should be declared always a criminal act. I bring that question to you out of personal experience. I counsel women prior to abortions. I counsel adults prior to suicides. In almost all cases, I counsel against both of those acts. I believe that they are often morally wrong, but I question whether they are always so and that we should create a ban on them. I think this bill is more fairly named the late-term but pre-viability abortion criminalization act. And that's what I'm here to oppose. Because...why is that the case that I question it? Because these decisions are highly complex, contextualized decisions and I believe that at some times they are morally right. And if there are cases that they are morally right and if the bill has not been written so as to protect those cases from punishment, there should be no criminal sanction in taking those right actions or even in taking the actions in the reasonable belief that they are morally right. I would ask you to look about and see if there are cases beyond those excepted in the statute in which abortions post 20 weeks are morally right or reasonably possible to be so. I actually am here this afternoon because of reading this morning, in the Lincoln Journal-Star, Tiffany Campbell's story. And I thought there would possibly be such a case, sure sounded like one to me. I now heard Mr. Mosher's story. It sounds like one to me. I ask you to pay attention to those stories. They would be criminals under your act. The decision to abort a human embryo is a very difficult decision, painful emotionally to us all and the mother most specifically. In many cases, they may be morally wrong. But

if there are cases in which they are morally right then we cannot criminalize those acts. As a lawyer, I would say we cannot criminalize them. As a minister, I say we must trust the grace of God and the professionalism of our doctors and the well-formed consciences of our state's women to decide what is right for us all in their very personal situations. I appreciate your attention. [LB1103]

SENATOR LATHROP: (See also Exhibits 18-22) Thank you very much. I appreciate that. Let's see if there's any questions before you get away. I don't see any. Thank you for your testimony. Is anyone here...that will close the opposition testimony. And again, if you have any that you'd like to submit in writing, one of the pages, young ladies with the black vests on, will be happy to take that and add it to the record. Otherwise, we'll take neutral testimony from anyone here wishing to testify in a neutral capacity. And seeing none, Mr. Speaker, you are free to close. [LB1103]

SENATOR FLOOD: Thank you, Vice Chairman Lathrop, members of the committee. First of all, I want to thank you all for your attention, your consideration and your questions, each and every one of them. And I want to thank all the folks that came to testify, regardless of their position on my bill. This is part of the process and this is good for all of us to have this discussion. There has been good discussion about the constitutionality of this bill, which I certainly appreciate. This Legislature works best when there is full and fair opportunity for debate. In his dissent in Stenberg, Justice Anthony Kennedy emphasized that Casey held that it was "inappropriate for the judicial branch to provide an exhaustive list of state interests implicated by abortion." And that, "Casey is premised on the state's having an important constitutional role in defining their interest in the abortion debate." In my opinion, Justice Kennedy was being quite clear. As a state Legislature we have a role in this debate. We are not foreclosed from acting when the scientific evidence presents itself. Regarding constitutionality or whether the court would be amenable to a bill like LB1103, you don't have to take my opinion or Professor Collett's opinion about Gonzales. Professor Erwin Chemerinsky, a prominent constitutional law scholar, has stated in a Law Review article, "Gonzales signaled a major shift in the law that is likely to have significant long-term consequences." So long as states do not ban all abortions, this case is a "signal that they can adopt much greater restrictions on abortion." This bill represents a modest step to alleviate the pain of the unborn. It is a step, I think, the court, especially Justice Kennedy would look at favorably. Thank you. [LB1103]

SENATOR LATHROP: Mike, I've got a question for you. And we appreciate your bill, the opportunity to hear the folks that came here and we certainly had a good lineup of experts on both the legal aspects and the medical. I kind of followed this argument. And it sounds like with viability being the measure or the yardstick for when we can impose reasonable restrictions on abortion and moving it to 20 weeks, I don't know if we...if in preparing this bill if you've thought of the Tiffany Campbell situations, which when we make a bright line we go from a line that's dependent upon viability to a bright line, 20

weeks, and say it's the mother's health. What about the situations where...and you were here for her testimony where there's twins and they will both die if one is not sacrificed and it will provide the opportunity for the other. How do we work that into the structure of a bill like this? Or do we just say that's just the way it is? [LB1103]

SENATOR FLOOD: Well, if you listened, and we all listened to the testimony. If that doesn't make you think about whether it fits within the medical exception... [LB1103]

SENATOR LATHROP: But that's a medical exception for the mother, isn't it? And it doesn't talk about the kids. [LB1103]

SENATOR FLOOD: You know, my first reaction is that's correct. I guess, the value of her testimony was I am thinking in my mind, having just heard it a few minutes ago, what the bill would look like if it protected the life of an unborn child when you have two children and multiple gestation. And so I'd like some time to think on that. I'd like some time to get my hands around that issue. There will always be cases that a bright line rule has impacts. And I appreciate your question. In that situation we're talking about protecting an unborn life as well. [LB1103]

SENATOR LATHROP: Yeah. [LB1103]

SENATOR FLOOD: And I get your question. And, I guess, I'd like the opportunity to think on it a little bit and come back to the committee with some ideas and a better perspective. [LB1103]

SENATOR LATHROP: It would certainly be ironic if in our attempt to save more unborn we cause that to happen. [LB1103]

SENATOR FLOOD: Understood, understood. And I appreciate the fact that she and the gentleman before her took the time to come down here and share those stories. [LB1103]

SENATOR LATHROP: Right. Senator Council. [LB1103]

SENATOR COUNCIL: Yes. Thank you, Senator Lathrop. And, Senator Flood, I think you also would need to look at the situation that was presented by Mr. Mosher's testimony as well. I mean, there's a situation where by all medical evidence their daughter was going to suffer a very cruel and painful death if she made it through the birthing process. And there's nothing in LB1103 that addresses that circumstance either. Had they been in Nebraska they...and LB1103 had been in effect, they, too, would be criminals. [LB1103]

SENATOR FLOOD: And, Senator Council, I certainly am taking in all the testimony. I

think it's important to note my bill does not make the patient a criminal. The criminal sanction applies to the provider of the abortion. And I think that needs to be said because there's been a lot of talk about criminalizing the patient here, and that was not my intent. And if you can find that in the bill and point that out to me, I'd appreciate it, because that's nowhere in the green copy. I am not criminalizing the patient that receives this service. It is a criminal sanction that applies to the physician that performs the procedure. [LB1103]

SENATOR COUNCIL: Well, in actuality you're correct. But it places the patient in a position of seeking someone to perform a criminal act. [LB1103]

SENATOR FLOOD: But they would not face any criminal liability. [LB1103]

SENATOR COUNCIL: So, I mean, no, they wouldn't. But the fact of the matter is that they would have to be complicit in a criminal act, although they would not be subject to criminal sanctions. [LB1103]

SENATOR FLOOD: I appreciate everybody that came today. And I listened to the whole thing. I made notes on the whole thing. And I had an opportunity to visit with a few folks that testified in opposition toward the end there. I appreciate the fact they came. [LB1103]

SENATOR LATHROP: Good. Thanks, Mike. [LB1103]

SENATOR FLOOD: Thank you. [LB1103]

SENATOR LATHROP: That will bring to a close our hearing on the bill and our hearing for the day, the hearings for the week and the hearings for the year. [LB1103]