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PAGES 1 - 174

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

PLANNED PARENTHOOD)
FEDERATION OF AMERICA, INC.)
AND PLANNED PARENTHOOD)
GOLDEN GATE,)
)
PLAINTIFFS,)
)
VS.) NO. C 03-4872 PJH
)
JOHN ASHCROFT, ATTORNEY) MONDAY, MARCH 29, 2004
GENERAL OF THE UNITED)
STATES, IN HIS OFFICIAL) SAN FRANCISCO, CALIFORNIA
CAPACITY,)
)
DEFENDANT.)
_____)

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS: BINGHAM MCCUTCHEON LLP
THREE EMBARCADERO CENTER
SAN FRANCISCO, CALIFORNIA 94111-4003
BY: BETH H. PARKER, ATTORNEY AT LAW
DEBORAH ADLER, ESQUIRE

PLANNED PARENTHOOD FEDERATION OF
AMERCIA
434 W. 33RD STREET.
NEW YORK, NEW YORK 10001
BY: EVE C. GARTNER, ESQUIRE

(APPEARANCES CONTINUED ON NEXT PAGE)

REPORTED BY: DIANE E. SKILLMAN, CSR 4909
OFFICIAL COURT REPORTER

PLANNED PARENTHOOD FEDERATIONF AMERICA
1780 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 200036
BY: HELENE T. KRASNOFF, ESQUIRE

FOR INTERVENOR PLAINTIFFS CITY AND COUNTY OF SAN FRANCISCO:
OFFICE OF THE CITY ATTORNEY
1390 MARKET STREET, SUITE 1008
SAN FRANCSICO, CALIFORNIA 94102
BY: KATHLEEN SUZANNE MORRIS,
ALEETA MARIE VAN RUNKLE,
DEPUTY CITY ATTORNEYS

FOR DEFENDANT:
U.S. DEPARTMENT OF JUSTICE
20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
WASHINGTON, D.C. 20530
BY: MARK THOMAS QUINLIVAN
W. SCOTT SIMPSON,
KAIJA MARIE CLARK,
ASSISTANT U.S. ATTORNEYS

MONDAY, MARCH 29, 2004 8:30 A.M.

THE COURT: ALL RIGHT. CALL THE CASE.

THE CLERK: CIVIL ACTION 03-4872, PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL VERSUS JOHN ASHCROFT.

YOUR APPEARANCES, PLEASE.

MS. GARTNER: EVE GARTNER FOR PLANNED PARENTHOOD FEDERATION OF AMERICA AND PLANNED PARENTHOOD GOLDEN GATE.

THE COURT: GOOD MORNING.

MS. MORRIS: KATHLEEN MORRIS FOR THE CITY AND COUNTY OF SAN FRANCISCO.

THE COURT: GOOD MORNING.

MS. VAN RUNKLE: ALEETA VAN RUNKLE FOR THE CITY AND COUNTY OF SAN FRANCISCO.

THE COURT: GOOD MORNING.

MS. ADLER: DEBORAH ADLER, BINGHAM MCCUTCHEN, FOR PLANNED PARENTHOOD FEDERATION OF AMERICA AND PLANNED PARENTHOOD GOLDEN GATE.

THE COURT: GOOD MORNING.

MS. KRASNOFF: HELENE KRASNOFF, PLANNED PARENTHOOD FEDERATION OF AMERICA, AND PLANNED PARENTHOOD GOLDEN GATE.

THE COURT: GOOD MORNING.

MS. PARKER: AND BETH PARKER, PLANNED PARENTHOOD FEDERATION OF AMERICA AND PLANNED PARENTHOOD GOLDEN GATE.

THE COURT: GOOD MORNING.

MR. SIMPSON: SCOTT SIMPSON, YOUR HONOR, FOR THE DEPARTMENT OF JUSTICE FOR THE DEFENDANT, JOHN ASHCROFT.

THE COURT: GOOD MORNING.

MR. QUINLIVAN: AND, YOUR HONOR, MARK QUINLIVAN WITH THE DEPARTMENT OF JUSTICE, AS WELL, FOR THE DEFENDANT.

MS. CLARK: KAIJA CLARK, FOR THE DEFENDANT.

THE COURT: ALL RIGHT. GOOD MORNING.

ALL RIGHT. THE ONLY THING I WANTED TO MAKE SURE YOU ALL UNDERSTOOD IS THAT THERE WILL BE ONE ATTORNEY PER WITNESS. SO THAT ATTORNEY WILL BE RESPONSIBLE FOR THE DIRECT AND CROSS AND ALL OBJECTIONS. OKAY?

ALL RIGHT. WE DISCUSSED AT THE PRETRIAL THAT THERE WOULD BE NO NEED FOR OPENING STATEMENTS. I DID RECEIVE YOUR PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW. OBVIOUSLY, I HAVE NOT HAD A CHANCE TO REVIEW THEM, BUT THAT WILL SUBSTITUTE FOR ANY OPENING STATEMENTS.

YOU ALL ARE FREE, HOWEVER, TO MAKE A CLOSING ARGUMENT AT THE END OF THE PROCEEDINGS.

ARE WE READY WITH OUR FIRST WITNESS?

MS. GARTNER: WE ARE, YOUR HONOR.

THE COURT: ALL RIGHT, MS. GARTNER.

MS. GARTNER: YES, YOUR HONOR. PLAINTIFFS CALL DR. MAUREEN PAUL TO THE STAND.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

///

DR. MAUREEN PAUL,

CALLED AS A WITNESS FOR THE PLAINTIFF, HAVING BEEN DULY SWORN,

TESTIFIED AS FOLLOWS:

THE WITNESS: I DO.

THE CLERK: PLEASE TAKE THE STAND.

PLEASE STATE YOUR NAME FOR THE COURT.

THE WITNESS: MAUREEN PAUL.

THE CLERK: PLEASE SPELL YOUR LAST NAME.

THE WITNESS: P-A-U-L.

THE CLERK: THANK YOU.

DIRECT EXAMINATION

BY MS. GARTNER:

Q. GOOD MORNING, DR. PAUL.

A. GOOD MORNING.

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS TO HAND HER HER CURRICULUM VITAE?

THE COURT: YES.

BY MS. GARTNER:

Q. DR. PAUL, I HAVE JUST HANDED YOU WHAT HAS BEEN MARKED EXHIBIT 60 IN THIS CASE. COULD YOU LOOK AT THAT DOCUMENT, PLEASE?

IS THIS A CURRENT COPY OF YOUR CURRICULUM VITAE?

A. IT IS.

Q. DID YOU PREPARE THIS DOCUMENT?

A. I DID.

Q. AND IS THE INFORMATION ON THIS CURRICULUM VITAE TRUE AND CORRECT?

A. IT IS.

MS. GARTNER: PLAINTIFFS WOULD MOVE TO INTRODUCE EXHIBIT 60 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MR. QUINLIVAN: NO OBJECTION, YOUR HONOR.

THE COURT: ALL RIGHT. ADMITTED.

THE CLERK: SIXTY INTO EVIDENCE.

(PLAINTIFF'S EXHIBIT 60
WAS RECEIVED IN EVIDENCE.)

BY MS. GARTNER:

Q. DR. PAUL, ARE YOU BOARD CERTIFIED IN ANY AREA?

A. YES, IN OBSTETRICS AND GYNECOLOGY AND ALSO OCCUPATIONAL AND ENVIRONMENTAL MEDICINE.

Q. AND ARE YOU THE CHIEF MEDICAL OFFICER AT PLANNED PARENTHOOD GOLDEN GATE?

A. YES, I AM.

Q. WHAT DOES THAT POSITION ENTAIL?

A. THE ACTUAL OVERSEEING THE QUALITY OF MEDICAL CARE AT PLANNED PARENTHOOD GOLDEN GATE; PROVIDING DIRECT CLINICAL SERVICES, PARTICIPATING IN STRATEGIC PLANNING FOR THE ORGANIZATION; HIRING OF THE PHYSICIANS TO WORK AT GOLDEN GATE; AND ALSO SUPERVISING BOTH THE PHYSICIANS AND THE ADVANCED PRACTICE CLINICIANS WHO WORK AT PLANNED PARENTHOOD GOLDEN GATE,

AS WELL AS DEVELOPING CLINICAL PROTOCOLS THAT WE USE IN THE CLINICS.

Q. AT HOW MANY SITES DOES PLANNED PARENTHOOD GOLDEN GATE PROVIDE MEDICAL SERVICES?

A. EIGHT.

Q. AND WHERE ARE THOSE SITES LOCATED, GENERALLY?

A. THROUGHOUT THE SAN FRANCISCO BAY AREA.

Q. AND WHAT MEDICAL SERVICES ARE AVAILABLE AT PLANNED PARENTHOOD GOLDEN GATE?

A. PLANNED PARENTHOOD GOLDEN GATE PROVIDES PRIMARY HEALTH CARE SERVICES, IN THAT WE DO GENERAL PHYSICAL EXAMS AND TAKE CARE OF COMMON HEALTH CONDITIONS THAT PEOPLE MAY HAVE.

WE ALSO PROVIDE A BROAD RANGE OF REPRODUCTIVE HEALTH CARE SERVICES, INCLUDING CONTRACEPTION AND ABORTION, BASIC GYNECOLOGICAL EXAMS, PAP TESTS, TREATMENT OF ABNORMAL PAP TESTS, DIAGNOSIS OF AND MANAGEMENT OF SEXUALLY-TRANSMITTED INFECTIONS AND HIV TESTING AND REFERRAL.

Q. AND ARE ABORTIONS AVAILABLE AT ALL EIGHT OF THE PLANNED PARENTHOOD GOLDEN GATE SITES?

A. YES.

Q. AND TO WHAT GESTATIONAL AGE ARE ABORTIONS PERFORMED AT PLANNED PARENTHOOD GOLDEN GATE?

A. EIGHTEEN WEEKS, SIX DAYS OF PREGNANCY.

Q. AND WHAT METHODS OF ABORTION ARE AVAILABLE AT PLANNED PARENTHOOD GOLDEN GATE?

A. WE PROVIDE EARLY MEDICAL ABORTION, VACUUM ASPIRATION ABORTION, AND DILATION AND EVACUATION OR D&E ABORTION.

Q. AND YOU SAID THAT YOU CURRENTLY PROVIDE ABORTIONS TO 18 WEEKS, SIX DAYS; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. IS IT YOUR PLAN TO INCREASE THE GESTATIONAL AGE AT WHICH ABORTIONS ARE AVAILABLE AT PLANNED PARENTHOOD GOLDEN GATE?

A. YES.

Q. NOW, IN ADDITION TO YOUR WORK AS THE CHIEF MEDICAL OFFICER PLANNED PARENTHOOD GOLDEN GATE, ARE YOU ALSO AN ASSOCIATE CLINICAL PROFESSOR IN THE DEPARTMENT OF OBSTETRICS GYNECOLOGY AND REPRODUCTIVE SCIENCES AT UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO?

A. YES, I AM.

Q. AND WHAT DOES THAT INVOLVE?

A. THAT INVOLVES TEACHING, AND WE ARE ALSO SETTING UP A COLLABORATIVE RESEARCH PROGRAM BETWEEN UCSF AND PLANNED PARENTHOOD GOLDEN GATE. THE TEACHING PRIMARILY INVOLVES EARLY ABORTION METHODS.

Q. AND ARE YOU ALSO THE DIRECTOR OF TRAINING AT THE UCSF CENTER FOR REPRODUCTIVE HEALTH RESEARCH AND POLICY?

A. YES, I AM.

Q. AND WHAT DOES THAT INVOLVE?

A. THAT IS THE POSITION THAT I HOLD WHERE I DO THE TRAINING IN EARLY ABORTION, PRIMARILY FOR PRIMARY CARE RESIDENCY PROGRAMS,

SUCH AS FAMILY PRACTICE RESIDENCY PROGRAMS WHERE BUILDING AND TRAINING CONSORTIUM, ACADEMIC COMMUNITY COLLABORATION TO PROVIDE TRAINING TO THE RESIDENTS AND FACULTY IN THE PRIMARY CARE RESIDENCY PROGRAMS.

Q. AND DR. PAUL, DO YOU HAVE CLINICAL EXPERIENCE PERFORMING FIRST-TRIMESTER ABORTIONS USING BOTH SURGICAL AND MEDICAL METHODS?

A. YES, I DO.

Q. IS THAT A SIGNIFICANT PART OF YOUR MEDICAL PRACTICE?

A. YES, IT IS.

Q. AND DO YOU HAVE CLINICAL EXPERIENCE PERFORMING D&E ABORTIONS?

A. YES, I DO.

Q. AND IS THAT A SIGNIFICANT PART OF YOUR MEDICAL PRACTICE?

A. YES, IT IS.

Q. AND IN YOUR CURRENT PRACTICE TO WHAT GESTATIONAL AGE DO YOU PERSONALLY PERFORM D&E ABORTIONS?

A. I PERFORM D&E ABORTIONS TO 18 WEEKS, SIX DAYS GESTATION.

Q. AND AT OTHER TIMES IN YOUR CAREER HAVE YOU PERFORMED D&E'S TO LATER GESTATIONAL AGES?

A. YES, I HAVE. DURING RESIDENCY I PERFORMED D&E'S TO ABOUT 23 WEEKS GESTATION.

Q. AND DO YOU HAVE CLINICAL EXPERIENCE PERFORMING INDUCTION ABORTIONS?

A. YES, I DO.

Q. DO YOU PERFORM INDUCTION ABORTIONS IN YOUR CURRENT PRACTICE?

A. NO, I DON'T.

Q. WHEN DID YOU PERFORM INDUCTIONS?

A. I PERFORMED INDUCTIONS WHEN I WAS A FACULTY MEMBER AT TUFTS NEW ENGLAND MEDICAL CENTER AND AT THE UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER. IT WAS A PERIOD OF ABOUT 12 YEARS.

Q. HAVE YOU EVER CONDUCTED CLINICAL RESEARCH IN THE AREA OF ABORTION?

A. YES, I HAVE.

Q. HAVE YOU EVER DESIGNED OR CONDUCTED A RANDOMIZED TRIAL?

A. YES, I HAVE.

Q. AND DID THAT INVOLVE ABORTION?

A. NO, I CONDUCTED A RANDOMIZED TRIAL THAT COMPARED METHODS OF INDUCTION AT TERM.

Q. AND DO YOU CURRENTLY TEACH ABORTION METHODS?

A. I DO.

Q. TO WHOM DO YOU CURRENTLY TEACH ABORTION METHODS?

A. I TEACH ABORTION METHODS TO THE FAMILY PRACTICE RESIDENTS THAT I REFERRED TO EARLIER. THAT IS PRIMARILY EARLY ABORTION METHODS. ALSO TEACH EARLY MEDICAL ABORTION METHODS TO THE ADVANCED PRACTICE CLINICIANS WHO WORK AT GOLDEN GATE.

I SOMETIMES TEACH SECOND-TRIMESTER D&E METHODS TO THE PHYSICIANS WHO WORK AT PLANNED PARENTHOOD GOLDEN GATE.

I HAVE A HISTORY OF GIVING LECTURES IN THE MEDICAL SCHOOLS IN WHICH I WORKED, AND THOSE INVOLVED ABORTIONS.

Q. AND WHEN YOU REFER TO TEACHING ABORTION METHODS TO RESIDENTS, ARE THOSE RESIDENTS OF UCSF?

A. YES, THE RESIDENTS -- WE DO TEACH THE RESIDENTS AT UCSF. WE ALSO TEACH RESIDENTS WHO ARE IN OTHER RESIDENCY PROGRAMS THROUGHOUT THE BAY AREA. AND THEY COME OVER TO PLANNED PARENTHOOD GOLDEN GATE TO TRAIN IN EARLY SURGICAL ABORTION METHODS.

Q. AND, DR. PAUL, AM I CORRECT THAT YOU ARE THE EDITOR-IN-CHIEF OF THE RECENT TEXT ON ABORTION?

A. YES.

Q. AND WHAT IS THAT TEXT?

A. IT'S CALLED A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION.

Q. AND IN ADDITION TO BEING THE EDITOR-IN-CHIEF OF THAT TEXT, DID YOU AUTHOR OR CO-AUTHOR ANY OF THE CHAPTERS IN THAT BOOK?

A. YES, I DID.

Q. WHEN WAS THAT -- WHEN WAS THAT BOOK PUBLISHED?

A. 1999.

Q. CAN YOU DESCRIBE WHAT YOUR ROLE WAS AS EDITOR-IN-CHIEF OF THAT TEXT?

A. YES. AS EDITOR-IN-CHIEF I WAS RESPONSIBLE FOR OVERSEEING THE PROCESS OF PRODUCTION OF THE BOOK, AND I WAS THE PRIMARY CONTACT WITH THE PUBLISHER. I ALSO WAS THE PRIMARY PERSON TO

COORDINATE THE WORK OF THE OTHER EDITORS.

I DID WORK DIRECTLY WITH SOME OF THE AUTHORS. I REVIEWED ALL OF THE CHAPTERS OF THE BOOK, AND EXERCISED EDITORIAL AUTHORITY OVER THOSE CHAPTERS.

Q. AND DO YOU KNOW WHAT THE REPUTATION OF THIS TEXT IS IN THE MEDICAL COMMUNITY?

A. I BELIEVE IT'S THE STANDARD REFERENCE TEXT ON ABORTION CARE.

Q. IN ADDITION TO THE CLINICIAN'S GUIDE TEXT, DO YOU HAVE OTHER PUBLICATIONS IN THE AREA OF ABORTION?

A. YES. I HAVE SEVERAL PUBLICATIONS IN THE PEER REVIEW LITERATURE.

Q. ARE THOSE OUTLINED ON YOUR CURRICULUM VITAE?

A. THEY ARE.

Q. DR. PAUL, IN ADDITION TO BEING A BOARD CERTIFIED OB/GYN, YOU HAVE A MASTER'S IN PUBLIC HEALTH WITH A CONCENTRATION IN EPIDEMIOLOGY; IS THAT CORRECT?

A. YES.

Q. WHAT IS EPIDEMIOLOGY?

A. EPIDEMIOLOGY IS THE STUDY OF THE DISTRIBUTION AND DETERMINANTS OF HEALTH-RELATED CONDITIONS IN THE POPULATION. SIMPLY PUT, IT'S APPLYING RESEARCH METHODS TO DETERMINE WHO GETS HEALTH-RELATED CONDITIONS AND WHY.

Q. AND WHAT ROLE DOES EPIDEMIOLOGY PLAY IN YOUR WORK?

A. I APPLY EPIDEMIOLOGIC METHODS WHEN I DO RESEARCH. I ALSO

HAVE DONE PEER REVIEWS OF ARTICLES, MANUSCRIPTS THAT ARE SUBMITTED BY AUTHORS TO MAJOR MEDICAL JOURNALS. AND ONE THING WE HAVE TO DO IS DETERMINE WHETHER THE EPIDEMIOLOGIC METHODS THAT ARE USED ARE APPROPRIATE FOR THE TOPIC OF THE MANUSCRIPTS.

Q. HAVE YOU EVER TAUGHT EPIDEMIOLOGY?

A. I HELPED TO TEACH A REPRODUCTIVE EPIDEMIOLOGY COURSE AT THE BU SCHOOL OF PUBLIC HEALTH.

Q. WHAT IS "BU"?

A. I'M SORRY, BOSTON UNIVERSITY.

Q. DR. PAUL, HAVE YOU EVER TESTIFIED BEFORE AS AN EXPERT WITNESS IN A CASE CHALLENGING A LAW THAT RESTRICTS ABORTION PRACTICE OR RESTRICTS ACCESS TO ABORTION?

A. NO.

MS. GARTNER: YOUR HONOR, PLAINTIFFS WOULD MOVE TO QUALIFY DR. MAUREEN PAUL AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY, ALL FACETS OF ABORTION CARE, AND EPIDEMIOLOGY.

THE COURT: ANY OBJECTION?

MR. QUINLIVAN: NO OBJECTION.

THE COURT: DO YOU WISH TO VOIR DIRE THE WITNESS AT THIS TIME?

MR. QUINLIVAN: NOT AT THIS TIME, YOUR HONOR.

THE COURT: ALL RIGHT. SHE WILL BE ACCEPTED AS QUALIFIED.

MS. GARTNER: THANK YOU, YOUR HONOR.

BY MS. GARTNER:

Q. DR. PAUL, I WOULD LIKE TO ASK YOU SOME BACKGROUND QUESTIONS ABOUT PREGNANCY. WHAT IS THE AVERAGE LENGTH OF A FULL TERM PREGNANCY?

A. FORTY WEEKS.

Q. AND HOW IS THE GESTATIONAL AGE OF THE FETUS CALCULATED?

A. IN TWO WAYS. THE GESTATIONAL AGE CAN BE CALCULATED FROM THE FIRST DAY OF THE LAST MENSTRUAL PERIOD, WHICH IS SOMETIMES REFERRED TO AS LMP. OR AN ULTRASOUND CAN BE USED, ALSO, TO DATE THE PREGNANCY.

Q. IF ULTRASOUND IS USED TO DATE THE PREGNANCY, DO YOU STILL REFER TO THE GESTATIONAL AGE IN TERMS OF LMP?

A. IT IS COMMON, NO MATTER WHICH WAY YOU DATE THE PREGNANCY, TO SAY, FOR INSTANCE, THAT A WOMAN IS EIGHT WEEKS LMP.

Q. CAN YOU TELL ME WHEN THE FIRST-TRIMESTER OF PREGNANCY ENDS?

A. THE TOTAL DURATION OF PREGNANCY IS 40 WEEKS, AND PREGNANCY IS DIVIDED INTO THREE TRIMESTERS OF EQUAL DURATION. SO THE FIRST-TRIMESTER ENDS AT ABOUT 13 OR 14 WEEKS.

Q. AND WHEN DOES THE SECOND-TRIMESTER END?

A. ABOUT 27 WEEKS.

Q. DR. PAUL, WHAT DO YOU UNDER THE WORD "VIABILITY" TO MEAN?

A. I UNDERSTAND THE WORD "VIABILITY" TO MEAN THAT THE FETUS HAS A REALISTIC CHANCE OF LONG-TERM SURVIVAL OUTSIDE THE UTERUS.

Q. AND BASED ON THE AVAILABLE DATA, CAN YOU TELL ME WHEN, IN

YOUR OPINION, A NORMALLY-DEVELOPED FETUS IS LIKELY TO BECOME VIABLE?

A. ABOUT 24 WEEKS.

Q. AND IS THAT LMP?

A. YES.

Q. AND THROUGHOUT YOUR TESTIMONY, WHEN YOU REFER TO THE NUMBER OF WEEKS, ARE YOU REFERRING TO THAT NUMBER OF WEEKS LMP?

A. YES.

THE COURT: COULD I ASK A QUESTION? IS LMP THE FIRST DAY OR LAST DAY OF THE MENSTRUAL PERIOD?

THE WITNESS: THE FIRST DAY OF THE LAST MENSTRUAL PERIOD, YOUR HONOR.

BY MS. GARTNER:

Q. DR. PAUL, DOES PREGNANCY EVER CAUSE SERIOUS MEDICAL CONDITIONS FOR THE PREGNANT WOMAN?

A. YES.

Q. CAN YOU GIVE ME SOME EXAMPLES OF THOSE?

A. YES. THERE ARE CONDITIONS THAT ARE SPECIFIC TO PREGNANCY. ONE EXAMPLE IS A CONDITION CALLED "PREECLAMPSIA," WHICH IS A CONDITION THAT AFFECTS MANY OF THE SYSTEMS OF THE BODY. IT PRESENTS AS HIGH-BLOOD PRESSURE, AND PROTEIN IN THE URINE. BUT IT CAN ALSO INCLUDE ABNORMALITIES OF THE LIVER, ABNORMALITIES OF THE BLOOD-CLOTTING SYSTEM.

AND IT CAN PROGRESS TO SEIZURES, IN WHICH CASE THE CONDITION IS CALLED "ECLAMPSIA." THERE ARE INFECTIONS THAT ARE

SPECIFIC TO PREGNANCY LIKE CHORIOAMNIONITIS, WHICH IS AN INFECTION OF THE UTERUS THAT OCCURS ONLY DURING PREGNANCY.

AND THEN THERE ARE CONDITIONS THAT CAN HAPPEN IN NONPREGNANT WOMEN, BUT ARE MORE LIKELY TO HAPPEN IN PREGNANT WOMEN. AND AN EXAMPLE OF THAT WOULD BE THE PROPENSITY TO HAVE BLOOD CLOTS, EITHER IN THE LOWER EXTREMITIES OR IN THE LUNGS. AND THAT IS CALLED THROMBOEMBOLISM AND PULMONARY EMBOLUS.

Q. THESE CONDITIONS, THESE EXAMPLES YOU HAVE GIVEN OF PREECLAMPSIA, CHORIOAMNIONITIS AND THE BLOOD CLOTS, WHEN IN PREGNANCY ARE THESE CONDITIONS LIKELY TO OCCUR?

A. PREECLAMPSIA AND CHORIOAMNIONITIS ARE MORE LIKELY TO OCCUR IN THE SECOND AND THIRD-TRIMESTER. BLOOD CLOTS CAN OCCUR ANY TIME.

Q. AND WHAT ABOUT IN WOMEN THAT ARE ALREADY UNHEALTHY IN SOME RESPECT, CAN PREGNANCY EVER MAKE THEIR UNDERLYING MEDICAL CONDITIONS WORSE?

A. ABSOLUTELY.

Q. CAN YOU GIVE ME SOME EXAMPLES OF THAT?

A. YES. PREGNANCY ENTAILS MANY CHANGES THAT HAPPEN IN THE BODY THAT CAN BE TOLERATED BY NORMAL WOMEN, WHO ARE NORMAL AND HEALTHY, BUT CAN BE VERY TAXING TO WOMEN WHO HAVE UNDERLYING MEDICAL CONDITIONS.

AN EXAMPLE MIGHT BE HEART CONDITIONS. FOR INSTANCE, THE BLOOD VOLUME IN PREGNANCY NEARLY DOUBLES. THE HEART RATE GOES UP.

Q. LET ME JUST STOP YOU THERE. YOU ARE TALKING ABOUT THE BLOOD VOLUME OF THE PREGNANT WOMAN?

A. THE BLOOD VOLUME OF THE PREGNANT WOMAN, THAT'S RIGHT. THE AMOUNT OF BLOOD IN THE SYSTEM NEARLY DOUBLES DURING PREGNANCY, AND THE HEART RATE GOES UP. THE AMOUNT OF BLOOD THAT IS COMING THROUGH THE HEART AND THAT HAS TO GO OUT TO FEED THE TISSUES IS THEREFORE GREATER. AND THE HEART IS WORKING HARDER. SO THAT IF YOU HAVE A WOMAN WHO HAS A HEART CONDITION, THIS CAN BE VERY TAXING.

IT CAN CAUSE INCREASED PRESSURES IN THE HEART THAT CAN BACKUP INTO THE LUNGS AND YOU CAN GET THINGS CALLED "PULMONARY EDEMA," THAT IS FLUID IN THE LUNGS OR HEART FAILURE.

ANOTHER EXAMPLE WOULD BE DIABETES. THERE ARE HORMONAL CHANGES THAT HAPPEN IN PREGNANCY THAT CAN MAKE IT VERY DIFFICULT TO CONTROL THE BLOOD SUGARS IN A DIABETIC SO THAT YOU CAN GET DANGEROUSLY LOW BLOOD SUGARS LEADING TO SEIZURES, OR YOU CAN GET DANGEROUSLY HIGH BLOOD SUGARS, WHICH CAN RESULT IN COMA. SO THOSE ARE A COUPLE OF EXAMPLES.

Q. IS THERE A PARTICULAR TIME IN PREGNANCY WHEN SUCH UNDERLYING MEDICAL CONDITIONS TEND TO WORSEN?

A. THEY TEND TO WORSEN AS PREGNANCY PROGRESSES.

Q. AND, DR. PAUL, HAVE YOU TREATED PATIENTS IN YOUR MEDICAL PRACTICE WITH ALL OF THE TYPES OF CONDITIONS THAT WE'VE JUST DISCUSSED WHO HAVE CHOSEN TO END THEIR PREGNANCIES BECAUSE OF THOSE CONDITIONS?

A. YES, AND OTHERS.

Q. HAVE YOU TREATED PATIENTS WHO HAVE CHOSEN TO END THEIR PREGNANCY BECAUSE THE FETUS IS DIAGNOSED AS HAVING A SERIOUS ANOMALY?

A. YES.

Q. CAN YOU GIVE ME SOME EXAMPLES OF THOSE FROM YOUR MEDICAL PRACTICE?

A. BASICALLY TWO TYPES: ONE IS CHROMOSOMAL ANOMALIES.

Q. WHY DON'T YOU TELL US WHAT IS A CHROMOSOMAL ANOMALY?

A. THE CHROMOSOMES ARE BASICALLY PACKAGES OF GENETIC MATERIAL, SO IT IS GENETIC TYPES OF DEFECTS. YOU CAN HAVE TOO MANY CHROMOSOMES, TOO FEW CHROMOSOMES OR CHROMOSOMES THAT HAVE STRUCTURAL DEFECTS. AND I HAVE TREATED WOMEN WHO HAVE HAD ALL OF THOSE TYPES OF CHROMOSOMAL ANOMALIES.

THE OTHER THING IS JUST ANOMALIES OF THE FETUS THAT ARE STRUCTURAL ANOMALIES SO THAT THEY ARE VISIBLE BIRTH DEFECTS.

Q. CAN YOU GIVE ME ONE OR TWO EXAMPLES OF THOSE?

A. HEART DEFECTS, OR THERE IS A NEURAL TUBE DEFECTS THAT ARE DEFECTS OF THE SPINAL CORD OR BRAIN.

Q. HAVE YOU TREATED PATIENTS WITH THOSE SORTS OF FETAL ANOMALIES THAT HAVE CHOSEN TO END THEIR PREGNANCIES?

A. YES.

Q. AND AT WHAT GESTATIONAL AGES ARE ABORTIONS FOR FETAL ANOMALIES GENERALLY PERFORMED?

A. GENERALLY AFTER THE FIRST-TRIMESTER.

Q. AND WHY IS THAT?

A. BECAUSE WE OFTEN CAN'T DIAGNOSE THESE ANOMALIES UNTIL AFTER THE FIRST-TRIMESTER. THERE MAY BE ABNORMALITIES THAT APPEAR ON AN ULTRASOUND THAT JUST DON'T APPEAR UNTIL THE SECOND OR THIRD-TRIMESTER, AND THAT IS WHEN WE FIRST ATTACK THE ANOMALY. AND THERE IS ALSO GENETIC TESTS THAT CAN ONLY BE DONE IN SECOND-TRIMESTER.

Q. DR. PAUL, CAN YOU JUST DESCRIBE BRIEFLY WHAT IS "ULTRASOUND"?

A. "ULTRASOUND" IS USING SOUND WAVES IN ORDER TO VISUALIZE THE PREGNANCY.

Q. AND IS THERE A GENERAL TIME IN PREGNANCY WHEN WOMEN ROUTINELY HAVE AN ULTRASOUND?

A. IT IS VERY COMMON FOR WOMEN TO HAVE ULTRASOUND DURING PREGNANCY, AND MOST COMMONLY IN THE SECOND-TRIMESTER, MAYBE 13 TO 20 WEEKS. IF THERE IS ANY QUESTION ABOUT DATING, IT COULD OCCUR EARLIER, OR THERE COULD BE A SECOND ULTRASOUND OR EVEN A THIRD ULTRASOUND THAT IS DONE.

THE EARLIER IN A PREGNANCY THAT YOU DO THE ULTRASOUND, THE BETTER IT IS FOR THE DATING PURPOSES. BUT YOU REALLY NEED TO DO IT A LITTLE BIT LATER IN THE SECOND-TRIMESTER IF YOU ARE GOING TO LOOK FOR ANOMALIES AND THINGS LIKE THAT.

Q. WHEN YOU SAY "DATING," YOU MEAN TO DETERMINE THE GESTATIONAL AGE OF THE FETUS; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. AND WHAT SORTS OF ANOMALIES CAN BE DETECTED WITH ULTRASOUND?

A. WITH ULTRASOUND WE CAN DETECT SOME APPARENT BIRTH DEFECTS. SO THINGS LIKE ANENCEPHALY, WHICH IS THE ABSENCE OF THE BRAIN. THE ULTRASOUND IS VERY GOOD AT DETECTING THAT. THINGS LIKE ABNORMALITIES OF THE KIDNEYS OR THE HEART, IT'S NOT A HUNDRED PERCENT ACCURATE, BUT IT WILL PICK UP ABNORMALITIES LIKE THAT.

Q. NOW, WHAT ABOUT THE CHROMOSOMAL ANOMALIES THAT YOU WERE DESCRIBING, HOW ARE THOSE DETECTED?

A. THOSE ARE DETECTED THROUGH AMNIOCENTESIS OR CHORIONIC VILLUS SAMPLING.

Q. AND WHAT IS AMNIOCENTESIS?

A. AMNIOCENTESIS IS A METHOD OF OBTAINING A SAMPLE OF AMNIOTIC FLUID FROM THE PREGNANCY SAC BY INSERTING A NEEDLE THROUGH THE ABDOMEN INTO THE AMNIOTIC SAC.

Q. AND DO PREGNANT WOMEN ROUTINELY HAVE AMNIOCENTESIS?

A. NOT ALL PREGNANT WOMEN, NO.

Q. WHY IS THAT?

A. BECAUSE IT DOES CARRY SOME RISKS, SO IT TENDS TO HAPPEN ONLY -- IT TENDS TO BE RECOMMENDED ONLY IN WOMEN WHO HAVE RISK FACTORS FOR FETAL ANOMALIES. THE INCIDENCE OF FETAL ANOMALIES IN GENERAL POPULATION IS LOW, SO IT IS NOT -- IT'S NOT INDICATED TO DO AMNIOCENTESIS ON ALL WOMEN.

Q. SO UNDER WHAT CIRCUMSTANCES DO THE BENEFITS OF THE

AMNIOCENTESIS GENERALLY OUTWEIGH THE RISKS OF DOING IT?

A. THE BENEFITS OUTWEIGH THE RISK WHEN A WOMAN, PREGNANT WOMAN HAS RISK FACTORS FOR A FETAL ANOMALY. IT MAY OCCUR, FOR INSTANCE, IF THE WOMAN IS A LITTLE BIT OLDER IN AGE. OLDER WOMEN HAVE INCREASED RISK FOR CERTAIN BIRTH DEFECTS.

ANOTHER EXAMPLE WOULD BE IF A WOMAN HAD A FAMILY HISTORY OF A PARTICULAR TYPE OF GENETIC DEFECT, THEN IT WOULD BE INDICATED IN THAT SITUATION.

THERE ARE ALSO SITUATIONS WHERE THE ULTRASOUND WON'T SHOW A DEFECT, A BIRTH DEFECT, BUT IT WILL SHOW THINGS LIKE TOO MUCH AMNIOTIC FLUID OR TOO LITTLE AMNIOTIC FLUID, AND YOU WORRY THAT THAT MAY BE AN INDICATOR OF A CHROMOSOMAL ABNORMALITY, SO YOU WOULD DO AMNIOCENTESIS IN THAT CASE.

Q. WHAT IS THE TYPICAL GESTATIONAL AGE AT WHICH AMNIOCENTESIS IS PERFORMED?

A. SIXTEEN TO 18 WEEKS. ALTHOUGH, IT MAY BE PERFORMED LATER IF ONE OF THOSE ULTRASOUND INDICATORS LIKE THE TOO MUCH FLUID, TOO LITTLE FLUID OCCURS, BECAUSE I HAVE SEEN ULTRASOUND -- AMNIOCENTESIS DONE IN THE THIRD-TRIMESTER IF THERE IS A SUSPICION BY ULTRASOUND THAT THERE MAY BE A GENETIC DEFECT ASSOCIATED WITH THOSE ULTRASOUND FINDINGS.

Q. HOW LONG DOES IT TAKE FOR THE RESULTS OF AMNIOCENTESIS TO COME BACK, ON AVERAGE?

A. MINIMUM SEVEN DAYS. IT CAN TAKE TWO TO THREE WEEKS.

Q. SO DR. PAUL, YOU HAVE TESTIFIED THAT SOME MATERNAL

CONDITIONS TEND TO WORSEN AS PREGNANCY PROGRESSES, AND OTHER CONDITIONS DON'T DEVELOP UNTIL THE SECOND-TRIMESTER. AND YOU HAVE ALSO TESTIFIED THAT MANY ANOMALIES CAN'T BE DETECTED UNTIL THE SECOND-TRIMESTER. DOES THIS MEAN THAT ABORTIONS FOR MATERNAL OR FETAL INDICATIONS ARE MORE LIKELY AFTER THE FIRST-TRIMESTER OF PREGNANCY?

MR. QUINLIVAN: OBJECTION, YOUR HONOR, LEADING.

THE COURT: OVERRULED.

THE WITNESS: YES.

BY MS. GARTNER:

Q. DR. PAUL, DO YOU HAVE AN OPINION ON THE RELATIVE SAFETY OF CARRYING A PREGNANCY TO TERM AND THROUGH CHILDBIRTH VERSUS HAVING AN ABORTION?

A. YES, I DO. I -- OF COURSE, MANY WOMEN CARRY PREGNANCIES TO TERM, AND I HAVE BEEN PART OF THEIR LIVES IN THESE VERY JOYOUS TIMES. AND I -- SO MOST WOMEN WHO ARE HEALTHY DO VERY WELL.

BUT, IF YOU LOOK JUST AT SAFETY DATA, THEN CARRYING A PREGNANCY TO TERM IS MORE RISKY THAN HAVING AN ABORTION.

Q. I WOULD LIKE TO BREAK THAT OPINION DOWN A LITTLE BIT TO UNDERSTAND YOUR BASIS FOR CONCLUDING THAT. I WOULD LIKE TO START FIRST BY TALKING GENERALLY ABOUT THE SAFETY OF CARRYING A PREGNANCY TO TERM AND THROUGH CHILDBIRTH.

IN YOUR WORK, DR. PAUL, DO YOU REGULARLY REVIEW DATA ON THE SAFETY OF PREGNANCY?

A. YES, I DO.

Q. AND FROM WHAT SOURCES ARE THE DATA THAT YOU REGULARLY REVIEW?

A. THE CENTERS FOR DISEASE CONTROL AND PREVENTION, OR THE CDC, PUBLISH DATA ON PREGNANCY MORTALITY. AND THERE IS ALSO DATA ON COMPLICATIONS OF PREGNANCY THAT RESULT IN HOSPITALIZATION.

ALSO THE JOURNALS ARE FULL OF ARTICLES ABOUT SPECIFIC CONDITIONS THAT CAN OCCUR DURING PREGNANCY.

Q. WHEN YOU REVIEW SAFETY DATA, WHAT SORT OF ADVERSE OCCURRENCES DO YOU LOOK AT?

A. BOTH MORBIDITY AND MORTALITY.

Q. AND WHAT IS THE DIFFERENCE BETWEEN MORBIDITY AND MORTALITY?

A. MORTALITY RELATES TO DEATH, AND MORBIDITY RELATES TO COMPLICATIONS.

Q. AND BASED ON YOUR KNOWLEDGE OF THE LITERATURE IN THIS AREA, WHAT IS YOUR OPINION ABOUT THE OVERALL SAFETY OF CARRYING A PREGNANCY TO TERM IN TERMS OF MORTALITY?

A. CARRYING A PREGNANCY TO TERM DOES CARRY A RISK OF DEATH, ALBEIT SMALL. THE CURRENT PREGNANCY-RELATED MORTALITY RATE IN THE UNITED STATES IS ABOUT SEVEN TO EIGHT PER 100,000 LIVE BIRTHS. HOWEVER, THAT RATE IS INCREASED FOR CERTAIN GROUPS OF WOMEN, LIKE OLDER WOMEN, AFRICAN-AMERICAN WOMEN.

Q. AND BASED ON YOUR KNOWLEDGE OF THE LITERATURE IN THIS AREA, WHAT IS YOUR OPINION ABOUT THE OVERALL SAFETY OF CARRYING A PREGNANCY TO TERM IN TERMS OF THE MORBIDITY?

A. THERE ARE DATA THAT LOOK AT HOSPITALIZATIONS DURING

PREGNANCY AS AN INDICATOR OF PREGNANCY COMPLICATIONS. AND THE DATA SHOW -- THE MOST RECENT DATA SHOW THAT THERE ARE ABOUT 12 HOSPITALIZATIONS FOR OBSTETRICAL COMPLICATIONS PER 100 DELIVERIES. SO IT IS QUITE A HIGH RATE.

Q. SO DOES THAT MEAN THAT 12 PERCENT OF WOMEN THAT CARRY PREGNANCIES TO TERM ARE HOSPITALIZED BEFORE THEY GIVE BIRTH?

A. THE DENOMINATOR IS DELIVERIES, NOT WOMEN. SO IT IS A LITTLE BIT COMPLICATED. THAT IS A SIMPLIFIED WAY OF PUTTING IT, YES.

IT REALLY SAYS THAT EVERY 100 DELIVERIES THAT OCCUR, 12 WILL HAVE ADMISSIONS BEFORE THE DELIVERY THAT ARE DUE TO PREGNANCY COMPLICATIONS.

Q. AND DOES THE SAFETY OF CARRYING A PREGNANCY TO TERM VARY BASED ON MATERNAL AGE?

A. YES, IT DOES. IN FACT, THE DATA -- MOST RECENT DATA SHOW THAT AT -- IN TERMS OF MORTALITY -- THAT AT 35 TO 39 YEARS OLD, THE RISK OF DYING IS ABOUT TWICE THAT OF WOMEN WHO ARE LESS THAN 20 YEARS OLD. AND AT AGE 40 AND ABOVE, THE RISK IS ABOUT FIVE TIMES.

Q. FIVE TIMES?

A. THE RISK AT LESS THAN 20 YEARS OLD.

Q. OKAY. DR. PAUL, CAN YOU GIVE US AN HISTORICAL PERSPECTIVE ON THE SAFETY OF CARRYING A PREGNANCY TO TERM, INCLUDING CHILDBIRTH IN THIS COUNTRY?

A. YES. THE PREGNANCY-RELATED DEATH RATES HAVE DECREASED

SUBSTANTIALLY. FOR EXAMPLE, THERE WERE ABOUT 850 PER 100,000 LIVE BIRTHS IN 1900, AND THERE ARE SEVEN TO EIGHT PER 100,000 LIVE BIRTHS TODAY.

Q. AND WHEN YOU ARE SAYING 850 OR SEVEN TO EIGHT, ARE THOSE DEATHS DUE TO PREGNANCY?

A. YES.

Q. WHAT IS IT THAT HAS HAPPENED TO MAKE PREGNANCY SAFER IN THIS COUNTRY?

A. I AM NOT SURE IT IS PREGNANCY BEING SAFER SO MUCH AS OUR ABILITY TO TREAT THE CONDITIONS OF PREGNANCY HAS IMPROVED.

Q. DR. PAUL, I NOW WOULD LIKE TO ASK YOU A LITTLE BIT ABOUT THE SAFETY OF ABORTION, GENERALLY. DO YOU REVIEW DATA ON THE SAFETY OF ABORTION AS PART OF YOUR WORK?

A. YES, I DO.

Q. AND, AGAIN, AS WITH PREGNANCY, DO YOU REVIEW BOTH MORBIDITY AND MORTALITY DATA?

A. YES.

Q. WHAT DO YOU CONSIDER TO BE THE MOST RELIABLE SOURCES FOR DATA ON ABORTION-RELATED MORBIDITY?

A. STUDIES THAT WERE CONDUCTED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION IN THE 1970'S. IT WAS A PROGRAM CALLED "THE JOINT PROGRAM FOR THE STUDY OF ABORTION," OR JPSA.

Q. AND HOW WERE THE JPSA STUDIES CONDUCTED?

A. THE JPSA STUDIES WERE LARGE, VERY LARGE, AND COLLECTIVELY THE JPSA STUDIES INCLUDED PERHAPS A QUARTER OF A MILLION. AND

THEY WERE PROSPECTIVE, MULTI-CENTERED STUDIES, SO THAT THEY INVOLVED NUMEROUS HOSPITALS AND CLINICS THROUGHOUT THE UNITED STATES. AND THEIR PURPOSE WAS TO LOOK AT COMPLICATIONS ASSOCIATED WITH LEGAL ABORTION IN THE UNITED STATES.

Q. WHEN YOU SAY THESE STUDIES WERE "PROSPECTIVE," CAN YOU EXPLAIN WHAT YOU MEAN BY THAT?

A. YES, THEY CAN BE PROSPECTIVE, LOOKING FORWARD IN TIME OR IN RETROSPECTIVE WHERE THE EVENTS OCCURRED IN THE PAST, AND YOU LOOK BACKWARDS TO DETERMINE IF THERE IS ANY ASSOCIATIONS BETWEEN CERTAIN CONDITIONS AND DISEASES OR -- CERTAIN RISK FACTORS AND HEALTH CONDITIONS THAT YOU ARE LOOKING AT.

SO THESE WERE PROSPECTIVE STUDIES, WHICH ARE GENERALLY CONSIDERED TO BE BETTER THAN RETROSPECTIVE STUDIES.

THEY INVOLVED TRAINING PEOPLE AT THE HOSPITALS TO KEEP TRACK OF WOMEN FROM THE TIME THAT THEY HAD THEIR ABORTION FORWARD, LOOKING FORWARD TO WHETHER COMPLICATIONS OCCURRED.

Q. AND YOU MIGHT HAVE SAID THIS, BUT WHEN WERE THE JPSA STUDIES CONDUCTED?

A. FROM 1971 TO 1979.

Q. AND WHO WERE THE LEAD INVESTIGATORS OF THE JPSA STUDIES?

A. DR. WILLARD CATE DIRECTED THE PROGRAM, AND DR. DAVID GRIMES WAS THE CO-DIRECTOR.

Q. AND IS DR. DAVID GRIMES A CO-EDITOR OF THE TEXT THAT YOU WERE THE CHIEF EDITOR OF ON ABORTION?

A. YES.

Q. AND DID JPSA PUBLISH THE RESULTS OF ITS STUDIES?

A. YES, IN SEVERAL ARTICLES.

Q. AND IS THERE A PARTICULAR ARTICLE OR SOURCE THAT SUMMARIZES THE CONCLUSIONS OF THE JPSA STUDIES ON ABORTION-RELATED MORBIDITY?

A. THERE'S A FEW. THE ONE THAT I LIKE IS BY NANCY BINKIN (PHONETIC).

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS TO HAND HER THIS ARTICLE?

BY MS. GARTNER:

Q. DR. PAUL, I HAVE HANDED YOU WHAT IS LEARNED TREATISE NUMBER 15.

IS THIS THE ARTICLE THAT YOU WERE REFERRING TO?

A. YES, IT IS.

Q. AND FOR THE RECORD, CAN YOU TELL ME THE NAME OF THE ARTICLE, THE AUTHOR, THE PUBLICATION AND THE DATE OF PUBLICATION, PLEASE?

A. THE NAME OF THE ARTICLE IS "TRENDS IN INDUCED LEGAL ABORTION MORBIDITY AND MORTALITY." THE AUTHOR IS NANCY BINKIN. AND THIS WAS PUBLISHED IN "CLINICS IN OBSTETRICS AND GYNECOLOGY" IN 1986.

Q. THANK YOU. I WOULD LIKE TO DIRECT YOUR ATTENTION, DR. PAUL, TO PAGE 8, TABLE 7 OF THIS ARTICLE.

A. I DON'T HAVE A PAGE 8.

Q. OH, I AM SORRY. I BELIEVE IT IS THE LAST PAGE OF THE

ARTICLE.

A. TABLE 7, YES.

Q. DO YOU SEE TABLE 7?

A. I DO.

Q. OKAY, GOOD.

DR. PAUL, DOES THIS TABLE SUMMARIZE THE JPSA FINDINGS ON ABORTION-RELATED MORBIDITY?

A. YES.

MS. GARTNER: WE ARE ATTEMPTING -- WHAT ALWAYS SEEMS TO FAIL IS THE TECHNOLOGY TO PUT THIS UP ON THE SCREEN.

YOUR HONOR, WE HAVE A TECHNOLOGY PERSON.

THE COURT: CERTAINLY.

(PAUSE IN THE PROCEEDINGS.)

THE COURT: WHILE HE IS DOING THAT, GENERALLY WE DON'T PUBLISH THE EXHIBITS UNTIL THEY HAVE BEEN ADMITTED INTO EVIDENCE. AS I UNDERSTAND IT, BOTH SIDES HAVE LEARNED TREATISES THEY ARE GOING TO USE WITH THEIR EXPERTS BUT ARE NOT GOING TO MOVE THEM INTO EVIDENCE; IS THAT CORRECT?

MR. QUINLIVAN: THAT'S CORRECT.

MS. GARTNER: THAT'S CORRECT.

THE COURT: SO I AM ASSUMING THERE IS NO OBJECTION TO THE PROJECTION, EVEN THOUGH -- OF THESE ITEMS, EVEN THOUGH THEY ARE NOT GOING TO BE ADMITTED?

MR. QUINLIVAN: NO OBJECTION TO THE PROJECTION, BUT WE WILL HAVE AN OBJECTION IF IT IS BEING MOVED INTO EVIDENCE.

BUT WE DON'T HAVE AN OBJECTION AS TO THE PROJECTION.

MS. GARTNER: YES, AND WE DON'T PLAN TO MOVE IT INTO EVIDENCE, YOUR HONOR.

THE COURT: ALL RIGHT.

BY MS. GARTNER:

Q. DR. PAUL, REFERRING SPECIFICALLY TO THIS TABLE, CAN YOU TELL ME -- ALONG THE TOP IT SAYS "JPSA I, JPSA II AND JPSA III," WITH ROMAN NUMERALS. CAN YOU TELL ME WHAT THE DIFFERENCE IS BETWEEN JPSA I, JPSA II AND JPSA III?

A. THEY WERE THREE PHASES OF THE JPSA STUDIES. THE TIME INTERVALS, WHICH YOU CAN SEE, AT WHICH THEY WERE DONE WERE DIFFERENT. THEY ALSO INVOLVED DIFFERENT SUBJECTS, DIFFERENT WOMEN AND DIFFERENT INSTITUTIONS.

Q. OKAY. WHAT DOES THIS TABLE TELL YOU ABOUT THE JPSA FINDINGS WITH RESPECT TO ABORTION-RELATED MORBIDITY?

A. MAY I USE THE POINTER?

Q. YES.

THE COURT: YES.

THE WITNESS: THANK YOU.

YOU SEE THE TABLE IS ENTITLED: "MAJOR COMPLICATION RATES PER 100 PROCEDURES BASED ON JPSA STUDIES."

HERE IT SHOWS THE TYPE OF PROCEDURE IN THE LEFT-HAND COLUMN, AND THE RATES IN THE REST OF THE COLUMNS. SO, WHAT IT SHOWS IS THAT FOR FIRST-TRIMESTER SUCTION CURETTAGE, WHICH IS ANOTHER NAME FOR VACUUM ASPIRATION, THE RATES WERE ABOUT 0.2 TO

0.6 PER -- AND THAT IS A PERCENT. SO 0.2 TO 0.6 PERCENT. FOR INDUCTION METHODS THAT WERE USED AT THE TIME, WHICH SALINE INSTILLATION, AND THIS IS CALLED PROSTAGLANDIN INSTILLATION, THE RATES RANGED FROM 1.7 PERCENT TO 3 PERCENT.

AND FOR D&E ABORTION, THE RATES RANGED FROM 0.6 PERCENT TO 0.9 PERCENT.

BY MS. GARTNER:

Q. AND, AGAIN, WHEN YOU SAY "THE RATES," THAT IS THE RATE OF MAJOR COMPLICATIONS; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. AND IN THE JPSA STUDIES, WHAT WAS CONSIDERED TO BE A MAJOR COMPLICATION OF ABORTION?

A. JPSA COLLECTED DATA ON 15 DIFFERENT SERIOUS TYPES OF COMPLICATIONS, BUT MOST OF THEM FELL INTO THREE DIFFERENT MAJOR COMPLICATIONS. AND THEY ARE SHOWN DOWN HERE: A FEVER THAT IS SUSTAINED FOR THREE OR MORE DAYS; HEMORRHAGE REQUIRING TRANSFUSION; AND UNINTENDED MAJOR SURGERY: ABDOMINAL SURGERY, HYSTERECTOMY, MAJOR SURGERY.

Q. AND DID THE JPSA STUDIES CONSIDER RETAINED PLACENTA TO BE A COMPLICATION OF ABORTION?

A. YES, BUT NOT A SERIOUS ONE.

Q. AND, DR. PAUL, ARE THE ABORTION METHODS THAT WERE ASSESSED IN THE JPSA STUDIES THE SAME ONES THAT ARE USED TODAY?

A. THERE ARE SIGNIFICANT DIFFERENCES.

Q. HOW WERE THE D&E METHODS USED TODAY DIFFERENT THAN THE ONES

THAT WERE USED AT THE TIME OF THE JPSA STUDIES?

A. THE MAIN DIFFERENCE IS IN THE WAY WE DILATE THE CERVIX.

Q. AND HOW ARE THE INDUCTION METHODS USED TODAY DIFFERENT THAN THE METHODS THAT WERE USED AT THE TIME OF THE JPSA STUDIES?

A. WE USE DIFFERENT TYPES OF MEDICATIONS AND DIFFERENT GROUPS OF ADMINISTRATION.

Q. GIVEN THE DIFFERENCES IN HOW ABORTIONS ARE DONE TODAY, IN YOUR OPINION IS IT VALID TO RELY ON THE JPSA STUDIES IN ASSESSING ABORTION-RELATED MORBIDITY?

A. I THINK IT IS BECAUSE JPSA ESTABLISHED THE FOUNDATION FOR ABORTION SAFETY. IT IS THE LARGEST DATA SET AVAILABLE ON COMPLICATION RATES FROM LEGAL ABORTION IN THE UNITED STATES. THERE IS JUST NOTHING THAT RIVALS IT.

Q. IN YOUR OPINION, IS THERE A DIFFERENCE IN THE ABORTION-RELATED MORBIDITY TODAY THAN THERE WAS AT THE TIME OF THE JPSA STUDIES?

A. I CAN ONLY SPECULATE, BUT BECAUSE OUR METHODS HAVE IMPROVED I WOULD ASSUME THAT ABORTION SAFETY HAS ALSO IMPROVED FOR ALL METHODS.

Q. DOES JPSA STILL EXIST AS PART OF THE CDC?

A. NO.

Q. WHY DOES IT NO LONGER EXIST?

A. IT WAS DISCONTINUED BECAUSE THE QUESTION THAT IT HAD BEEN DESIGNED TO ANSWER ABOUT ABORTION SAFETY AFTER LEGALIZATION OF ABORTION HAD BEEN ANSWERED. IT SHOWED UNEQUIVOCALLY THAT

ABORTION WAS A SAFE PROCEDURE.

Q. AND ARE THERE ANY ADDITIONAL RECENT STUDIES LOOKING AT ABORTION-RELATED MORBIDITY?

A. YES, THERE ARE ARTICLES IN JOURNALS THAT MOSTLY ARE SINGLE -- COME FROM A SINGLE INSTITUTION, AND THEY ARE SMALLER, BUT THEY GENERALLY CONFIRM THE SAFETY OF ABORTION.

Q. AND, DR. PAUL, WHAT DO YOU CONSIDER TO BE THE MOST RELIABLE DATA ON ABORTION-RELATED MORTALITY?

A. THE CDC DATA.

Q. AND IS THAT DATA DIFFERENT FROM THE JPSA CDC DATA?

A. YES. THE CDC HAS AN ACCURATE SURVEILLANCE PROGRAM FOR IDENTIFYING DEATHS RELATED TO BOTH PREGNANCY AND ABORTION.

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS TO HAND HER ANOTHER ARTICLE?

THE COURT: YES.

MS. GARTNER: THANK YOU.

BY MS. GARTNER:

Q. DR. PAUL, I AM HANDING YOU WHAT IS EXHIBIT 63. CAN YOU TELL ME, DR. PAUL, WHAT THIS DOCUMENT IS?

A. THIS IS AN ARTICLE THAT SUMMARIZES THE INFORMATION ON ABORTION MORTALITY COLLECTED BY THE CDC FROM 1972 TO 1987.

Q. AND IS THIS ARTICLE PREPARED BY CDC PERSONNEL?

A. YES, IT IS.

Q. AND IS IT BASED ON DATA COLLECTED BY THE CDC?

A. YES, IT IS.

MS. GARTNER: YOUR HONOR, WE WOULD MOVE TO INTRODUCE THIS EXHIBIT 63 INTO EVIDENCE UNDER THE PUBLIC RECORDS AND VITAL STATISTICS EXCEPTIONS TO THE HEARSAY RULE, WHICH ARE FEDERAL RULES OF EVIDENCE 8038 AND 8039.

THE COURT: ANY OBJECTION?

MR. QUINLIVAN: JUST A MOMENT, YOUR HONOR.

YOUR HONOR, WE DO HAVE AN OBJECTION. MY UNDERSTANDING IS THAT THIS WAS NOT PUBLISHED BY CDC. IF IT WAS PUBLISHED BY CDC, WE WOULD NOT HAVE AN OBJECTION. IF THAT IS CLARIFIED, I'LL WITHDRAW THE OBJECTION. BUT MY UNDERSTANDING IS THAT THIS PAPER WAS NOT PUBLISHED BY THE CDC.

THE COURT: ALL RIGHT.

MS. GARTNER: YOUR HONOR, I THINK THAT IS CORRECT, THAT IT WAS PUBLISHED IN THE JOURNAL, "AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY." HOWEVER, THE EXCEPTION STATES THAT THE DOCUMENTS THAT ARE EXCEPTIONS TO THE HEARSAY RULE INCLUDE -- AND I AM READING NOW FROM 8038:

"RECORDS, REPORTS, STATEMENTS OR DATA COMPILATIONS IN ANY FORM OF PUBLIC OFFICES OR AGENCIES SETTING FORTH THE ACTIVITIES OF THE OFFICE OR AGENCY."

AND IT GOES ON. SO IT DOES SAY "IN ANY FORM," AND AS DR. PAUL HAS TESTIFIED THE AUTHORS OF THIS ARTICLE ARE ALL EMPLOYEES OF THE CDC. AND THE DATA REPORTED IN THIS STUDY IS ALL DATA THAT WAS COLLECTED BY THE CDC AS A PUBLIC AGENCY. SO WE WOULD SAY THIS FALLS WITHIN THE EXCEPTION.

THE COURT: ALL RIGHT. AND YOU BECAME AWARE OF THIS PARTICULAR ITEM THROUGH THE JOURNAL, AS IT WAS PUBLISHED IN THE JOURNAL?

THE WITNESS: YES, I DID.

THE COURT: ALL RIGHT. ANYTHING ELSE ON THE MATTER?

MR. QUINLIVAN: NOTHING MORE ON THIS.

THE COURT: I THINK IT IS NOT PRECLUDED BY SECTION 8 AND IT CLEARLY ISN'T BY SECTION 9, SO I WILL PERMIT IT.

MS. GARTNER: THANK YOU, YOUR HONOR.

THE CLERK: SIXTY-THREE INTO EVIDENCE.

(PLAINTIFF'S EXHIBIT 63
WAS RECEIVED IN EVIDENCE.)

BY MS. GARTNER:

Q. DR. PAUL, IS THE DATA CONTAINED IN THIS ARTICLE THE SORT OF DATA THAT YOU REGULARLY REVIEW IN YOUR WORK?

A. YES.

Q. AND HOW IS THE DATA IN THIS PUBLICATION COMPILED?

A. THE CDC, AS I TESTIFIED EARLIER, HAS AN ACTIVE SURVEILLANCE SYSTEM TO IDENTIFY ABORTION-RELATED DEATHS. THAT MEANS THAT IT GOES TO GREAT LENGTHS TO IDENTIFY DEATHS AND USES SEVERAL SOURCES TO DO THAT, INCLUDING VITAL RECORDS, DEATH CERTIFICATES OF THE STATES, MEDICAL EXAMINER REPORTS, HEALTH CARE PROVIDERS, MEDIA REPORTS.

THERE IS ABOUT 10 DIFFERENT SOURCES THAT THEY USE TO ASCERTAIN THE DEATHS.

Q. DR. PAUL, JUST FOR SHORTHAND, CAN WE REFER TO THIS PUBLICATION AS LAWSON, OR THE LAWSON PUBLICATION?

A. LAWSON IS THE FIRST AUTHOR, YES, SO THAT IS FINE.

Q. DR. PAUL, I WOULD LIKE TO DIRECT YOUR ATTENTION TO TABLE III, ROMAN NUMERAL III OF THIS ARTICLE WHICH APPEARS ON PAGE 1368, WHICH IS ALSO THE TABLE THAT IS -- THAT APPEARS ON THE SCREEN.

CAN YOU SUMMARIZE WHAT THIS TABLE TELLS US ABOUT THE RISK OF DEATH FROM ABORTION IN THE TIME PERIOD COVERED BY THIS ARTICLE FROM 1972 TO 1987?

A. AGAIN, IF I CAN USE MY POINTER.

THE TABLE IS CASE FATALITY RATES, WHICH IS THE SAME AS DEATH RATES, WHICH IS THE NUMBER OF LEGAL INDUCED ABORTION DEATHS PER 100,000 LEGAL INDUCED ABORTIONS.

AND I DO WANT TO CLARIFY THAT "INDUCED" IS BEING USED IN A VERY GENERIC WAY HERE. IT IS NOT REFERRING JUST TO INDUCTION ABORTION. "INDUCED ABORTION" IS A VERY GENERIC TERM THAT IS USED SOMETIMES FOR ALL METHODS OF ABORTION.

SO IT IS THE CASE FATALITY RATES FOR LEGAL INDUCED ABORTION BY TYPE OF PROCEDURE AND LENGTH OF GESTATION, UNITED STATES, 1972 THROUGH '87. AND ACROSS HERE IS THE DIFFERENT GESTATIONAL AGES. AND THESE ARE THE TYPES OF PROCEDURES.

BUT IN ORDER TO SUMMARIZE, I WOULD DIRECT ATTENTION TO THIS FIGURE OF ONE, WHICH IS THE OVERALL DEATH RATE FROM ALL METHODS OF ABORTION. IT IS ONE PER 100,000 PROCEDURES. SO IT

IS VERY LOW.

AND THE OTHER THING IN GENERAL THAT YOU NOTICE IS THAT THE DEATH RATE INCREASES AS GESTATIONAL AGE INCREASES.

Q. ARE YOU LOOKING FOR THAT AT THE BOTTOM LINE, THE TOTAL?

A. THE TOTAL, YES. SO THESE ARE THE -- THIS IS THE TOTAL DEATH RATE FROM -- AT EIGHT WEEKS OR LESS, FROM ALL TYPES OF PROCEDURES THAT ARE DONE AT THAT GESTATIONAL AGE.

AND THE DEATH RATE IS 0.4 FOR 100,000. WHEREAS, IF YOU LOOK AT 21 WEEKS OR GREATER, AGAIN, THE RATE IS 10 PER 100,000 PROCEDURES.

Q. DOES THE LAWSON ARTICLE TELL US WHETHER THE RISK OF DEATH FROM ABORTION HAS CHANGED IN THE PERIOD SINCE ABORTION WAS LEGALIZED NATIONWIDE IN 1973?

A. IT'S NOT REFLECTED ON THIS TABLE, BUT THE ARTICLE TELLS US, YES, THAT THE RISK OF DEATH HAS DECREASED OVER 90 PERCENT, FROM ABOUT FOUR PER 100,000 IN 1972, TO ABOUT 0.4 IN 1987.

Q. DR. PAUL, EARLIER WHEN YOU WERE DISCUSSING THE SAFETY OF CARRYING A PREGNANCY TO TERM AND THROUGH CHILDBIRTH, YOU SAID THAT AS WOMEN GET OLDER THE RISK FOR CARRYING A PREGNANCY TO TERM INCREASES; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. IS THE SAME THING TRUE FOR ABORTION?

A. NO.

Q. IS THAT REFLECTED IN THE LAWSON ARTICLE?

A. WHEN THEY LOOKED AT THE MOST RECENT PERIOD OF 1983, 1987,

THERE WAS -- WHICH IS OUR MOST RECENT DATA -- THERE WERE -- THERE WAS NO ASSOCIATION BETWEEN THE AGE OF A WOMAN AND HER RISK OF DEATH FROM ABORTION.

Q. AND THEN, DR. PAUL, TO SUMMARIZE ALL OF YOUR TESTIMONY ABOUT ABORTION-RELATED MORBIDITY AND MORTALITY, WHAT IS YOUR OPINION ON THE OVERALL SAFETY OF ABORTION?

A. THAT IT IS VERY SAFE.

Q. NOW, YOU'VE JUST BEEN TESTIFYING ABOUT THE OVERALL SAFETY OF PREGNANCY THROUGH CHILDBIRTH AND THE OVERALL SAFETY OF ABORTION. BASED ON THE VARIOUS DATA YOU HAVE BEEN TESTIFYING ABOUT, WHAT OVERALL CONCLUSIONS DO YOU DRAW ABOUT THE RELATIVE SAFETY OF ABORTION AND PREGNANCY CONTINUED THROUGH CHILDBIRTH?

A. THE CONCLUSION I DRAW IS THAT OVERALL ABORTION IS SAFER THAN CARRYING A PREGNANCY TO TERM AND GOING THROUGH CHILDBIRTH. AND THAT'S BASED ON BOTH MORTALITY DATA OVER ALL THE RISK OF CHILDBIRTH -- OF DEATH FROM CHILDBIRTH IS ABOUT 10 TIMES THAT THE RISK OF HAVING AN ABORTION.

AND IF YOU LOOK AT SECOND-TRIMESTER, THAT UNDER 16 WEEKS GESTATION THAT THE RISK OF HAVING AN ABORTION IS CLEARLY LESS THAN THE RISK OF CARRYING A PREGNANCY TO TERM.

AT 16 WEEKS GESTATION AND HIGHER, THE RATES ARE ABOUT THE SAME. BUT FOR OLDER WOMEN, THE RATES OF DYING FROM PREGNANCY AND CHILDBIRTH ARE HIGHER THAN THE RISK OF HAVING AN ABORTION. I WOULD SAY THAT INCLUDES IN THE SECOND-TRIMESTER.

AND THEN, IN TERMS OF COMPLICATION RATES, THE DATA

THAT I TALKED ABOUT IN TERMS OF HOSPITALIZATION SHOW THAT IT'S VERY COMMON TO HAVE COMPLICATIONS OCCUR DURING PREGNANCY. AND THAT WHEN YOU LOOK AT THAT MORBIDITY DATA THAT, IN MY OPINION, HANDS DOWN ABORTION IS A SAFER OPTION THAN CARRYING TO TERM.

Q. THANK YOU.

NOW, DR. PAUL, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT HOW OFTEN ABORTIONS ARE PERFORMED AND AT WHAT GESTATIONAL AGES THEY TEND TO BE PERFORMED. ARE THERE AGENCIES THAT COLLECT AND COMPILE DATA ABOUT ABORTION?

A. YES.

Q. WHAT ARE THOSE AGENCIES?

A. THE CENTERS FOR DISEASE CONTROL AND PREVENTION, AND THE ALAN GUTTMACHER INSTITUTE.

Q. WHAT IS THE ALAN GUTTMACHER INSTITUTE?

A. IT'S A PRIVATE, INDEPENDENT RESEARCH INSTITUTE BASED IN NEW YORK CITY.

Q. CAN I REFER TO THAT AS AGI? WILL YOU KNOW WHAT I AM REFERRING TO?

A. SURE.

Q. WHICH OF THESE ORGANIZATIONS, CDC OR AGI, IS GENERALLY UNDERSTOOD AS HAVING THE MOST COMPLETE DATA ON THE NUMBERS OF ABORTIONS PERFORMED IN THIS COUNTRY OVERALL?

A. THE AGI. THE CDC EVEN ACKNOWLEDGES THAT THE AGI HAS THE BETTER DATA ON THAT PARTICULAR ASPECT OF ABORTION.

Q. AND WHAT IS THE MOST CURRENT YEAR FOR WHICH AGI HAS DATA ON

THE NUMBER OF ABORTIONS IN THIS COUNTRY?

A. IN THE YEAR 2000.

Q. AND ACCORDING TO THAT DATA, HOW MANY ABORTIONS WERE PERFORMED IN THIS COUNTRY IN THE YEAR 2000?

A. ABOUT 1.3 MILLION.

Q. AND DO EITHER THE CDC OR AGI COLLECT DATA SHOWING THE FREQUENCY OF ABORTIONS AT PARTICULAR GESTATIONAL AGES?

A. YES, THE CDC DOES.

Q. WHERE IS THAT PUBLISHED BY THE CDC?

A. IN A PUBLICATION CALLED "MORBIDITY AND MORTALITY WEEKLY REPORT," OR MMWR.

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS?

BY MS. GARTNER:

Q. I AM HANDING YOU EXHIBIT 7, DR. PAUL. DR. PAUL, IS THIS THE DOCUMENT THAT YOU WERE REFERRING TO A MOMENT AGO?

A. YES, IT IS.

Q. AND FOR THE RECORD, CAN YOU STATE THE FULL NAME OF THIS DOCUMENT?

A. IT'S ENTITLED: "ABORTION SURVEILLANCE-UNITED STATES, 2000."

AND IT'S THE "MORBIDITY AND MORTALITY WEEKLY REPORT" OF NOVEMBER 28TH, 2003.

Q. AND DOES THE CDC PUBLISH "MORBIDITY AND MORTALITY WEEKLY REPORTS" ON OTHER THINGS, IN ADDITION TO ABORTION?

A. OH, YES, ON MANY CONDITIONS, PREGNANCY-RELATED AND NOT PREGNANCY-RELATED.

Q. AND DO YOU ROUTINELY REVIEW THE MMWR AS PART OF YOUR WORK?

A. YES, I HAVE AN ONLINE SUBSCRIPTION.

Q. AND AS FAR AS YOU KNOW, IS THIS THE MOST CURRENT MMWR RELATED TO ABORTION?

A. YES, IT IS.

Q. AND HOW DOES THE CDC COMPILE THE DATA IN THIS REPORT?

A. FROM STATE HEALTH DEPARTMENTS AND THE HEALTH DEPARTMENTS OF NEW YORK CITY AND THE DISTRICT OF COLUMBIA.

MS. GARTNER: YOUR HONOR, WE WOULD MOVE TO INTRODUCE EXHIBIT 7 INTO EVIDENCE AGAIN, UNDER THE PUBLIC RECORDS AND REPORTS AND VITAL STATISTICS EXCEPTIONS TO THE HEARSAY RULE.

THE COURT: AND DOES THE GOVERNMENT CONTINUE ITS OBJECTION?

MR. QUINLIVAN: GIVEN THAT IT IS PUBLISHED BY THE CDC, WE DON'T HAVE AN OBJECTION, YOUR HONOR.

THE COURT: THANK YOU. ADMITTED.

THE CLERK: SEVEN INTO EVIDENCE.

(PLAINTIFF'S EXHIBIT 7
WAS RECEIVED IN EVIDENCE.)

BY MS. GARTNER:

Q. DR. PAUL, I WOULD LIKE TO DIRECT YOUR ATTENTION TO PAGE 16, TABLE 1 OF THIS EXHIBIT, WHICH MS. PARKER IS ALSO PUTTING UP ON THE SCREEN.

DR. PAUL, IS THIS THE TABLE IN THIS DOCUMENT, THE MMWR DOCUMENT, WHERE THE FREQUENCY OF ABORTIONS AT DIFFERENT GESTATIONAL AGES IS DISCUSSED?

A. YES.

Q. CAN YOU TELL US GENERALLY WHAT INFORMATION IS CONTAINED IN THIS TABLE?

A. YES. THE TABLE IS CALLED "CHARACTERISTICS OF WOMEN WHO OBTAINED LEGAL ABORTIONS, UNITED STATES." CHALLENGED IN SEEING THAT FAR. 1973 TO 2000.

IT'S PART OF A LARGER TABLE. WHAT THIS IS IS THE INFORMATION ON THE GESTATIONAL AGES AT WHICH ABORTIONS ARE DONE.

SO, ON THE LEFT HERE YOU HAVE THE WEEKS OF PREGNANCY, THE WEEKS OF GESTATION DIVIDED INTO DIFFERENT INTERVALS. AND THESE ARE THE DIFFERENT YEARS FOR WHICH THE DATA IS COLLECTED. AND THIS IS THE COLUMN FOR THE YEAR 2000, WHICH IS THE MOST RECENT YEAR.

Q. OKAY. AND IN GENERAL, WHAT DOES THIS TABLE TELL US ABOUT THE GESTATIONAL AGES AT WHICH ABORTIONS ARE PERFORMED?

A. THAT MOST OF THEM ARE PERFORMED IN THE FIRST-TRIMESTER.

Q. AND SPECIFICALLY, WHAT DOES THIS TABLE TELL US ABOUT THE PERCENTAGE OF ABORTIONS THAT WERE PERFORMED PRIOR TO 13 WEEKS LMP IN THE YEAR 2000?

A. YOU HAVE TO DO A LITTLE ADDING OF THE COLUMNS HERE. BUT IF YOU ADD UP THE FIGURES HERE FOR LESS THAN 13 WEEKS, YOU GET

ABOUT 88 PERCENT.

Q. AND WHAT DOES THIS TABLE TELL US ABOUT THE PERCENTAGE OF ABORTIONS THAT WERE PERFORMED BETWEEN 13 AND 15 WEEKS IN THE YEAR 2000?

A. YOU CAN SEE THAT DIRECTLY ON THE TABLE, THAT ABOUT 6.2 PERCENT OF ABORTIONS WERE PERFORMED BETWEEN 13 AND 15 WEEKS GESTATION.

Q. AND WHAT PERCENTAGE OF ABORTIONS WERE DONE BETWEEN 16 AND 20 WEEKS GESTATION?

A. 4.3 PERCENT.

Q. AND WHAT PERCENTAGE OF ABORTIONS WERE DONE AFTER 20 WEEKS IN THE YEAR 2000?

A. 1.4 PERCENT.

Q. SO I AM GOING TO CHALLENGE YOUR MATH ABILITIES A LITTLE MORE, DR. PAUL. YOU PREVIOUSLY TESTIFIED THAT THERE ARE APPROXIMATELY 1.3 MILLION ABORTIONS IN THIS COUNTRY IN THE YEAR 2000; IS THAT RIGHT?

A. YES.

Q. SO LOOKING AT TABLE 1, OUT OF THE 1.3 MILLION TOTAL ABORTIONS, APPROXIMATELY HOW MANY WERE PERFORMED IN THE YEAR 2000 AFTER 16 WEEKS LMP?

A. APPROXIMATELY 74,000.

Q. AND AFTER 20 WEEKS LMP?

A. APPROXIMATELY 18,000.

Q. DR. PAUL, WHAT I WOULD LIKE TO DO NOW IS TO GIVE THE COURT

AN OVERVIEW OF THE DIFFERENT METHODS OF ABORTIONS THAT ARE AVAILABLE FOR WOMEN TO CHOOSE FROM. FIRST OF ALL, WHAT ARE SOME OF THE FACTORS THAT DETERMINE WHAT METHODS OF ABORTION ARE AVAILABLE TO A WOMAN TO CHOOSE FROM?

A. THE GESTATIONAL AGE OF THE PREGNANCY IS PROBABLY THE BIGGEST, BUT ALSO THE AVAILABILITY OF A TRAINED PROVIDER FOR THE PARTICULAR METHODS.

Q. AND ARE ALL ABORTION METHODS GENERALLY AVAILABLE THROUGHOUT THE UNITED STATES?

A. NO. THERE IS A SHORTAGE OF PROVIDERS IN THE UNITED STATES SUCH THAT ABOUT 87 PERCENT OF COUNTIES IN THE UNITED STATES HAVE NO ABORTION PROVIDER. WHERE THERE IS AN ABORTION PROVIDER IT IS MORE LIKELY THAT THE PROVIDER IS TRAINED IN FIRST-TRIMESTER ABORTIONS INSTEAD OF THE LATER ABORTIONS.

AND WHERE THERE IS A SECOND-TRIMESTER PROVIDER, IT IS MORE LIKELY THAT THE PHYSICIAN IS TRAINED IN INDUCTION ABORTION RATHER THAN D&E.

Q. DR. PAUL, YOU SAID THAT GESTATIONAL AGE IS THE MOST IMPORTANT DETERMINANT OF WHAT METHODS ARE AVAILABLE TO A WOMAN. SO I WANT TO FOLLOW UP ON THAT. WHAT METHODS OF ABORTION ARE AVAILABLE TO A WOMAN IN THE FIRST-TRIMESTER OF PREGNANCY?

A. THERE'S EARLY MEDICAL ABORTION METHODS THAT BASICALLY INVOLVE GIVING MEDICATION TO CAUSE THE PREGNANCY TO STOP GROWING AND TO BE EXPELLED FROM THE UTERUS, AND THERE IS VACUUM ASPIRATION ABORTION.

Q. AND CAN YOU DESCRIBE BRIEFLY WHAT VACUUM ASPIRATION ABORTION IS?

A. IT IS USING A SOURCE OF SUCTION TO EVACUATE THE UTERUS. IT CAN BE MANUAL VACUUM ASPIRATION, JUST A SYRINGE-LIKE DEVICE THAT WE USE TO CREATE THE SUCTION, OR IT CAN BE AN ELECTRIC PUMP THAT CREATES THE SUCTION.

Q. AND WHAT METHODS OF ABORTION ARE AVAILABLE IN THE SECOND-TRIMESTER OF PREGNANCY?

A. D&E ABORTION, DILATION AND EVACUATION, WHICH CAN OCCUR EITHER THROUGH DISARTICULATION OR AS AN INTACT PROCEDURE. AND THERE IS INDUCTION ABORTION, WHICH IS BASICALLY GIVING MEDICATIONS TO CAUSE LABOR CONTRACTIONS TO HAVE THE WOMAN EXPEL THE FETUS.

Q. AND, DR. PAUL, IS THERE A PARTICULAR TERM THAT YOU USE TO DESCRIBE D&E'S THAT OCCUR BY INTACT EXTRACTION?

A. I SAY THE WORD "INTACT" D&E. I THINK IT IS REALLY JUST A VARIANT OF D&E, SO I WOULDN'T NECESSARILY ALWAYS IDENTIFY THEM SEPARATELY.

IN THE TEXTBOOK WHEN WE HAVE A SECTION ON IT WE REFER TO IT AS "INTACT D&E."

Q. AND WHEN YOU SAY "THE TEXTBOOK," ARE YOU REFERRING TO YOUR "A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION"?

A. YES, I AM.

Q. DR. PAUL, IF YOU KNOW, DO SOME DOCTORS USE THE TERM D&X TO DESCRIBE ABORTIONS IN WHICH THE FETUS IS REMOVED WITH INTACT

EXTRACTION?

A. I HAVE SEEN THAT USED IN VARIOUS WAYS. I MEAN, I HAVE HEARD PHYSICIANS USE IT GENERICALLY TO BE PRETTY SYNONYMOUS WITH INTACT D&E.

I DO KNOW THAT ACOG HAD A SPECIFIC DEFINITION IN A PUBLICATION THAT IT HAD DESCRIBED SOMETHING THAT WAS MUCH MORE SPECIFIC, BUT I FIND THAT IT IS NOT REALLY UNIFORM THE WAY THAT PEOPLE USE THAT TERM.

Q. DR. PAUL, WHEN YOU SAY "ACOG," IS THAT THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS?

A. YES, IT IS.

Q. IN YOUR OPINION, ARE INTACT D&E OR D&X A DISTINCT PROCEDURE FROM D&E?

A. NOT IN MY OPINION. I CONSIDER THEM A VARIANCE OF D&E.

Q. DR. PAUL, WHERE ARE MOST -- WHERE ARE MOST D&E PROCEDURES PERFORMED?

A. IN CLINICS.

Q. AND IS THAT AN OUTPATIENT TYPE SETTING?

A. YES, A NONHOSPITAL-BASED OUTPATIENT CLINIC.

Q. AND WHERE ARE MOST INDUCTION ABORTIONS PERFORMED?

A. IN HOSPITALS.

Q. AND WHY IS THAT?

A. WELL, INDUCTION ABORTION INVOLVES GIVING MEDICATIONS TO PUT A WOMAN INTO LABOR, WHICH CAN HAPPEN OVER SEVERAL HOURS, SOMETIMES EVEN TAKES A DAY OR TWO. SO -- AND THERE ARE SOME

SIDE EFFECTS THAT OCCUR. SO IN ORDER TO BE ABLE TO GIVE THE WOMAN THE MEDICATIONS TO INDUCE THE LABOR IN ADDITION TO GIVE HER MEDICATIONS TO HELP WITH THE PAIN THAT SHE MAY BE HAVING DURING THE CONTRACTIONS AND TO TREAT SIDE EFFECTS THAT CAN OCCUR, LIKE NAUSEA, VOMITING OR FEVER, MONITORING IN A HOSPITAL IS IMPORTANT OVER THAT EXTENDED PERIOD OF TIME. AND CLINICS ARE NOT SET UP TO DO THAT KIND OF LONGER TERM MONITORING.

Q. NOW, IF FOR SOME MEDICAL REASON A WOMAN WHO WAS HAVING A SECOND-TRIMESTER ABORTION COULDN'T HAVE EITHER A D&E OR AN INDUCTION PROCEDURE, ARE THERE OTHER ABORTION METHODS THAT ARE AVAILABLE TO HER?

A. THERE IS HYSTEROTOMY OR HYSTERECTOMY. THEY ARE METHODS THAT ARE AVAILABLE, ALTHOUGH THE DEATH RATES FROM THEM, IN MY OPINION, ARE PROHIBITIVELY HIGH.

Q. CAN YOU JUST DESCRIBE BRIEFLY WHAT HYSTEROTOMY AND HYSTERECTOMY ARE?

A. A HYSTEROTOMY IS REMOVAL OF THE PREGNANCY THROUGH AN INCISION IN THE UTERUS, AND SO YOU DO AN ABDOMINAL INCISION TO GET TO THE UTERUS, AND THEN ANOTHER INCISION IN THE UTERUS TO REMOVE THE PREGNANCY.

AND HYSTERECTOMY IS REMOVAL OF THE ENTIRE UTERUS, IN WHICH CASE THE PREGNANCY IS ALSO REMOVED.

Q. AND ARE THOSE, HYSTEROTOMY AND HYSTERECTOMY, ARE THOSE COMMONLY PERFORMED IN THIS COUNTRY?

A. NO, THEY ARE VERY UNCOMMON, THANK GOODNESS. OVERALL, THEY

ARE ABOUT 0.01 PERCENT OF ALL ABORTIONS AND ABOUT 0.07 PERCENT OF SECOND-TRIMESTER ABORTIONS.

Q. DR. PAUL, ARE THERE DATA SHOWING WHAT PERCENTAGE OF ABORTIONS ARE PERFORMED BY EACH AVAILABLE METHOD AT PARTICULAR GESTATIONAL AGES?

A. YES.

Q. AND WHO COLLECTS THAT DATA?

A. THE CDC.

Q. AND IS THAT PART OF THE CDC ABORTION SURVEILLANCE DOCUMENT THAT WE WERE JUST LOOKING AT?

A. YES, IT IS.

Q. DR. PAUL, IF YOU WOULD LIKE TO TURN BACK TO EXHIBIT 7, WHICH YOU SHOULD HAVE THERE STILL TO PAGE 32.

IS TABLE 18 ON PAGE 32 THE DATA THAT YOU ARE REFERRING TO?

A. YES.

Q. CAN YOU EXPLAIN THE INFORMATION THAT IS CONTAINED IN THIS TABLE, PLEASE?

A. YES. TITLE IS "REPORTED LEGAL ABORTIONS BY KNOWN WEEKS OF GESTATION AND TYPE OF PROCEDURE."

AND ON THE LEFT-HAND COLUMN HERE IS THE TYPE OF PROCEDURE. ACROSS THE ROWS WE HAVE THE GESTATIONAL AGES INCREASING FROM LEFT TO RIGHT. AND THEN, THE DATA IS IN THE REST OF THE TABLE.

Q. AND WHAT IS MEANT ON THIS TABLE? I'M LOOKING AT THE

LEFT-HAND COLUMN, IT SAYS:

"INTRAUTERINE SALINE INSTILLATION, INTRAUTERINE PROSTAGLANDIN INSTILLATION AND MEDICAL."

WHAT PROCEDURE DO THOSE REFER TO?

A. THOSE ARE DIFFERENT METHODS OF INDUCTION ABORTION THAT WERE USED AT THE TIME.

Q. AND THAT ALL THREE OF THOSE ARE INDUCTION ABORTIONS?

A. YES, THEY ARE.

Q. AND WHERE --

A. ALTHOUGH, I -- YES, THAT'S RIGHT. THERE IS A FOOTNOTE IN THIS TABLE THAT INDICATES THAT "MEDICAL" INVOLVES PRIMARILY THE USE OF VAGINAL PROSTAGLANDINS, WHICH IS A METHOD FOR USE TO INDUCE AN INDUCTION ABORTION.

Q. AND WHERE IN THIS TABLE ARE DATA FOR D&E REFLECTED?

A. UNDER "CURETTAGE." SO THE D&E'S WOULD BE THE CURETTE ABORTIONS THAT WERE DONE AT 13 WEEKS OR GREATER. SO, THAT'S HOW THE CDC CATEGORIZES THEM.

Q. AND ARE DATA FOR INTACT D&E ABORTIONS REFLECTED IN THIS TABLE?

A. NOT SEPARATELY. BUT AS I SAID, INTACT D&E IS A VARIANT OF D&E, SO I STRONGLY SUSPECT THAT THERE ARE INTACT D&E'S THAT ARE INCLUDED IN THIS -- THESE DATA, AS WELL AS D&E'S THAT PROCEED BY DISARTICULATION.

Q. LOOKING AT THESE DATA FOR 16 TO 20 WEEKS GESTATION, WHAT PERCENTAGE OF ABORTIONS WERE DONE BY D&E VERSUS WHAT PERCENT

FOR INDUCTIONS?

A. AT 16 TO 20 WEEKS GESTATION ABOUT 95 PERCENT WERE DONE BY D&E.

Q. IS THAT -- I AM SORRY. JUST TO BE CLEAR. IT IS A LITTLE HARD TO READ. ARE YOU THERE POINTING TO THE NUMBER OF 94.6?

A. 94.6, YES. THIS 16 TO 20; IS THAT WHAT YOU ARE ASKING?

Q. YES.

A. SO 94.6, WHICH I AM ROUNDING OFF TO 95 PERCENT. ABOUT 95 PERCENT WERE DONE BY D&E ABORTION, AND ABOUT 5 PERCENT BY INDUCTION.

Q. AND THEN, LOOKING AT THESE DATA WITH RESPECT TO ALL ABORTIONS AFTER 20 WEEKS GESTATION, THE SAME QUESTION: WHAT PERCENTAGE OF WOMEN HAD D&E VERSUS WHAT PERCENT HAD INDUCTION ABORTIONS?

A. THOSE DATA ARE RIGHT HERE. ABOUT 85 PERCENT HAD D&E ABORTION, AND ABOUT 15 PERCENT HAD INDUCTION ABORTION AT 21 WEEKS OR GREATER.

Q. DR. PAUL, WE HAVE GONE THROUGH A LOT OF BACKGROUND INFORMATION, BUT NOW I WOULD LIKE TO FOCUS IN ON THE PARTICULAR METHODS OF ABORTION THAT WOULD, IN YOUR OPINION, BE AFFECTED BY THE LAW AT ISSUE IN THIS CASE.

SO WHY DON'T WE IDENTIFY WHAT THOSE ARE? IN YOUR OPINION, WOULD ANY OF THE FIRST-TRIMESTER METHODS THAT YOU DESCRIBED EVER BE AFFECTED BY THIS LAW?

A. NOT IN MY OPINION.

Q. AND IN YOUR OPINION, WOULD HYSTEROTOMY OR HYSTERECTOMY ABORTIONS EVERY BE AFFECTED BY THIS LAW?

A. NO.

Q. IN YOUR OPINION, WOULD THE D&E METHOD EVER BE AFFECTED BY THIS LAW?

A. YES.

Q. AND IN YOUR OPINION, WOULD THE INDUCTION METHOD EVER BE AFFECTED BY THIS LAW?

A. IT COULD BE.

Q. WHY DON'T WE START BY TALKING ABOUT THE D&E ABORTIONS? WHAT I WOULD LIKE YOU TO DO IS TO EXPLAIN IN GREATER DETAIL HOW YOU PERFORM A D&E. AND START WITH TELLING US IN GENERAL WHAT ARE THE PRIMARY COMPONENTS INVOLVED IN A D&E ABORTION?

A. THERE ARE TWO PRIMARY COMPONENTS. ONE IS CERVICAL PREPARATION, AND THE OTHER IS EVACUATION OF THE UTERUS.

MS. GARTNER: YOUR HONOR, WITH YOUR PERMISSION WE HAVE SOME CHARTS OR DIAGRAMS THAT MAY BE HELPFUL. THANK YOU.

YOUR HONOR, ARE THOSE PLACED IN A WAY THAT YOU CAN SEE IT?

THE COURT: I CAN SEE IT.

THE WITNESS: MAY I STEP DOWN, YOUR HONOR --

THE COURT: SURE.

THE WITNESS: -- IF I NEED TO?

BY MS. GARTNER:

Q. DR. PAUL, WHAT I WOULD LIKE YOU TO DO IS EXPLAIN TO THE

COURT WHY IT IS NECESSARY TO PREPARE THE CERVIX FOR A D&E ABORTION. AND IF IT IS HELPFUL TO YOU, YOU KNOW, FEEL FREE TO USE ONE OF THESE DIAGRAMS.

A. I THINK I WILL USE THIS DIAGRAM OVER HERE TO ILLUSTRATE THAT. THIS IS THE UTERUS (INDICATING). THE UTERUS -- AS YOU CAN SEE, THIS IS A NONPREGNANT UTERUS. IT IS A PEAR-SHAPED ORGAN, AND IT HAS A NARROWING THAT HAPPENS DOWN HERE AT THE NECK. THAT IS CALLED THE CERVIX.

THE CERVIX HAS SOME LENGTH. THERE IS SOMETHING CALLED THE EXTERNAL OS, WHICH IS THE EXTERNAL OPENING THAT'S RIGHT AT THE TOP OF THE VAGINA.

AND THEN, THERE IS THE INTERNAL OS, WHICH IS AT THE OTHER END OF THE CERVIX.

Q. AND WHAT IS THE DISTANCE, ON AVERAGE, BETWEEN THE INTERNAL OS AND THE EXTERNAL OS?

A. IT CERTAINLY CAN VARY, AND ESPECIALLY DURING PREGNANCY. BUT IT CAN BE AS MUCH AS 3 INCHES. IT CAN BE AS LITTLE AS 1 INCH.

Q. AND I AM SORRY TO INTERRUPT YOU. AND THEN, WHAT IS IT -- IF YOU CAN EXPLAIN TO US WHY THE CERVIX NEEDS TO BE PREPARED FOR THE D&E ABORTION.

A. SO THE CERVIX IS NORMALLY CLOSED. IT'S THE ENTRANCE INTO THE UTERUS WHERE THE PREGNANCY IS. AND OUR GOAL IN DOING ANY ABORTION IS TO GET SOMETHING LARGER, WHICH IS THE FETUS, OUT OF SOMETHING SMALLER, WHICH IS THE CERVIX, WITHOUT CAUSING INJURY

TO THE CERVIX.

SO IN ORDER TO DO THAT, IT'S NECESSARY TO PREPARE THE CERVIX BEFORE YOU TRY TO BRING OUT THE FETUS. AND THAT MEANS TO DILATE THE CERVIX, SOFTEN THE CERVIX, GET IT READY, BASICALLY, FOR THE EVACUATION.

Q. THANK YOU.

YOU MENTIONED TWO THINGS: DILATING THE CERVIX AND SOFTENING THE CERVIX. WHAT ARE THE WAYS THAT YOU USE TO DILATE THE CERVIX?

A. I WOULD SAY THAT THERE ARE WAYS THAT I USE TO PREPARE THE CERVIX, BECAUSE EACH METHOD WILL DO SOME DILATION AND SOME SOFTENING. SO IT IS KIND OF A BLURRING OF THOSE, SO I JUST WANT TO BE CLEAR ABOUT WHAT I AM SAYING. AND THAT IS: WHAT ARE THE METHODS THAT I USE TO PREPARE THE CERVIX?

ONE OF THEM IS THE USE OF OSMOTIC DILATORS, AND THE OTHER IS THE USE OF MEDICATIONS TO PREPARE THE CERVIX.

Q. THANK YOU FOR THAT CLARIFICATION. WHY DON'T WE TALK FIRST ABOUT THE OSMOTIC DILATORS. CAN YOU EXPLAIN WHAT THAT TERM MEANS?

A. AN OSMOTIC DILATOR IS A SHORT STICK OF COMPRESSED SEAWEED OR SYNTHETIC MATERIAL THAT IS PLACED INTO THE CERVIX. IT ABSORBS FLUID FROM THE CERVIX AND VAGINA, AND EXPANDS, KIND OF LIKE A DRIED PIECE OF SEAWEED ON THE BEACH EXPANDS WHEN IT GETS WET AND GRADUALLY STRETCHES THE CERVIX OPEN.

MS. GARTNER: YOUR HONOR, I HAVE A LAMINARIA. WOULD

YOU OBJECT IF I HANDED IT TO DR. PAUL?

THE COURT: SURE.

BY MS. GARTNER:

Q. DR. PAUL, IS THAT A LAMINARIA?

A. YES, IT IS.

THE COURT: LAMINARIA BEING WHAT? MAY I SEE IT?

THE WITNESS: SO THIS IS AN EXAMPLE OF A LAMINARIA. IT'S ONE TYPE OF OSMOTIC DILATOR. IT IS MADE OF COMPRESSED SEAWEED.

BY MS. GARTNER:

Q. AND DO LAMINARIA COME IN DIFFERENT SIZES?

A. YES.

Q. AND WHAT SIZE IS THIS ONE?

A. THIS IS A LARGE.

Q. AND WHEN YOU SAY -- WHEN YOU SAY "THEY COME IN DIFFERENT SIZES," DO THEY COME IN DIFFERENT LENGTHS AND DIFFERENT WIDTHS OR --

A. DIFFERENT WIDTHS.

Q. CAN YOU DESCRIBE HOW YOU INSERT THE LAMINARIA INTO THE WOMAN'S CERVIX?

A. YES. FIRST I DO AN EXAMINATION, GET AN IDEA OF -- JUST TO BE SURE THAT THINGS ARE FINE IN TERMS OF THE SIZE OF THE UTERUS, THE POSITION OF THE UTERUS, WHERE THE CERVIX IS LOCATED IN RELATION TO THE VAGINA. I THEN INSERT A SPECULUM, WHICH IS WHAT WE USE WHEN WE DO PAP SMEARS AND GENERAL GYNECOLOGICAL

EXAMS TO VISUALIZE CERVIX, SO IT IS A SMALL INSTRUMENT THAT WE PUT INTO THE VAGINA AND OPEN UP, AND THE CERVIX COMES INTO VIEW.

I THEN WIPE OFF THE CERVIX WITH AN ANTISEPTIC SOLUTION. AND SOMETIMES I WILL PUT A LITTLE NUMBING MEDICINE AROUND THE CERVIX TO MAKE THE INSERTION MORE COMFORTABLE.

I THEN USE AN INSTRUMENT TO GRASP THE LAMINARIA, AND I PUT THE LAMINARIA INTO THE CANAL. SO I AM PUTTING IT THROUGH THAT EXTERNAL OS AND UP THE CANAL AND INTO THAT -- JUST A LITTLE PASSED THAT INTERNAL OS.

Q. AND I THINK YOU MAY HAVE SAID THIS, BUT WHAT IS IT ABOUT THE LAMINARIA THAT CAUSES DILATION?

A. THEY ABSORB FLUID AND EXPAND AND STRETCH THE UTERUS, THE CERVIX OPEN.

Q. AND HOW MANY LAMINARIA DO YOU USE?

A. AS MANY AS WILL COMFORTABLY FIT WITHOUT FORCING.

Q. AND DOES THAT NUMBER VARY BY THE GESTATIONAL AGE OF THE PREGNANCY?

A. WELL, I HAVE MINIMUM CRITERIA BY GESTATIONAL AGE. SO THAT, YOU KNOW, IT IS IMPORTANT, FOR INSTANCE, AT 14 TO 16 WEEKS GESTATION, I WOULD WANT AT LEAST TWO LARGE LAMINARIA. AT 16 TO 17, A MINIMUM OF THREE. AND THEN, AT 17 TO 18, SIX, A MINIMUM OF FOUR. BUT I REALLY WANT TO EMPHASIZE THE MINIMUM, BECAUSE IN MY OPINION THE MORE YOU CAN GET COMFORTABLY IN WITHOUT FORCING THE BETTER.

Q. OKAY. AND DO YOU EVER DO A SECOND INSERTION OF LAMINARIA FOR ONE PATIENT?

A. VERY RARELY.

Q. AND HOW LONG DO YOU LEAVE THE LAMINARIA IN PLACE BEFORE YOU BEGIN THE EVACUATION PART OF THE PROCEDURE?

A. IT CAN VARY, AGAIN, BY GESTATIONAL AGE, BUT GENERALLY AT 16 WEEKS AND OVER WE LEAVE THE LAMINARIA IN OVERNIGHT.

Q. AND CAN YOU PREDICT THE AMOUNT OF DILATION YOU WILL ACHIEVE WITH THE LAMINARIA?

A. NO.

Q. WHY IS THAT?

A. BECAUSE WOMEN CERVIXES JUST DIFFER, AND THERE IS JUST GREAT VARIABILITY IN THE AMOUNT OF DILATION YOU CAN GET IN DIFFERENT WOMEN, GIVEN THE SAME NUMBER OF LAMINARIA INSERTED.

Q. AND HOW DO YOU DETERMINE IF THE DILATION THAT YOU'VE ACHIEVED IS SUFFICIENT TO CONTINUE WITH THE PROCEDURE?

A. I NEED ENOUGH DILATION TO GET THE INSTRUMENTS IN THAT I USE AND TO HAVE SOME EXTRA MOBILITY TO BE ABLE TO MOVE THOSE INSTRUMENTS.

SO THE INSTRUMENTS THAT I USE ON THE GESTATIONAL AGES I DO ARE 16 TO 17 MILLIMETERS IN DIAMETER. SO I AM GOING TO WANT, YOU KNOW, 18 OR MORE MILLIMETERS AS A BALLPARK.

Q. IN YOUR OPINION, IN DOING A D&E, IS IT POSSIBLE TO ACHIEVE TOO MUCH CERVICAL DILATION?

A. NOT IN MY OPINION.

Q. WHY IS THAT?

A. BECAUSE THE MORE DILATION THAT YOU HAVE --

THE COURT: EXCUSE ME. SOMEBODY HAS A TELEPHONE THAT IS GOING OFF.

THE WITNESS: I WONDER IF SOMEONE WANTS TO CHECK MY BAG JUST TO BE SURE.

THE COURT: IT IS 10:00 O'CLOCK. WE WILL TAKE OUR 15 MINUTE RECESSES AT INTERVALS OF 10 AND 11:45 EACH MORNING. SO THIS MIGHT BE A GOOD TIME TO TAKE IT.

THE WITNESS: TO TURN IT OFF. IT MIGHT BE MINE. I AM ON CALL, YOUR HONOR, SO I AM SORRY.

THE COURT: WE WILL TAKE A 15-MINUTE BREAK.

MS. GARTNER: THANK YOU, YOUR HONOR.

(RECESS TAKEN AT 10:00 A.M.)

(PROCEEDINGS RESUMED AFTER MORNING RECESS AT 10:15 A.M.)

THE COURT: MS. GARTNER, PLEASE CONTINUE.

MS. GARTNER: YOUR HONOR, BEFORE I CONTINUE WITH DR. PAUL, I WANTED TO BRING TO THE COURT'S ATTENTION JUST THAT MS. GLORIA FELT, WHO IS THE PRESIDENT AND CEO OF PLANNED PARENTHOOD FEDERATION IS IN THE FRONT ROW IN THE WHITE JACKET, AND DIANE HARRISON, WHO IS THE CEO AND PRESIDENT OF PLANNED PARENTHOOD GOLDEN GATE, IS IN THE FRONT ROW WITH THE BLUE JACKET.

THE COURT: OKAY.

BY MS. GARTNER:

Q. DR. PAUL, I THINK I HAD JUST ASKED YOU WHETHER IN DOING D&E ABORTIONS AND PREPARING THE CERVIX IF IT IS EVER POSSIBLE TO ACHIEVE TOO MUCH CERVICAL DILATION, IN YOUR OPINION?

A. NOT IN MY OPINION.

Q. AND WHY IS THAT?

A. BECAUSE THE MORE DILATION THAT I HAVE, THE EASIER THE EVACUATION IS, AND USUALLY THE FASTER, TOO.

Q. IF DILATION IS SO BENEFICIAL, WHY DON'T YOU ROUTINELY DILATE MORE THAN YOU DO NOW?

A. WELL, I ALREADY SAID THAT I PUT IN AS MANY LAMINARIA AS I CAN THAT WILL COMFORTABLY FIT WITHOUT FORCING. AND THAT GENERALLY GIVES ME THE AMOUNT OF DILATION THAT I NEED TO ACCOMPLISH THE ABORTION SAFELY AT THE GESTATIONAL AGES THAT I DO IT.

IF I AM GOING TO DO MORE DILATION, I WOULD NEED TO BRING THE PATIENT BACK FOR A SECOND SET OF DILATOR INSERTIONS, WHICH WOULD BE -- WHICH WOULD DELAY THE ABORTION BY 24 HOURS. AND AS YOU WEIGH KIND OF THE FACTORS IT JUST DOESN'T MAKE A LOT OF SENSE FOR THE GESTATIONAL AGES THAT I DO TO DO TWO SETS OF DILATOR INSERTIONS.

Q. AND AT WHAT GESTATIONAL AGE DO YOU BEGIN USING OVERNIGHT LAMINARIA BEFORE THE ABORTION?

A. SIXTEEN WEEKS.

Q. SO, YOU SAID THAT OSMOTIC DILATION IS ONE OF THE WAYS YOU PREPARE THE CERVIX; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. WHAT ARE SOME OF THE OTHER WAYS THAT YOU PREPARE THE CERVIX FOR THE EVACUATION?

A. THE OTHER MAIN WAY IS TO USE A MEDICATION CALLED MISOPROSTOL?

Q. WHAT IS MISOPROSTOL?

A. IT IS A PROSTAGLANDIN AGENT. AND PROSTAGLANDIN AGENTS CAN CAUSE SOME CONTRACTIONS, AND THEY ALSO AFFECT THE SUBSTANCE OF THE CERVIX IN A WAY THAT SOFTENS IT.

Q. I DON'T KNOW IF YOU CAN DESCRIBE BRIEFLY HOW THAT WORKS.

A. YOU MEAN, HOW -- HOW IT WORKS?

Q. YES.

A. WELL, THE CERVIX IS MADE UP OF FIBERS CALLED "COLLAGEN FIBERS" THAT ARE KIND OF CROSS-LINKED, AND IT AFFECTS THE FIBERS IN A WAY THAT MAKES THE CERVIX SOFTER.

AND IT ALSO CAUSES CONTRACTIONS, OF COURSE, WHICH HELPS TO DILATE AND SOFTEN THE CERVIX.

Q. AND HOW IS THE MISOPROSTOL ADMINISTERED TO THE WOMAN?

A. IN VARIOUS WAYS. IT CAN BE ADMINISTERED THROUGH THE VAGINA, JUST PLACED INTO THE -- THEY ARE LITTLE WHITE TABLETS THAT WE PLACE INTO THE VAGINA. THEY CAN BE SWALLOWED. AND THEY CAN BE PLACED IN THE CHEEKS. THAT IS CALLED BUCCAL ADMINISTRATION, OR UNDER THE TONGUE, WHICH IS SUBLINGUAL

ADMINISTRATION.

Q. AND IN YOUR PRACTICE, HOW DO YOU ADMINISTER MISOPROSTOL?

A. BUCCAL ADMINISTRATION.

Q. AND JUST FOR THE COURT REPORTER, COULD YOU SPELL "BUCCAL," PLEASE?

A. B-U-C-C-A-L.

Q. AND WHEN IN RELATION TO THE EVACUATION PART OF THE PROCEDURE DO YOU ADMINISTER THE MISOPROSTOL?

A. WE GENERALLY ADMINISTER IT ABOUT 90 MINUTES BEFORE THE ABORTION. THERE'S A RANGE. IT CAN BE 90 MINUTES TO THREE HOURS.

Q. AND DO ALL WOMEN RESPOND TO CERVICAL RIPENING WITH MISOPROSTOL IN THE SAME WAY?

A. NO. ONCE AGAIN, THERE IS A LOT OF VARIABILITY IN WOMEN'S RESPONSE TO THE CERVICAL RIPENING.

Q. AFTER YOU HAVE GIVEN THE WOMAN THE MISOPROSTOL, DO YOU ALLOW HER TO LEAVE THE HEALTH CENTER?

A. NO.

Q. WHY IS THAT?

A. BECAUSE WOMEN CAN GET CONTRACTIONS AND ACTUALLY HAVE A SIMULTANEOUS ABORTION. THEY CAN ACTUALLY MISCARRY, WHICH WE DON'T WANT TO HAVE HAPPEN AT HOME. IT HAS BEEN REPORTED IN THE LITERATURE IF YOU USE IT THE NIGHT BEFORE AN ABORTION THAT WOMEN CAN ACTUALLY EXPEL A FETUS AT HOME, AND WE DON'T WANT THAT TO HAPPEN.

Q. AND, DR. PAUL, I THINK I SHOULD HAVE ASKED YOU THIS BEFORE, BUT AFTER YOU INSERT THE LAMINARIA WHEN YOU ARE USING LAMINARIA IN AN OVERNIGHT SETTING, AFTER YOU HAVE INSERTD THE LAMINARIA, CAN THE WOMAN LEAVE THE HEALTH CENTER WITH THE LAMINARIA IN PLACE?

A. YES. SHE CAN CARRY OUT HER NORMAL LIFE.

Q. YOU SAID THAT THE FETUS, THAT THE MISOPROSTOL CAN RESULT IN THE FETUS BEING EXPELLED; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. DOES IT SOMETIMES HAPPEN THAT THE FETUS IS COMPLETELY EXPELLED FROM THE WOMAN AS A RESULT OF THE MISOPROSTOL?

A. YES, I HAVE HAD THAT HAPPEN.

Q. DOES IT SOMETIMES HAPPEN THAT THE FETUS IS PARTIALLY EXPELLED FROM THE UTERUS AS A RESULT OF JUST THE MISOPROSTOL?

MR. QUINLIVAN: OBJECTION, LEADING, YOUR HONOR.

THE COURT: OVERRULED.

THE WITNESS: YES.

BY MS. GARTNER:

Q. WHEN THAT HAPPENS, WHEN THE FETUS IS PARTIALLY EXPELLED, COULD A PART OF THE FETUS PAST THE NAVEL BE OUTSIDE OF THE UTERUS?

MR. QUINLIVAN: OBJECTION.

THE WITNESS: ABSOLUTELY.

MR. QUINLIVAN: OBJECTION, LEADING.

THE COURT: OVERRULED.

BY MS. GARTNER:

Q. COULD A PART OF THE FETUS PAST THE NAVEL BE OUTSIDE THE WOMAN'S BODY AS A RESULT OF THE MISOPROSTOL?

A. YES.

Q. COULD IT BE ALIVE WHEN THAT HAPPENS?

A. YES.

Q. IN THAT SITUATION WHERE THE FETUS IS PARTLY EXPELLED SIMPLY AS A RESULT OF THE ADMINISTRATION OF MISOPROSTOL, HOW WOULD YOU COMPLETE THE PROCEDURE IN THAT CIRCUMSTANCE?

A. WELL, I WOULD APPLY TRACTION AND PULL ON THE FETUS TO SEE IF THE WHOLE FETUS WOULD DELIVER WITHOUT ANY OTHER KIND OF INTERVENTION. IF THE HEAD WAS LODGED AT THE INTERNAL OS AND COULDN'T COME THROUGH, THEN I WOULD DISARTICULATE THE NECK, AND THEN COMPLETE THE PROCEDURE WITH MY FORCEPS, GOING IN TO GET THE CALVARIUM, WHICH IS THE HEAD OF THE FETUS.

Q. DR. PAUL, FOR HOW LONG HAVE YOU BEEN USING MISOPROSTOL FOR CERVICAL RIPENING BEFORE DOING D&E ABORTIONS?

A. ABOUT THREE YEARS.

Q. AT WHAT GESTATIONAL AGES DO YOU USE IT?

A. I USE IT BY ITSELF USUALLY BETWEEN 14 WEEKS AND THE BEGINNING OF THE 16TH WEEK. SIXTEEN TO 17 WEEKS I TEND TO USE OVERNIGHT LAMINARIA. AND THEN, AT 17 WEEKS AND UP, I TEND TO COMBINE THE METHODS, USING BOTH LAMINARIA AND MISOPROSTOL.

Q. SO FROM 16 TO 17 WEEKS YOU WOULD TEND TO USE ONLY THE LAMINARIA; IS THAT RIGHT?

A. YES, IT IS LIKE 16 -- THROUGHOUT THE 16TH WEEK. AND THEN, ONCE 17 WEEKS COMES, I TEND TO USE BOTH. IT CAN VARY A LITTLE BIT, DEPENDING ON IF THE WOMAN HAD A LOT OF DELIVERIES IN THE PAST IN WHICH CASE I AM GOING TO HAVE TO DILATE A LITTLE EASIER WITH MY METHOD. SO, BUT, IN GENERAL, THOSE ARE MY -- THE PROTOCOLS THAT I FOLLOW.

Q. DR. PAUL, I WOULD LIKE YOU NOW TO DESCRIBE IN DETAIL THE EVACUATION PART OF THE D&E PROCEDURE. WHEN THE WOMAN RETURNS TO YOUR HEALTH CENTER AFTER THE LAMINARIA HAS BEEN IN PLACE OVERNIGHT OR IF SHE HAS ONLY HAD THE MISOPROSTOL, IF THE MISOPROSTOL HAS BEEN IN PLACE FOR THE REQUISITE TIME PERIOD, PLEASE DESCRIBE IN DETAIL WHAT YOU DO UP TO THE POINT WHERE YOU ARE GOING TO EXTRACT THE FETUS.

A. I DO A PELVIC EXAMINATION AGAIN. IF SHE HAS LAMINARIA, AND SOMETIMES I CAN REMOVE THE LAMINARIA DURING THAT EXAMINATION JUST WITH MY HANDS.

PELVIC EXAMINATION INVOLVES PUTTING TWO FINGERS IN THE VAGINA, AND THE OTHER HAND ON TOP OF THE WOMAN'S ABDOMEN AND KIND OF TRYING TO ASSESS, AGAIN, THE SIZE AND POSITION OF THE UTERUS, WHICH IS EXTREMELY IMPORTANT BEFORE YOU DO A PROCEDURE.

SO, WHEN I HAVE MY FINGERS IN THE VAGINA SOMETIMES I CAN JUST EXTRACT THE LAMINARIA AT THAT TIME.

Q. LET ME INTERRUPT YOU. CAN YOU DESCRIBE WHAT YOU MEAN BY "THE POSITION OF THE UTERUS"?

AND IF IT HELPS, FEEL FREE TO USE THAT.

A. CAN I USE THE DIAGRAM?

THE COURT: YES.

THE WITNESS: I DON'T KNOW WHERE THE POINTER WENT.

ANYWAY, THIS IS A SIDE VIEW OF THE WOMAN. SO HERE YOU SEE THIS IS THE BLADDER FROM THE SIDE (INDICATING).

THIS IS THE VAGINA (INDICATING).

AND THIS, AGAIN, ALL WE HAVE IS A NONPREGNANT UTERUS IN THE DIAGRAM. THIS IS THE UTERUS, AND THIS HERE IS THE CERVIX (INDICATING). THESE ARE THE BOWELS BACK HERE (INDICATING).

SO AS YOU CAN SEE, THERE IS A NATURAL ANGLE THAT OCCURS BETWEEN THE VAGINA AND THE UTERUS. THAT CHANGES SOMEWHAT, OF COURSE, AS THE UTERUS ENLARGES. BUT THERE IS ALSO A NATURAL ANGLE BETWEEN THE CERVICAL CANAL AND THE BODY, REST OF THE BODY OF THE UTERUS.

SO BEFORE I DO A PROCEDURE WHERE I AM GOING TO INSERT INSTRUMENTS INTO THE UTERUS, I NEED TO KNOW WHERE THE UTERUS IS SITTING. THIS SHOWS THE UTERUS IS SITTING TOWARDS THE FRONT OF THE WOMAN'S ABDOMEN. BUT YOU CAN HAVE UTERUSES THAT CAN SIT IN THE MIDDLE OR YOU CAN HAVE THE UTERUS KIND OF TIPPED TOWARDS THE BACK.

AGAIN, AS THE PREGNANCY GROWS, THAT CAN CHANGE A LITTLE BIT. BUT I HAVE HAD SITUATIONS WHERE EVEN IN THE SECOND-TRIMESTER THE UTERUS REMAINS TIPPED TOWARDS THE BACK.

SO IT IS VERY, VERY, VERY IMPORTANT TO KNOW THE POSITION OF THE UTERUS SO YOU HAVE AN IDEA OF WHICH WAY TO PUT YOUR INSTRUMENTS IN SO AS NOT TO CAUSE INJURY.

BY MS. GARTNER:

Q. AND I AM SORRY. I INTERRUPTED YOU IN MIDSTREAM. I LOST TRACK OF EXACTLY WHAT YOU WERE SAYING. I THINK YOU WERE TALKING ABOUT THE PELVIC EXAM THAT YOU DO AT THE BEGINNING.

A. IF I CAN REMOVE THE LAMINARIA AT THAT TIME, THEN I DO, IF IT IS EASY. I THEN ADMINISTER PAIN MEDICATIONS THAT USUALLY BEFORE A SECOND-TRIMESTER ABORTION WE WILL GIVE PAIN MEDICATIONS AND A SEDATIVE THROUGH AN INTRAVENOUS LINE.

WE DON'T PUT WOMEN ALL THE WAY TO SLEEP. IT'S CALLED "CONSCIOUS SEDATION." IT HELPS WOMEN RELAX AND ALSO DECREASES THE DISCOMFORT ASSOCIATED WITH THE PROCEDURE.

I THEN INSERT THE SPECULUM INTO THE VAGINA AND VISUALIZE THE CERVIX. AND I PUT A GRASPING INSTRUMENT CALLED A TENACULUM ON THE CERVIX TO STABILIZE IT, AND SO THAT I CAN MOVE THIS SORT OF LAYER IN THE PROCEDURE. BUT I COULD PUT A TENACULUM, USUALLY, ON THE CERVIX.

AND THEN I ADMINISTER NUMBING MEDICINE, THE CERVICAL ANESTHESIA. AND I USE A SMALL FORCEP TO REMOVE THE LAMINARIA, IF THEY ARE IN PLACE.

Q. AND, DR. PAUL, CAN YOU EXPLAIN AGAIN WHY YOU USE THE TENACULUM ON THE CERVIX? WHAT DO YOU DO WITH THE TENACULUM?

A. THERE IS A COUPLE OF THINGS YOU CAN DO. AS YOU ARE PULLING

OUT THE LAMINARIA, IT HOLDS THE CERVIX STILL SO THAT THE WHOLE UTERUS ISN'T MOVING WITH YOU AS YOU ARE TRYING TO GET OUT THE LAMINARIA, RIGHT? AND DURING THE EVACUATION PROCEDURE ESPECIALLY I USE IT TO DRAW THE CERVIX AS FAR DOWN TO ME, TOWARDS ME AS POSSIBLE, TOWARDS THE OPENING OF THE VAGINA.

SO, I USE IT FOR MOBILITY TO BE ABLE TO MOVE THE UTERUS AROUND, MOVE THE CERVIX AROUND DURING THE EVACUATION PROCEDURE.

Q. DR. PAUL, BEFORE YOU DO ANYTHING TO MOVE THE CERVIX, WHAT IS AN AVERAGE LENGTH OR AN AVERAGE DISTANCE FROM THE OPENING OF THE CERVIX THAT'S CLOSEST TO THE VAGINAL OPENING -- TO THE VAGINAL OPENING?

A. IT CAN REALLY VARY. IT REALLY -- I REALLY CAN'T SAY THAT THERE IS AN AVERAGE LENGTH. IT MAY BE SITTING JUST A COUPLE OF INCHES UP FROM THE VAGINAL INTROITUS. IT MAY BE FOUR OR FIVE INCHES UP. SO IT CAN VARY.

Q. AND YOU USED THE TERM "VAGINAL INTROITUS." WHAT IS THAT?

A. THE OPENING OF THE VAGINA.

Q. WHEN YOU SAY THAT YOU USE THE TENACULUM TO PULL ON THE CERVIX, HOW FAR CAN YOU BRING THE CERVIX DOWN TOWARDS THE VAGINAL INTROITUS?

A. IT VARIES, BUT FREQUENTLY IT IS VERY CLOSE TO THE VAGINAL INTROITUS.

Q. DO YOU TRY TO AVOID THE CIRCUMSTANCE WHERE IT COMES CLOSE TO THE VAGINAL INTROITUS?

A. NO, I MEAN, I LIKE WHEN IT COMES CLOSE TO THE VAGINAL INTROITUS. IT ALLOWS ME TO SEE BETTER, AND TO -- IT BRINGS THE CERVIX CLOSER TO ME, SO IT MAKES IT EASIER FOR ME TO INSERT MY INSTRUMENTS.

AND THE IMPORTANCE OF IT IS THAT IT HELPS TO STRAIGHTEN OUT THOSE ANGLES SO THAT YOU CAN GET YOUR INSTRUMENTS IN EASIER.

Q. AND WHEN YOU SAY "THOSE ANGLES" --

A. THE ANGLES OF THE UTERUS THAT I WAS REFERRING TO WHEN I WAS AT THE DIAGRAM.

Q. DR. PAUL, IS THERE ANYTHING ELSE YOU DO BEFORE YOU ACTUALLY BEGIN THE EVACUATION?

A. NO. I HAVE GIVEN THE NUMBING MEDICINE, GIVEN THE MEDICINE THROUGH THE IV, CLEAN OFF THE CERVIX WITH AN ANTISEPTIC SOLUTION.

Q. WHAT IS THE FIRST THING YOU DO TO EVACUATE THE UTERUS?

A. I BREAK THE BAG OF WATER, EITHER BY JUST BREAKING IT AND ALLOWING IT TO DRAIN, THE FLUID TO DRAIN OUT, OR USING SUCTION.

Q. AND WHAT IS THE BAG OF WATER?

A. IT IS THE AMNIOTIC SAC, IS THE TECHNICAL TERM FOR IT. IT IS THE FLUID IN WHICH -- IT IS THE SAC IN WHICH THE PREGNANCY IS LOCATED.

Q. AND I INTERRUPTED YOU. YOU WERE SAYING THAT SOMETIMES YOU USE SUCTION TO BREAK THE BAG OF WATERS?

A. YES. SOMETIMES I WILL INSERT A SUCTION CANNULA IT'S CALLED

WITH A LITTLE TUBE ATTACHED TO SUCTION THAT BREAKS THE BAG AND SUCKS OUT THE FLUID.

Q. AND WHEN YOU BEGIN THE EVACUATION, IS THE FETUS EVER ALIVE?

A. YES.

Q. HOW DO YOU KNOW THAT?

A. BECAUSE I DO MANY OF MY PROCEDURES ESPECIALLY AT 16 WEEKS UNDER AN ULTRASOUND GUIDANCE, SO I WILL SEE A HEARTBEAT.

Q. DO YOU PAY ATTENTION TO THAT WHILE YOU ARE DOING THE ABORTION?

A. NOT PARTICULARLY.

I JUST NOTICE IT SOMETIMES.

Q. SO AFTER YOU'VE BROKEN THE BAG OF WATERS AND THE FLUID IS EITHER DRAINED OR YOU'VE SUCTIONED OUT THE FLUID, WHAT DO YOU DO NEXT?

A. I EVACUATE THE FETUS.

Q. AND CAN YOU DESCRIBE HOW YOU DO THAT?

A. YES. I DO IT USING AN INSTRUMENT CALLED FORCEPS. SO I INSERT THE FORCEPS AND GRASP THE FETUS AND PULL. THAT'S ALL THE WHILE PUTTING TRACTION ON THE TENACULUM TO STRAIGHTEN OUT THAT ANGLE. AND SOMETIMES THE FETUS COMES OUT IN PIECES, AND I MAKE INSTRUMENT PASSES UNTIL THE ENTIRE FETUS IS EVACUATED. AND SOMETIMES THE WHOLE FETUS WILL COME DOWN INTO THE VAGINA, AT LEAST AS FAR AS THE HEAD.

Q. OKAY. DOES IT EVER COME OUT COMPLETELY WITHOUT THE HEAD BECOMING LODGED?

A. RARELY IT DOES.

Q. AND, IN GENERAL, WHAT IS YOUR OBJECTIVE IN EVACUATING THE UTERUS?

A. MY OBJECTIVE IS TO EMPTY THE UTERUS IN THE SAFEST WAY POSSIBLE.

Q. IS THERE ANY ADVANTAGE TO DOING THE EVACUATION QUICKLY?

A. YES, QUICKLY AND SAFELY IS BEST. BUT IF YOU CAN DO THE PROCEDURE EXPEDITIOUSLY, THERE ARE SOME ADVANTAGES, THE BIGGEST BEING THAT YOU HAVE LESS BLEEDING AND SHORTER DURATION OF DISCOMFORT FOR THE WOMAN.

Q. WHY IS THERE LESS BLEEDING IF THE PROCEDURE TAKES LESS TIME? WHERE IS THE BLEEDING COMING FROM?

A. WELL, IF THE PLACENTA HAS DETACHED AT ALL, THEN THERE IS BLOOD VESSELS THERE THAT CAN BLEED. AND THE KEY THING IS THAT THE UTERUS CAN'T CONTRACT WELL TO SEAL OFF BLOOD VESSELS AND STOP BLEEDING UNTIL IT IS EMPTY.

Q. OKAY. TALKING NOW ABOUT THE SITUATIONS WHERE THE FETUS COMES OUT IN PARTS, HOW MANY INSTRUMENTAL PASSES DOES IT TYPICALLY TAKE TO EMPTY THE UTERUS?

A. THERE IS NO TYPICAL. IT COULD BE AS MANY AS -- AS LITTLE AS TWO OR THREE OR AS MANY AS 10 TO 15.

Q. AND DO YOU HAVE A GOAL FOR HOW MANY PASSES IT WILL TAKE?

A. AS FEW AS POSSIBLE.

Q. AND WHY IS THAT YOUR GOAL?

A. BECAUSE EVERY TIME YOU PASS A FORCEPS INTO THE UTERUS,

THERE IS A SMALL RISK OF INJURY.

Q. AND CAN YOU EXPLAIN HOW THAT WOULD HAPPEN?

A. YES. YOU CAN GET A LACERATION OF THE CERVIX OR A PERFORATION OR LACERATION OF THE UTERINE WALL WITH THE INSTRUMENTS.

Q. AND WOULD THAT STILL BE A POSSIBILITY IF YOU WERE DOING THE PROCEDURE UNDER ULTRASOUND?

A. YES.

Q. WHEN THE PROCEDURE GOES IN SUCH A WAY THAT THE FETUS IS DRAWN OUT IN PARTS, HOW DOES THE DISARTICULATION OF THE FETAL PARTS OCCUR?

A. IT OCCURS BECAUSE YOU HAVE THE FETAL PART DRAWN OUTSIDE OF THE CERVIX, AND THEN THERE IS A COUNTERPRESSURE THAT OCCURS AT THE INTERNAL OS. AND WHEN YOU PULL, THE -- IT DISARTICULATES THAT PART.

Q. SO, IS THE PART THAT IS BEING DISARTICULATED INSIDE THE UTERUS OR OUTSIDE OF THE UTERUS AT THE MOMENT OF DISARTICULATION?

A. OUTSIDE.

Q. CAN IT BE OUTSIDE THE WOMAN'S BODY?

A. YES.

Q. AND YOU HAD SAID THAT SOMETIMES WHEN YOU APPLY TRACTION TO THE FETUS IT COMES OUT INTACT UP TO POINT WHERE THE CALVARIUM LODGES; IS THAT CORRECT?

A. YES.

Q. IN THAT CIRCUMSTANCE, WHAT DO YOU DO TO COMPLETE THE PROCEDURE?

A. WELL, THERE ARE TWO THINGS YOU CAN DO. YOU CAN DISARTICULATE AT THE NECK, OR WHAT I PREFER TO DO IS TO JUST REACH IN WITH MY FORCEPS AND COLLAPSE THE SKULL AND BRING THE FETUS OUT INTACT.

Q. SO WHEN YOU -- IN THE FIRST SCENARIO WHERE YOU DISARTICULATE, WOULD YOU CONSIDER THAT TO BE AN INTACT D&E?

A. NO.

Q. DO YOU HAVE A PREFERENCE IN YOUR MEDICAL PRACTICE BETWEEN D&E'S THAT RESULT IN DISARTICULATION AND D&E'S THAT RESULT IN INTACT EXTRACTION OF THE FETUS?

A. I ABSOLUTELY PREFER INTACT EXTRACTION.

Q. CAN YOU EXPLAIN WHY THAT IS?

A. BECAUSE IT INVOLVES FEWER INSTRUMENT PASSES, AND AS I EXPLAINED EARLIER, EACH INSTRUMENT PASS THERE IS A SMALL RISK OF INJURING THE UTERUS. AND BECAUSE IT IS FASTER, GENERALLY.

Q. WHEN YOU ARE PERFORMING A D&E, WHEN YOU ARE BEGINNING TO APPLY TRACTION ON THE FETUS TO BRING IT OUT, DO YOU TAKE STEPS TO TRY TO KEEP THE FETUS AS INTACT AS POSSIBLE?

A. IF I KNOW I HAVE GOOD DILATION AND I REACH IN AND THE FETUS STARTS TO COME OUT AND I THINK I CAN ACCOMPLISH IT, THE ABORTION WITH AN INTACT DELIVERY, THEN I USE MY FORCEPS A LITTLE BIT DIFFERENTLY. I DON'T CLOSE THEM QUITE SO MUCH, AND I JUST GENTLY DRAW THE TISSUE OUT ATTEMPTING TO HAVE AN INTACT

DELIVERY, IF POSSIBLE.

Q. JUST TO BE CLEAR ABOUT THIS, IN THOSE SITUATIONS WHERE YOU ARE ABLE TO BRING IT OUT INTACT, BUT THE CALVARIUM LODGES AT THE OS, WHY DOES IT LODGE THERE? WHY CAN'T YOU JUST EXTRACT THE ENTIRE FETUS?

A. IT IS THE BIGGEST PART OF THE FETUS. SOMETIMES THE DILATION ISN'T ENOUGH FOR IT TO COME THROUGH.

Q. IN YOUR PRACTICE, DR. PAUL, HOW OFTEN DO YOU PERFORM D&E'S INVOLVING INTACT DELIVERY TO THE POINT WHERE THE CALVARIUM LODGES AT THE CERVIX?

A. I AM GUESSING, BECAUSE UNTIL THIS CASE HAPPENED I DIDN'T PAY MUCH ATTENTION TO IT. IT WAS JUST A VARIATION OF THE WAY I DID D&E. BUT I AM GUESSING 1 TO 10 TO 1 TO 20 MAYBE OF THE PROCEDURES I DO.

Q. OF THE D&E PROCEDURES?

A. YES, OF THE D&E PROCEDURES.

Q. WHAT DETERMINES WHETHER THE PROCEDURE WILL PROCEED WITH DISARTICULATION VERSUS WHETHER THERE WILL BE AN INTACT EXTRACTION?

A. IT'S PRIMARILY THE AMOUNT OF DILATION.

Q. AND BEFORE BEGINNING THE PROCEDURE, CAN YOU PREDICT IF YOU WILL HAVE ENOUGH DILATION TO BRING THE FETUS OUT WITH AN INTACT EXTRACTION?

A. NO, I CAN'T.

Q. BUT IF YOU HAVE ENOUGH DILATION TO DO SO, DO YOU ATTEMPT

THAT?

A. YES.

Q. DR. PAUL, YOU'VE SAID THAT THE ONE OF THE REASONS WHY YOU PREFER THE INTACT EXTRACTION IS BECAUSE OF THE REDUCTION OF INSTRUMENTAL PASSES; IS THAT CORRECT?

A. YES, THAT'S ONE REASON.

Q. ARE THERE OTHER ADVANTAGES IN YOUR OPINION IN BRINGING THE FETUS OUT INTACT?

A. I MENTIONED THAT IT TENDS TO BE FASTER, AND THEREFORE YOU MAY HAVE LESS BLEEDING AND LESS DISCOMFORT FOR THE PATIENT.

ALSO, WHAT I FIND ADVANTAGEOUS IS THAT I KNOW I HAVE REMOVED THE WHOLE FETUS. WHEN YOU DO A DISARTICULATION D&E, YOU KNOW, SOMETIMES IT IS NOT AS EASY TO TELL THAT YOU HAVE ALL OF THE PARTS. SO, IF I HAVE AN INTACT FETUS, I KNOW I HAVE REMOVED THAT ENTIRE PREGNANCY.

Q. WHAT HAPPENS IN A DISARTICULATION D&E IF SOME TISSUE ACTUALLY DOES REMAIN IN THE UTERUS?

A. YOU CAN GET BLEEDING OR INFECTION.

Q. AND DO YOU THINK IT IS POSSIBLE TO LEAVE SOME TISSUE IN THE UTERUS EVEN IF YOU ARE DOING THE PROCEDURE UNDER ULTRASOUND GUIDANCE?

A. I THINK IT IS POSSIBLE TO LEAVE A SMALL PART OR TO LEAVE PART OF THE PLACENTA.

Q. AND WOULD EVEN A SMALL PIECE OF TISSUE OR PLACENTA RESULT IN POSSIBLE COMPLICATIONS?

A. YES. I HAVE ALWAYS BEEN SURPRISED OF HOW LITTLE IT TAKES.

Q. DR. PAUL, HOW LONG DOES THE EVACUATION PART OF THE D&E TAKE WHEN THE FETUS IS DISARTICULATED IN THE PROCESS?

A. IT REALLY VARIES, BUT GENERALLY 10 TO 15 MINUTES.

Q. AND WHAT IS A TYPICAL LENGTH OF THE EVACUATION PART OF THE PROCEDURE IF THE FETUS REMAINS INTACT?

A. IT IS USUALLY MUCH QUICKER. I HAVE HAD IT HAPPEN IN A MINUTE OR TWO.

Q. IN YOUR MEDICAL PRACTICE, DR. PAUL, HAVE YOU PERSONALLY EVER PERFORATED A WOMAN'S UTERUS IN THE PROCESS OF DOING A D&E ABORTION?

A. YES.

Q. AND HAS IT EVER HAPPENED THAT YOU'VE PERFORATED A WOMAN'S UTERUS IN CIRCUMSTANCES WHERE YOU EXTRACTED THE FETUS INTACT OR RELATIVELY INTACT?

A. IT HAS ONLY HAPPENED A COUPLE OF TIMES, BUT IT HASN'T BEEN -- THOSE TWO TIMES WAS NOT ASSOCIATED WITH AN INTACT EXTRACTION.

Q. YOU TESTIFIED EARLIER, DR. PAUL, THAT THE FETUS CAN BE ALIVE WHEN THE EVACUATION BEGINS; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. WHEN IN THE COURSE OF THE ABORTION DOES THE FETUS -- DOES FETAL DEMISE OCCUR?

A. I DON'T KNOW FOR SURE. I CERTAINLY KNOW THAT IF I DELIVER INTACT AND COLLAPSE THE SKULL THAT DEMISE OCCURS.

Q. AFTER THE EVACUATION PART OF THE PROCEDURE IS COMPLETE, WHAT DO YOU DO TO COMPLETE THE ABORTION?

A. I USE SUCTION TO REMOVE ANY PLACENTA THAT MAY BE LEFT IN THE UTERUS. I ALSO USE AN INSTRUMENT CALLED A CURETTE. IT IS A LITTLE SPOON-LIKE INSTRUMENT JUST TO GENTLY GO OVER THE WALLS OF THE UTERUS AND JUST BE SURE THAT ANYTHING FEELS -- THE UTERUS FEELS EMPTY.

Q. DR. PAUL, I AM GOING TO ASK YOU SOME QUESTIONS ABOUT THE IMPACT OF THIS LAW ON YOUR MEDICAL PRACTICE.

MS. GARTNER: AND, YOUR HONOR, WE HAVE A BLOWUP OF THE ACT, IF YOU DON'T MIND.

THE COURT: SURE.

BY MS. GARTNER:

Q. DR. PAUL, THIS CHART CONTAINS THE OPERATIVE PORTIONS OF THE LAW THAT IS AT ISSUE IN THIS CASE. CAN YOU JUST BRIEFLY REVIEW IT SO YOU CAN RECOLLECT THE LANGUAGE?

DR. PAUL, ARE YOU CONCERNED ABOUT THE POTENTIAL IMPACT OF THIS LAW ON YOUR MEDICAL PRACTICE?

A. ABSOLUTELY.

Q. CAN YOU OUTLINE YOUR CONCERNS FOR US?

A. WELL, MY OVERRIDING CONCERN IS THAT IF I CONTINUE TO PRACTICE ABORTION, SECOND-TRIMESTER ABORTIONS, IN THE WAY I BELIEVE IS THE SAFEST FOR WOMEN, THAT I COULD BE IN PRISON.

Q. IN YOUR OPINION, COULD THIS LAW BE UNDERSTOOD AS BANNING SOME OF THE D&E'S THAT YOU DO?

MR. QUINLIVAN: YOUR HONOR, OBJECTION. IT IS OUR POSITION THAT QUESTION OF THE INTERPRETATION OF THE LAW IS NOT SOMETHING THAT IS SUBJECT TO EXPERT TESTIMONY. THAT IS A SUBJECT THAT THE COURT WILL CONSIDER AFTER ARGUMENTS BY BOTH PARTIES. BUT IT IS NOT SOMETHING THAT IS PROPERLY SUBJECT TO AN EXPERT'S OPINION.

MS. GARTNER: YOUR HONOR, I THINK IT WOULD BE HELPFUL -- AND OBVIOUSLY THE FINAL DETERMINATION ON THIS IS YOUR HONOR'S -- BUT I THINK IT WOULD BE HELPFUL FOR DR. PAUL TO EXPLAIN HOW SHE USED THESE TERMS AND HOW SHE THINKS THAT THESE TERMS, WHICH ARE NOT NECESSARILY CLEAR ON THEIR FACE, WOULD APPLY TO HER SPECIFIC MEDICAL PRACTICE AND HOW SHE DOES ABORTIONS.

THE COURT: I AM GOING TO PERMIT IT.

MS. GARTNER: THANK YOU.

BY MS. GARTNER:

Q. DR. PAUL, COULD THIS LAW BE UNDERSTOOD AS BANNING SOME OF THE D&E'S THAT YOU DO?

A. YES.

Q. IF YOU LOOK AT THE LAW, IT STATES THAT:

"THE TERM 'PARTIAL-BIRTH ABORTION' MEANS AN ABORTION IN WHICH THE PERSON PERFORMING THE ABORTION DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVERS A LIVING FETUS."

DO YOU SEE THAT LANGUAGE?

A. YES.
Q. WHAT DOES THE TERM "VAGINALLY DELIVERS" MEAN TO YOU AS AN OB/GYN?
A. "VAGINALLY DELIVERS" MEANS THE FETUS COMES OUT THROUGH THE VAGINA.
Q. AND WHAT DOES THE TERM "LIVING FETUS" MEAN TO YOU?
A. WELL, "LIVING" COULD BE WHEN THERE IS A HEARTBEAT DETECTED ON ULTRASOUND, WHICH COULD BE AS EARLY AS FIVE WEEKS GESTATION. "FETUS" USUALLY APPLIES TO THE PRODUCTS OF CONCEPTION AT 10 WEEKS AND UP. SO IF I PUT THE TWO TOGETHER, I WOULD SAY A FETUS AT 10 WEEKS GESTATION, OR MORE, THAT HAS A HEARTBEAT.
Q. AND YOU SAID THAT THE TERM "FETUS" WAS USED BEGINNING AT 10 WEEKS GESTATION; IS THAT RIGHT?
A. TEN WEEKS LMP, YES. BEFORE THAT THE PRODUCTS OF CONCEPTION ARE KNOWN AS AN EMBRYO.
Q. IN YOUR MIND IS THE TERM "LIVING FETUS" EQUIVALENT TO THE TERM "VIABLE FETUS"?
A. ABSOLUTELY NOT.
Q. IN THE D&E'S THAT YOU DO, DO YOU EVER DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVER A LIVING FETUS AS PART OF THE PROCEDURE?
A. YES.
Q. DR. PAUL, CONTINUING READING IN THIS DEFINITION, IT SAYS THAT -- JUST TO REPEAT WHAT WE HAVE ALREADY GONE OVER -- THAT:
"THE ABORTION OCCURS SUCH THAT THE PHYSICIAN

DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVERS A LIVING FETUS UNTIL, IN THE CASE OF A HEAD-FIRST PRESENTATION, THE ENTIRE FETAL HEAD IS OUTSIDE THE BODY OF THE MOTHER, OR IN THE CASE OF BREECH PRESENTATION, ANY PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE MOTHER."

DO YOU SEE THAT?

A. YES.

Q. WHEN THE LAW SAYS THAT "ANY PART OF THE FETAL TRUNK PAST THE NAVEL" IS OUTSIDE THE BODY OF THE MOTHER, WHAT DO YOU UNDERSTAND THAT TO MEAN?

A. WELL, IT COULD MEAN A COUPLE OF THINGS. ONE IS THAT THE FETUS HAS COME OUT FAR ENOUGH THAT THE FETAL BODY ABOVE THE NAVEL IS OUTSIDE OF THE CERVIX. THE OTHER -- OUTSIDE THE BODY OF THE MOTHER. AND THE OTHER IS THAT IF YOU WERE TO DISARTICULATE A FETAL PART THAT WAS ABOVE THE NAVEL, LIKE A LIMB WITH PART OF A SHOULDER, I WOULD THINK THAT THAT WOULD ALSO APPLY.

Q. SO, JUST TO BE CLEAR ABOUT THAT, AS YOU READ THIS LAW, DOES THE FETUS HAVE TO BE DELIVERED INTACT UP TO THE POINT WHERE THE CALVARIUM LODGES AT THE CERVIX FOR A VIOLATION TO OCCUR?

A. NO.

Q. DOES IT HAVE TO BE BROUGHT OUT INTACT TO ANY POINT FOR A VIOLATION TO OCCUR?

A. IT HAS TO BE BROUGHT OUT -- ONE SCENARIO IS THAT IT'S

BROUGHT OUT PAST THE NAVEL INTACT. AND THE OTHER IS THAT, AS I SAY, TO DISARTICULATE A PART ABOVE THE NAVEL, AND THEN CONTINUE TO PUT YOUR FORCEPS IN TO DELIVER THE REST OF THE FETUS.

Q. AND IN DOING D&E'S DO YOU EVER DELIVER THE FETUS TO THE POINT WHERE PART OF THE FETAL TRUNK INTACT WITH THE REST OF IT IS OUTSIDE THE BODY OF THE MOTHER?

A. YES.

Q. DO YOU EVER DELIVER THE FETUS SUCH THAT A DISARTICULATED PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE MOTHER?

A. YES.

Q. AND DOES THAT EVER HAPPEN WHEN THE FETUS IS STILL LIVING?

A. YES.

Q. DR. PAUL, CONTINUING TO READ THIS DEFINITION, IT SAYS THAT THE FETUS IS -- JUST TO SUMMARIZE IT -- IS BROUGHT OUTSIDE THE BODY OF THE MOTHER TO THE POINT WE HAVE JUST DISCUSSED:

"FOR THE PURPOSE OF PERFORMING AN OVERT ACT THAT THE PERSON KNOWS WILL KILL THE PARTIALLY-DELIVERED LIVING FETUS."

DO YOU SEE THAT LANGUAGE?

A. YES.

Q. LET ME ASK YOU FIRST, DO YOU UNDERSTAND THE TERM "OVERT ACT"?

A. NOT REALLY.

Q. I WILL JUST LEAVE THAT. IN THOSE CIRCUMSTANCES THAT YOU'VE

JUST DESCRIBED TO ME IN DOING A D&E WHERE THE FETUS HAS BEEN BROUGHT OUT IN A WAY THAT COULD BE DESCRIBED AS BEING TO A POINT WHERE A PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE MOTHER, WHAT DO YOU DO TO COMPLETE THE ABORTION?

A. I EITHER DISARTICULATE AT THE NECK, OR I PUT MY FORCEPS IN AND COLLAPSE THE SKULL AND COMPLETE THE DELIVERY.

Q. AND IN YOUR OPINION, WOULD THOSE STEPS BE LETHAL ACTS THAT THE FETUS COULDN'T SURVIVE IF IT WERE ALIVE BEFORE YOU DID THEM?

A. I HAVE NO DOUBT THAT COLLAPSING A SKULL OR DISARTICULATING AT THE NECK WOULD CAUSE FETAL DEMISE.

Q. AND THEN AFTER TAKING THOSE STEPS, EITHER COLLAPSING THE CALVARIUM OR USING DISARTICULATION, DO YOU THEN COMPLETE THE PROCEDURE?

A. YES.

Q. IN THE ABORTIONS THAT YOU HAVE DONE WHERE THIS HAS OCCURRED WHERE YOU BROUGHT THE FETUS OUT INTACT UP TO THE POINT WHERE THE HEAD LODGES AT THE CERVIX, DID YOU DELIVER THE FETUS TO THAT POINT FOR THE PURPOSE OF COMPRESSING THE CALVARIUM?

A. OF COURSE NOT. I DID IT TO EMPTY THE UTERUS.

Q. DR. PAUL, NOW THAT WE HAVE GONE THROUGH THE ACT IN THIS WAY, ARE YOU STILL CONCERNED ABOUT THE IMPACT OF THIS LAW ON YOUR PRACTICE?

A. OH, ABSOLUTELY.

Q. DO YOU FIND ANY COMFORT IN THE "FOR THE PURPOSE OF" LANGUAGE IN THIS STATUTE, GIVEN THAT YOU'VE TOLD US THAT YOU DON'T BRING THE FETUS OUT TO THAT PARTICULAR POINT FOR THE PURPOSE OF COLLAPSING THE CALVARIUM OR DISARTICULATING AT THE NECK?

A. I FIND NO COMFORT IN THAT. I MEAN, I KNOW WHAT MY PURPOSE IS. THAT MY PURPOSE IN BRINGING THE FETUS OUT PAST THE NAVEL, THE FETAL TRUNK OUT PAST THE NAVEL IS TO EMPTY THE UTERUS IN THE SAFEST WAY POSSIBLE.

YET, THIS LANGUAGE IMPLIES THAT I HAVE THIS OTHER PURPOSE, WHICH IS TO KILL THE FETUS. SO, TO ME, IT'S LIKE -- KIND OF LIKE THERE IS AN ELEPHANT IN THE ROOM BESIDES ME AND MY PATIENT. IT IS NOT JUST ME BEING ALLOWED TO DO AN ABORTION IN THE WAY THAT I THINK IN MY MEDICAL JUDGMENT IS SAFEST FOR A WOMAN, BUT THERE IS SOMEBODY JUDGING WHAT MY PURPOSE IS IN BRINGING THE FETUS OUT A CERTAIN WAY.

AND I DON'T FEEL LIKE I CAN PRACTICE MEDICINE WELL BEING SECOND-GUESSED BY A THIRD PARTY ABOUT WHAT MY PURPOSE IS IN COMPLETING AND IN DOING A CERTAIN ACT DURING AN ABORTION WHEN THAT PERSON ALSO HAS THE POWER TO PUT ME IN PRISON.

Q. THANK YOU.

MS. GARTNER: YOUR HONOR, MAY I PUT UP A SECOND CHART?

THE COURT: YES.

BY MS. GARTNER:

Q. DR. PAUL, THIS IS ACTUALLY THE BEGINNING PART OF THE STATUTE THAT WE HAVE BEEN DISCUSSING. AND THIS IS THE PORTION OF THE LAW THAT CONTAINS THE LIFE EXCEPTION TO THE ACT, WHICH IS STATED IN THE SECOND SENTENCE IN THAT PARAGRAPH. COULD YOU JUST READ THAT TO YOURSELF, PLEASE?

AND, DR. PAUL, WHEN YOU WERE TEACHING IN A STAFF POSITION AT THE UNIVERSITY OF MASSACHUSETS MEDICAL CENTER, DID YOU PERFORM ABORTIONS FOR MATERNAL HEALTH CONDITIONS?

A. OH, YES.

Q. AND WAS THAT A REGULAR PART OF YOUR PRACTICE THERE?

A. YES.

Q. IN YOUR OPINION, WOULD THE LIFE EXCEPTION TO THIS LAW ENABLE PHYSICIANS TO PERFORM ABORTIONS IN ALL SITUATIONS WHERE A PREGNANT WOMAN'S LIFE IS AT RISK FROM CONTINUING THE PREGNANCY?

A. NO, IT IS NOT HOW I WOULD INTERPRET THIS LANGUAGE.

Q. WHAT -- WHY DO YOU THINK THIS WOULDN'T COVER ALL SITUATIONS WHERE A WOMAN'S LIFE WAS AT RISK FROM THE PREGNANCY?

A. MY OBJECTION REALLY REVOLVES AROUND THAT WORD "NECESSARY." IT SAYS THAT:

"THIS SUBSECTION DOES NOT APPLY TO A PARTIAL-BIRTH ABORTION THAT IS NECESSARY TO SAVE THE LIFE OF A MOTHER."

BUT IT DOESN'T SAY WHO DECIDES IF IT IS NECESSARY. THERE IS NOTHING THAT SAYS "IS NECESSARY WITHIN THE JUDGMENT OF

A TREATING PHYSICIAN."

IT JUST SAYS "NECESSARY." SO WHO DETERMINES IF IT IS NECESSARY? AND IS IT POSSIBLE THAT, AGAIN, A PHYSICIAN WHO IS TREATING A WOMAN COULD BE SECOND-GUESSED ABOUT THAT DECISION THAT IT WAS NECESSARY?

THE OTHER THING THAT I HAVE A PROBLEM WITH WITH THIS IS THAT IT SAYS "THAT IT IS NECESSARY TO SAVE THE LIFE OF A MOTHER."

WELL, THERE IS ALWAYS THE ALTERNATIVE OF HYSTEROTOMY AND HYSTERECTOMY. BUT IN MY OPINION, THAT IS NOT A REAL ALTERNATIVE FOR WOMEN BECAUSE OF THE HIGH RATES OF MORBIDITY AND MORTALITY THAT ARE ASSOCIATED WITH THAT PROCEDURE.

Q. DR. PAUL, EARLIER THIS MORNING YOU TESTIFIED GENERALLY ABOUT THE OVERALL SAFETY OF SECOND-TRIMESTER ABORTIONS AND THE RELATIVE SAFETY OF ABORTION AND CARRYING A PREGNANCY TO TERM. BUT WE DIDN'T FOCUS SPECIFICALLY ON THE RELATIVE SAFETY OF THE DIFFERENT SECOND-TRIMESTER ABORTION METHODS.

I WOULD LIKE TO JUST GO OVER THAT BRIEFLY WITH YOU.

AND TALKING FIRST ABOUT THE MORBIDITY ASSOCIATED WITH THE DIFFERENT SECOND-TRIMESTER ABORTION METHODS. AND I WOULD ASK YOU TO LOOK BACK AT THE EXHIBIT THERE THAT IS THE BINKIN ARTICLE, WHICH WAS LEARNED TREATISE 15.

DR. PAUL, CAN YOU TELL ME WHAT CONCLUSIONS THE JPSA STUDIES REACHED ABOUT THE RELATIVE SAFETY OF D&E AND INDUCTION ABORTIONS?

A. AS YOU CAN SEE FROM THIS TABLE HERE, THESE ARE MAJOR COMPLICATION RATES FOR 100 PROCEDURES. SO THIS IS A PERCENT. AND THESE ARE THE INDUCTION METHODS HERE (INDICATING) INSTILLATION, SALINE INSTILLATION, PROSTAGLANDIN INSTILLATION (INDICATING). AND THIS IS THE D&E METHOD (INDICATING).

AS YOU CAN SEE, IN GENERAL, THE RATES OF MAJOR COMPLICATIONS BY JPSA STUDY WERE LOWER FOR D&E THAN THEY WERE FOR THE INSTILLATION, INDUCTION ABORTION METHODS THAT WERE USED AT THAT TIME.

Q. DR. PAUL, CAN YOU DRAW ANY CONCLUSIONS FROM THE JPSA STUDIES ABOUT THE SAFETY OF D&E ABORTIONS IN WHICH THE FETUS WAS EXTRACTED INTACT OR RELATIVELY INTACT?

A. WELL, JPSA DIDN'T ANALYZE THAT SEPARATELY. IT IS MY OPINION THAT -- AGAIN, BECAUSE I CONSIDER INTACT DELIVERY JUST A VARIANT OF D&E -- THAT IF YOU HAD A QUARTER OF A MILLION WOMEN INVOLVED IN THE JPSA STUDIES THAT YOU DEFINITELY HAD CASES OF ABORTIONS IN WHICH THE D&E WAS ACCOMPLISHED WITH INTACT DELIVERY.

Q. AND THEN, DR. PAUL, I WOULD LIKE YOU TO LOOK AGAIN BRIEFLY AT THE LAWSON ARTICLE THAT WE DISCUSSED EARLIER, WHICH IS EXHIBIT 63, WHICH WILL BE ON THE SCREEN NOW.

IN THIS ARTICLE, IF COULD YOU FOCUS YOUR ATTENTION ON TABLE ROMAN NUMERAL III, ON PAGE 1368, WHICH IS HERE (INDICATING). AND, AGAIN, THE LAWSON DATA, IS THAT MORTALITY DATA FOR ABORTION?

A. YES.
Q. AND DOES THIS TABLE CONTAIN A SUMMARY OF THE CDC DATA ON ABORTION-RELATED MORTALITY BROKEN DOWN BY WHAT PROCEDURE WAS PERFORMED?
A. YES, IT DOES.
Q. AND WHAT DO THESE CDC DATA TELL US ABOUT THE RELATIVE MORTALITY OF D&E AND INDUCTION ABORTIONS PRIOR TO 16 WEEKS GESTATION?
A. AGAIN, THESE ARE CASE FATALITY RATES OR DEATH RATES EXPRESSED AS THE NUMBER OF ABORTION DEATHS PER 100,000 LEGAL-INDUCED ABORTIONS.

AND HERE, EVACUATION THEY SEPARATE OUT D&E. THEY CALL IT "EVACUATION" HERE. AND THEN, YOU HAVE THE INSTILLATION METHODS, ARE WHICH ARE THE INDUCTION METHODS THAT WERE USED AGAIN AT THE TIME OF THE JPSA STUDY OF THE -- AT THE TIME THAT THIS WAS COLLECTED.

AND WHAT YOU SEE HERE IS THAT PRIOR TO 16 WEEKS, THAT EVACUATION HAS A LOWER RISK OF DEATH THAN INSTILLATION. AND AT 16 WEEKS AND UP, THE RATES ARE IN THE SAME BALLPARK.
Q. AND WHAT DO THESE CDC DATA TELL US ABOUT THE RELATIVE MORTALITY OF EITHER D&E OR INDUCTION COMPARED TO HYSTEROTOMY OR HYSTERECTOMY?
A. THERE'S HYSTERECTOMY, HYSTEROTOMY. AND AS YOU CAN SEE, THE DEATH RATES ASSOCIATED WITH HYSTEROTOMY AND HYSTERECTOMY ARE MUCH HIGHER. AND I WOULD SAY PROHIBITIVELY HIGH. THERE 16 TO

20 WEEKS IT IS OVER A HUNDRED DEATHS PER 100,000 PROCEDURES. AND HERE, AT OVER -- AT 21 WEEKS AND OVER, IT IS 274 DEATHS.

SO, THEY ARE JUST INCREDIBLY MUCH HIGHER THAN THE DEATH RATES ASSOCIATED WITH THE OTHER METHODS OF ABORTION.

Q. AND JUST TO MAKE THE RECORD CLEAR, DR. PAUL, IN THE 16 TO 20 WEEK TIME FRAME, WHAT IS THE APPROXIMATE CASE FATALITY RATE FOR D&E AND INDUCTION ABORTION?

A. FOR D&E IT IS APPROXIMATELY 6.5 PER 100,000 PROCEDURES; FOR INSTILLATION 7.9, FOR 100,000 PROCEDURES.

Q. WHAT ABOUT OVER 20 WEEKS GESTATION?

A. FOR D&E, 11.9; AND FOR INSTILLATION, 10.3.

Q. NOW, DR. PAUL, YOU HAD TESTIFIED EARLIER THAT THE JPSA STUDIES INVOLVED OLDER METHODS OF DOING D&E AND INDUCTION; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. ARE THERE ANY STUDIES THAT SPECIFICALLY COMPARE THE RELATIVE RISKS OF D&E AND INDUCTION ABORTIONS, AS THOSE PROCEDURES ARE CURRENTLY PERFORMED?

A. THERE'S A COUPLE OF SMALL STUDIES.

Q. CAN YOU DESCRIBE THOSE FOR ME?

A. ONE IS BY AUTRY AND COLLEAGUES. AND WHAT THEY DID WAS A HISTORICAL COHORT STUDY, BASICALLY LOOKING BACK INTO MEDICAL RECORDS IDENTIFYING WOMEN WHO'VE HAD A MEDICAL ABORTION, WHICH WOULD BE THE INDUCTION TYPE OF ABORTION AND WOMEN WHO HAD D&E ABORTION, AND THEN DETERMINING WHAT THE COMPLICATIONS WERE WITH

THOSE PROCEDURES.

AND WHAT THEY FOUND WAS A HIGHER RATE OF COMPLICATIONS WITH INDUCTION METHODS THAN WITH THE D&E. BUT IT HAD TO DO MOSTLY WITH RETAINED PLACENTA, WHICH MEANS THAT THERE WAS QUITE A HIGH RATE OF RETAINED PLACENTA ASSOCIATED WITH THE INDUCTION ABORTION THAT REQUIRED SURGICAL REMOVAL OF THE PLACENTA THROUGH A CURETTAGE TECHNIQUE OR BY MANUAL REMOVAL.

THEY ALSO HAD ONE INCIDENCE OF UTERINE ROCHSHO (PHONETIC) ASSOCIATED WITH THE MEDICAL INDUCTION PROCEDURES.

Q. IN YOUR PRACTICE, DR. PAUL, IN PROVIDING INDUCTION ABORTIONS, CAN YOU DESCRIBE BRIEFLY WHAT'S INVOLVED WHEN THERE'S A RETAINED PLACENTA AS PART OF AN INDUCTION ABORTION?

A. I DID A LOT OF INDUCTION ABORTIONS AT THE UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER, AND THE MEDICATION WAS OFTEN SUCCESSFUL IN GETTING THE FETUS OUT, BUT THE PLACENTA REMAINED IN THE UTERUS.

GENERALLY, YOU WOULD WAIT AND WAIT. AND IT'S KIND OF STANDARD THAT IF TWO HOURS AFTER THE DELIVERY OF THE FETUS THE PLACENTA HAS NOT YET DELIVERED, THAT YOU TAKE SOME KIND OF INTERVENTION TO REMOVE THE PLACENTA.

SO, YOU COULD TRY TO REMOVE IT MANUALLY, IT'S PRETTY UNCOMFORTABLE; YOU CAN REACH UP AND TRY TO ACTUALLY GET IT WITH YOUR HANDS, OR YOU CAN DO BASICALLY A SUCTION AND CURETTAGE REMOVAL OF THE PLACENTA.

I KNOW AT THE UNIVERSITY WE OFTEN PUT PEOPLE TO

SLEEP TO DO THAT. I MEAN, IT WAS A BIG DEAL FOR WOMEN TO HAVE GONE THROUGH A WHOLE LABOR PROCESS THINKING THEY WEREN'T GOING TO HAVE SURGERY AND THEN END UP HAVING TO BE PUT TO SLEEP TO HAVE THE PLACENTA REMOVED.

Q. WHAT ARE THE RISKS -- YOU SAID THERE WAS A GENERAL RULE OF THUMB TO REMOVE THE PLACENTA AFTER TWO HOURS IF IT HADN'T DELIVERED ON ITS OWN.

WHAT WERE THE RISKS IF THE PLACENTA REMAINED INSIDE THE UTERUS LONGER THAN THAT?

A. THAT'S BEEN LOOKED AT IN THE LITERATURE, AND BASICALLY THERE IS AN INCREASE INCIDENCE OF BLEEDING AND FEVER IF YOU HAVE IT IN THERE FOR LONGER.

Q. OTHER THAN THE AUTRY STUDY, ARE YOU AWARE OF ANY OTHER RECENT STUDIES COMPARING THE MODERN METHODS OF D&E WITH MODERN METHODS OF INDUCTION ABORTIONS?

A. THERE IS A SMALL RANDOMIZED TRIAL BY DR. GRIMES.

Q. IS THAT THE SAME DR. GRIMES WHO IS THE CO-DIRECTOR OF THE JPSA STUDIES?

A. YES, IT IS.

Q. CAN YOU DESCRIBE THAT STUDY FOR ME, PLEASE?

A. IT WAS A PILOT RANDOMIZED STUDY --

MR. QUINLIVAN: YOUR HONOR, I HAVE AN OBJECTION. THAT STUDY WAS NOT DISCLOSED IN EITHER OF THE -- EITHER THE EXPERT REPORT OR THE REBUTTAL EXPERT REPORT THAT WAS SUBMITTED BY DR. PAUL.

MS. GARTNER: I BELIEVE THAT DR. PAUL TESTIFIED AS TO THIS IN HER DEPOSITION.

(PAUSE IN THE PROCEEDINGS.)

MS. GARTNER: YOUR HONOR, I APOLOGIZE, I DON'T HAVE THE PAGE HANDY. I DON'T THINK THIS IS A CENTRAL POINT. WE HAVE OTHER WITNESSES WHO WILL TESTIFY ABOUT THAT STUDY, SO WE CAN MOVE FORWARD ON THAT.

THE COURT: ALL RIGHT. WITHOUT SOME REFERENCE, YOU HAVE PUT THE DEFENSE ON NOTICE TO THAT STUDY, SHE MAY NOT DO SO. IF THERE IS SUCH NOTICE, EITHER IN THE EXPERT REPORT OR THE DEPOSITION TRANSCRIPT, I WOULD PERMIT IT.

MS. GARTNER: I UNDERSTAND, YOUR HONOR. I BELIEVE IT WAS IN THE DEPOSITION, BUT I DON'T WANT TO WASTE THE COURT'S TIME LOOKING FOR IT NOW.

BY MS. GARTNER:

Q. DR. PAUL, OTHER THAN THE JPSA STUDIES, THE LAWSON STUDY, AND THE AUTRY STUDY THAT YOU'VE JUST TALKED ABOUT, ARE THERE OTHER DATA OR STUDIES THAT WOULD HELP TO ASSESS THE SAFETY OF D&E ABORTIONS IN PARTICULAR?

A. WELL, THERE ARE SINGLE INSTITUTION REPORTS OF THE EXPERIENCE OF THE INSTITUTION OF DOING D&E'S AND GENERALLY CONFIRMING SAFETY.

AND THE SAME WITH INDUCTION, I MEAN, THERE ARE SINGLE INSTITUTION REPORTS OF EXPERIENCES OF RANDOM INDUCTION.

Q. WHAT DO THOSE SINGLE INSTITUTION REPORTS GENERALLY SHOW?

A. THEY GENERALLY CONFIRM THAT THEY BOTH ARE SAFE PROCEDURES, BUT THAT INDUCTION DOES HAVE THIS PROBLEM OF RETAINING THE PLACENTA VERY, VERY RARELY DURING INTERRUPTION.

Q. ARE YOU AWARE OF ANY DATA OR STUDIES COMPARING THE RELATIVE SAFETY OF D&E WITH INTACT EXTRACTION TO OTHER SECOND-TRIMESTER ABORTION METHODS?

A. NO.

Q. IN YOUR OPINION, IS IT SURPRISING THAT THERE ARE NO STUDIES SPECIFICALLY LOOKING AT D&E'S WITH INTACT EXTRACTION?

A. NO.

Q. WHY IS THAT?

A. FIRST OF ALL, I THINK IT'S CONSIDERED JUST A VALIANT, SO I AM NOT SURE PEOPLE OUGHT TO STUDY IT SEPARATELY, BUT I -- IT ALSO WOULD BE DIFFICULT TO SET UP A STUDY THAT LOOKED AT INTACT BECAUSE, FIRST OF ALL, THERE IS NOT -- IT WOULD BE HARD TO PREDICT IF THE FETUS WERE GOING TO COME OUT INTACT.

SO, I AM NOT SURE HOW YOU WOULD SET UP A STUDY TO REALLY LOOK AT THAT IN ANY KIND OF GOOD WAY, AND THE OTHER THING IS, IS THAT BECAUSE THERE'S -- IT'S A LITTLE HARD TO EXPLAIN -- BUT BASICALLY, TO SET UP A GOOD RANDOMIZED TRIAL WHERE YOU'RE PUTTING WOMEN INTO GROUPS, YOU KNOW, ONE GETTING INTACT EXTRACTION, THE OTHER GETTING DISARTICULATION OF D&E, RIGHT, IN A WAY THAT DOES NOT INTRODUCE BIAS, THE KIND OF BIASES THAT WE SEE IN STUDIES AND SO FORTH, YOU WOULD FIRST HAVE TO BE ABLE TO IDENTIFY WHO WOULD GET THOSE INTACT VERSUS

DISARTICULATION, I SAID, THAT WOULD BE HARD TO PREDICT, BUT THE OTHER THING IS THAT YOU WOULD NEED VERY LARGE NUMBERS IN EACH GROUP IN ORDER TO SEE IF THERE WAS A DIFFERENCE IN COMPLICATION RATES. ONE, BECAUSE COMPLICATION RATES DON'T OCCUR THAT OFTEN WITH ABORTION, RIGHT, COMPLICATIONS DON'T OCCUR THAT OFTEN WITH ABORTIONS, AND THE OTHER IS BECAUSE THE PERCENTAGE OF ABORTIONS THAT ARE DONE IN THE SECOND -- BEYOND THE FIRST-TRIMESTER ARE RELATIVELY SMALL.

SO, THAT JUST WOULD MAKE IT VERY, VERY DIFFICULT TO SET UP A REALLY GOOD RANDOMIZED TRIAL THAT COULD GIVE YOU THAT INFORMATION.

Q. OKAY.

IS THERE ANY REQUIREMENT IN THE MEDICAL PROFESSION THAT A MEDICAL TECHNIQUE BE SUBJECTED TO RANDOMIZED TRIAL BEFORE IT'S USED?

A. NO. WE LIKE WHEN WE HAVE RANDOMIZED TRIAL, BUT IT CERTAINLY IS NOT A REQUIREMENT BEFORE WE USE TECHNIQUES.

Q. ARE THERE OTHER ASPECTS OF ABORTION PRACTICE OTHER THAN THE INTACT EXTRACTION VARIANT OF D&E THAT HAVE NOT BEEN SUBJECTED TO RANDOMIZED TRIAL?

A. COULD YOU REPEAT THAT QUESTION?

Q. YES.

ARE THERE OTHER ASPECTS OF ABORTION PRACTICE THAT HAVE NOT BEEN SUBJECTED TO RANDOMIZED TRIAL? AND BY "OTHER," I MEAN OTHER THAN THE INTACT EXTRACTION.

A. YES. I MEAN, MOST OF WHAT WE DO IN ABORTION HAS NOT BEEN SUBJECTED TO RANDOMIZED TRIAL.

Q. DR. PAUL, WHAT IS EVIDENCE-BASED MEDICINE? WHAT DOES THAT TERM MEAN?

A. EVIDENCE-BASED MEDICINE IS A WAY OF DOING MEDICINE THAT TAKES INTO CONSIDERATION THE SCIENTIFIC INFORMATION THAT IS AVAILABLE.

Q. AND UNDER THE PRINCIPLES OF EVIDENCE-BASED MEDICINE, WHAT SHOULD A PHYSICIAN DO IF THERE ARE NO STUDIES ASSESSING THE SAFETY OF A PARTICULAR TECHNIQUE?

A. WELL, BASICALLY EVIDENCE-BASED MEDICINE SAYS THAT IF THERE IS GOOD EVIDENCE THAT ONE PARTICULAR METHOD SHOULD BE USED, THEN IT IS OUR RESPONSIBILITY TO USE THAT METHOD.

BUT WHERE THAT EVIDENCE IS LACKING OR IS INADEQUATE, THAT WE USE OUR BEST CLINICAL JUDGMENT TO RENDER THE SAFEST CARE POSSIBLE TO OUR PATIENTS.

Q. SO, DR. PAUL, GIVEN THE COMPARABLE SAFETY, WHAT YOU'VE TESTIFIED AS THE COMPARABLE SAFETY OF D&E AND INDUCTION BEGINNING AT ABOUT 16 WEEKS GESTATION, BASED ON YOUR EXPERIENCE PROVIDING ABORTIONS WHAT ARE SOME OF THE CONSIDERATIONS THAT GO INTO A WOMAN'S DECISION TO PICK ONE PROCEDURE OR THE OTHER IF SHE'S HAVING A SECOND-TRIMESTER ABORTION?

A. PATIENT PREFERENCE GO ONE PROCEDURE OVER THE OTHER IN MY EXPERIENCE AND FROM MY READING OF THE LITERATURE. INDUCTION ABORTION CAN BE PRETTY TRYING TO WOMEN, AND WOMEN TEND TO HAVE

A PREFERENCE FOR THE SHORTER D&E PROCEDURE.

Q. DR. PAUL, JUST TO CONCLUDE AND GO BACK AGAIN TO THE STATUTE IN THIS CASE, WHAT IMPACT WOULD THIS LAW HAVE ON YOUR PRACTICE IF IT TOOK EFFECT?

MR. QUINLIVAN: OBJECTION, YOUR HONOR, ASKED AND ANSWERED.

THE COURT: OVERRULED.

THE WITNESS: WELL, I THINK IT WOULD HAVE A TREMENDOUS IMPACT ON MY PRACTICE. I WOULD BE FORCED WITH A DECISION I WOULD HAVE NEVER FACED BEFORE IN MEDICINE AND THAT IS AS TO WHETHER TO CONTINUE TO DO PROCEDURES IN A WAY THAT I THINK ARE SAFEST FOR WOMEN BECAUSE IF I DID SO, I WOULD RISK IMPRISONMENT.

AND I HAVE DEDICATED A LOT OF MY LIFE AND CAREER AND BEEN PRETTY ADAMANT ABOUT WANTING TO PROVIDE CARE TO WOMEN, SO THIS WOULD BE A VERY DIFFICULT PERSONAL AND PROFESSIONAL DECISION TO ME -- FOR ME AS TO WHETHER I COULD CONTINUE TO DO SECOND-TRIMESTER ABORTIONS.

BY MS. GARTNER:

Q. IF THIS LAW TOOK EFFECT, WOULD IT AFFECT HOW YOU TEACH D&E ABORTIONS?

A. I THINK IT WOULD.

I WOULD HAVE TO MAKE A DECISION ABOUT WHETHER I COULD TEACH ALL METHODS, IF I COULD TEACH ABOUT INTACT EXTRACTION, SOME OF THE THINGS THAT MIGHT BE VIOLATED BY THIS

LAW. I WOULD, AT THE VERY LEAST, FEEL A RESPONSIBILITY TO INFORM THOSE WHOM I AM TEACHING THAT THEY COULD -- THAT THEY WOULD RISK IMPRISONMENT IF THEY PERFORMED AN D&E IN A PARTICULAR WAY.

Q. AND WOULD, IF THIS LAW WERE TO TAKE EFFECT, WOULD IT AFFECT YOUR RELATIONSHIP WITH YOUR PATIENTS IN YOUR OPINION?

A. YES.

I THINK FUNDAMENTALLY MY RELATIONSHIP WITH MY PATIENTS IS BASED ON TRUST, AND PART OF THAT TRUST IS THAT I AM GOING TO GIVE THEM THE BEST CARE POSSIBLE AND I AM GOING TO DO A PROCEDURE THE WAY I DEEM THAT IS SAFEST AT THE TIME. SO, THAT FUNDAMENTAL TRUST WOULD BE COMPROMISED.

AND THERE'S ALSO A PART OF THE LAW THAT SAYS SOMETHING ABOUT THAT CIVIL ACTION COULD BE TAKEN AGAINST ME IF A SPOUSE -- IF I DIDN'T OBTAIN THE CONSENT OF A SPOUSE OR, IN THE CASE OF A TEENAGER, HER PARENTS BEFORE I DID A PROCEDURE, THAT MIGHT VIOLATE THIS ACT.

SO, TO ME, THAT REALLY VIOLATES THE MOST FUNDAMENTAL TENETS OF PATIENT CONFIDENTIALITY. THERE IS NO REQUIREMENT IN CALIFORNIA FOR ME TO TELL A PARENT ABOUT -- TO GET THE CONSENT OF A PARENT TO DO AN ABORTION ON A MINOR. SO WHAT'S THAT MEAN NOW; SUDDENLY I HAVE TO DO THAT?

THERE IS CERTAINLY NOWHERE THAT THE SPOUSE HAS TO GIVE PERMISSION FOR A WOMAN TO HAVE AN ABORTION, SO THE WHOLE THING ABOUT PATIENT CONFIDENTIALITY, THE WHOLE BASIS ON WHICH

MY TRUSTED RELATIONSHIPS WITH PATIENTS ARE BUILT IS COMPROMISED.

MS. GARTNER: THANK YOU, DR. PAUL.

WE HAVE NO FURTHER QUESTIONS, YOUR HONOR.

THE COURT: ALL RIGHT. THANK YOU.

MR. QUINLIVAN?

CROSS-EXAMINATION

BY MR. QUINLIVAN:

Q. GOOD MORNING, DR. PAUL.

A. GOOD MORNING.

Q. I'M MARK QUINLIVAN. I'M ONE OF THE COUNSEL FOR THE DEFENDANT.

WE HAVE MET BEFORE, HAVEN'T WE?

A. WE HAVE.

Q. I TOOK YOUR DEPOSITION ABOUT A MONTH AGO?

A. THAT'S RIGHT.

Q. GOOD TO SEE YOU AGAIN.

DR. PAUL, LET ME JUST ASK YOU A COUPLE OF QUICK QUESTIONS.

YOU MENTIONED YOU WERE BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY AND OCCUPATIONAL AND ENVIRONMENTAL MEDICINE; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. IS THERE A SUBSPECIALTY WITHIN OBSTETRICS AND GYNECOLOGY THAT'S KNOWN AS MATERNAL FETAL MEDICINE?

A. YES.
Q. AND CAN YOU TELL US WHAT MATERNAL FETAL MEDICINE IS?
A. IT'S A SUBSPECIALTY THAT INVOLVES THE CARE OF HIGH RISK PREGNANCIES.
Q. ARE YOU BOARD CERTIFIED IN MATERNAL FETAL MEDICINE?
A. NO, I AM NOT.
Q. DR. PAUL, I THINK YOU TESTIFIED THAT IN 1988 YOU RECEIVED YOUR MASTER'S DEGREE IN EPIDEMIOLOGY; IS THAT CORRECT?
A. THAT'S RIGHT.
Q. AND I KNOW YOU TESTIFIED TO THIS ON DIRECT, BUT CAN YOU REPEAT AGAIN WHAT IS ENCOMPASSED WITHIN THE TERM "EPIDEMIOLOGY"?
A. I TESTIFIED THAT IT'S THE STUDY OF THE DISTRIBUTION AND DETERMINANT OF HEALTH-RELATED CONDITIONS IN A POPULATION. BASICALLY THE APPLICATION OF RESEARCH METHODS TO DETERMINE WHY -- WHO GETS CERTAIN CONDITIONS AND WHY.
Q. IS INTUITION EVER USED IN THE FIELD OF EPIDEMIOLOGY?
A. NOT PER SE, NO.
Q. WHY IS THAT?
A. I'M TRYING TO THINK IF WE'RE CLEAR ON THE DEFINITION OF INTUITION.
AS I TESTIFIED EARLIER, EPIDEMIOLOGY DOES INVOLVE TENETS OF EVIDENCE-BASED MEDICINE. SO, WHERE THE STUDIES LACKING, PHYSICIANS CAN USE THEIR CLINICAL JUDGMENT TO TAKE CARE OF PATIENTS IN THE BEST WAY. I AM NOT SURE IF THAT'S WHAT

YOU ARE CALLING INTUITION. I SEE INTUITION AS A LITTLE BIT DIFFERENT.

Q. AND MY QUESTION IS, IN THE FIELD OF EPIDEMIOLOGY ITSELF, NOT IN THE MEDICAL FIELD.

IN THE FIELD OF EPIDEMIOLOGY, IS INTUITION CONSIDERED A VALID RESEARCH METHOD?

A. NO.

Q. AND ONE OF THE METHODS OF STUDIES THAT YOU MENTIONED THAT AN EPIDEMIOLOGIST MIGHT LOOK AT IS A RANDOMIZED CONTROLLED CLINICAL TRIAL; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. AND CAN YOU DESCRIBE FOR US WHAT A WELL-CONSTRUCTED RANDOMIZED CLINICAL TRIAL -- OR CAN YOU DESCRIBE FOR US HOW A RANDOMIZED CONTROLLED TRIAL IS CONSTRUCTED?

A. BASICALLY A RANDOMIZED CONTROL TRIAL ALLOCATES WOMEN, GROUPS WOMEN IN GROUP SUBJECTS, INTO DIFFERENT TREATMENT GROUPS IN A WAY THAT IS NOT BIASED. SO THAT WHEN YOU LOOK AT THE TWO TREATMENT GROUPS, WHETHER THERE IS A DIFFERENCE IN OUTCOME, YOU CAN BE SURE TO DO WITH THE TREATMENT NOT JUST SOME OTHER FACTOR, YOU KNOW, SOME FACTOR OR SOME CHARACTERISTIC OF THE WOMAN, OR SOMETHING THAT WOULD EFFECT THAT OUTCOME.

Q. AND ANOTHER METHOD OF STUDY THAT AN EPIDEMIOLOGIST MIGHT LOOK AT WOULD BE A HISTORICAL COHORT STUDY; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. AND CAN YOU DESCRIBE WHAT A HISTORICAL COHORT STUDY IS?

A. A COHORT STUDY IS A STUDY WHERE YOU HAVE ONE GROUP COMPARED TO ANOTHER. YOU HAVE COMPARISON GROUPS. AND HISTORICAL COHORT STUDY LOOKS AT THINGS THAT HAVE OCCURRED IN THE PAST. YES, LOOKS AT THINGS THAT HAVE OCCURRED IN THE PAST.

Q. IS IT POSSIBLE TO DO A COHORT STUDY PROSPECTIVELY?

A. YES.

Q. AND EPIDEMIOLOGIST MIGHT ALSO LOOK AT A CASE SERIES, RIGHT?

A. THAT'S RIGHT.

Q. CAN YOU DESCRIBE HOW A CASE SERIES DIFFERS FROM A COHORT STUDY?

A. THERE IS NO COMPARISON FOR THE CASE SERIES.

Q. AND IN THE FIELD OF EPIDEMIOLOGY, ANY KIND OF RANKING FOR THESE VARIOUS KINDS OF STUDIES?

A. YES.

Q. CAN YOU TELL US WHAT IS CONSIDERED THE BEST FORM OF STUDY OR ANALYSIS?

A. A RANDOMIZED CONTROL TRIAL.

Q. AFTER A RANDOMIZED CONTROL TRIAL, WHAT'S NEXT?

A. COHORT OR WHAT'S CALLED CASE CONTROL STUDIES.

Q. AND AFTER THAT WOULD BE THE CASE SERIES?

A. THAT'S RIGHT.

Q. AND ALL OF THESE TYPES OF STUDIES ARE GENERALLY PUBLISHED IN PEER REVIEWED MEDICAL JOURNALS?

A. YOU CAN FIND ALL THESE TYPES OF STUDIES IN JOURNALS, YES.

Q. IS THERE AN IMPORTANCE THAT ONE OF THESE -- IS THERE A

REASON WHY IT'S IMPORTANT THAT A STUDY BE SUBJECTED TO PEER REVIEW?

A. YES.

Q. AND CAN YOU TELL US WHAT THAT IS?

A. JUST TO BE SURE THAT THE RESEARCH METHODOLOGY IS APPROPRIATE.

Q. DR. PAUL, I WOULD LIKE TO NOW TURN YOUR ATTENTION TO THE FIELD OF MEDICINE. AND YOU'VE MENTIONED THE TERM "EVIDENCE-BASED MEDICINE."

IS IT FAIR TO SAY THAT IN DETERMINING WHETHER A PARTICULAR PROCEDURE OR SURGICAL TECHNIQUE SHOULD BE USED PHYSICIANS OFTENTIMES CONSULT THE MEDICAL LITERATURE; IS THAT RIGHT?

A. YES.

Q. THEY WOULD CONSULT THE LITERATURE INVOLVING THE KINDS OF TRIALS THAT WE HAVE TALKED ABOUT JUST NOW, RANDOMIZED CONTROL TRIALS, COHORT STUDIES, CASE SERIES INVESTIGATIONS; IS THAT RIGHT?

A. YES.

Q. IS IT FAIR TO SAY THAT THE EVIDENCE-BASED MEDICINE APPROACH HAS COME TO BE ACCEPTED WITHIN THE MEDICAL COMMUNITY OVER THE LAST 10, 15, 20 YEARS?

A. INCREASINGLY SO.

Q. IN FACT, IT'S NOT TODAY CONSIDERED TO BE A CONTROVERSIAL SUBJECT IN THE MEDICAL FIELD, IS IT?

A. NO, IT'S NOT.
Q. AND YOU WOULD AGREE THAT IDEALLY A SURGICAL PROCEDURE SHOULD BE SUBJECTED TO STUDY AT SOME POINT; IS THAT RIGHT?
A. IDEALLY, SURE.
Q. IN FACT, YOU THINK IT'S OPTIMAL TO HAVE COMPARISON STUDIES OF DIFFERENT SURGICAL TECHNIQUES; ISN'T THAT RIGHT?
A. IDEALLY THAT WOULD BE THE CASE, YES.
Q. NOW, WHEN WAS THE FIRST TIME THAT YOU PERFORMED AN INTACT D&E DELIVERY, IF YOU CAN RECALL?
A. I DON'T KNOW.
Q. CAN YOU GIVE ME AN ESTIMATE? WAS IT IN THE 1990'S?
A. IT WAS WHEN I STARTED DOING D&E ABORTIONS.
SO, I DID SOME D&E ABORTIONS DURING MY RESIDENCY. I DID MOSTLY INDUCTIONS WHEN I WAS FACULTY AT THE UNIVERSITY OF MASSACHUSETTS. AND IT WASN'T UNTIL I JOINED THE PLANNED PARENTHOOD IN MASSACHUSETTS AS MEDICAL DIRECTOR IN 1998 THAT I BEGAN TO DO A NUMBER OF D&E ABORTIONS.
SO, AT SOME POINT WHEN I WAS DOING D&E'S I DID MY FIRST INTACT. I AM NOT SURE WHEN THAT WOULD BE.
Q. DO YOU RECALL SPECIFICALLY WHETHER IT MAY HAVE BEEN DURING YOUR RESIDENCY?
A. NO, I DON'T.
Q. WHEN WAS THE FIRST TIME THAT YOU HEARD THE INTACT D&E PROCEDURE ADDRESSED IN ANY KIND OF PUBLISHED OR ANY KIND OF PRESENTATION IF YOU CAN RECALL?

A. AT A NATIONAL ABORTION FEDERATION MEETING.
Q. DO YOU RECALL WHEN THAT WAS?
A. I DON'T RECALL THE EXACT YEAR, BUT MID 1990'S.
Q. DO YOU RECALL WHO GAVE THAT PRESENTATION?
A. DR. MCMAHON.
Q. ARE YOU AWARE THAT A DR. HASKELL HAD GIVEN A PRESENTATION TO THE NATIONAL ABORTION FEDERATION ABOUT THE INTACT D&E PROCEDURE IN 1992?
A. I AM AWARE OF THAT NOW. I WASN'T AT THAT PRESENTATION.
Q. SO, IT'S FAIR TO SAY IT'S BEEN ROUGHLY 11 AND A HALF YEARS SINCE DR. HASKELL MADE THAT PRESENTATION TO THE NATIONAL ABORTION FEDERATION --
MS. GARTNER: OBJECTION, LACK OF FOUNDATION.
THE COURT: SUSTAINED. SHE SAID SHE WASN'T AT THAT PRESENTATION.
MR. QUINLIVAN: I RECOGNIZE --
THE COURT: THE ONLY INFORMATION ABOUT WHEN IT OCCURRED IS WHAT YOU JUST ASKED HER.
MR. QUINLIVAN: I THOUGHT SHE THEN SAID THAT SHE'S AWARE OF THAT NOW.
THE COURT: SHE'S AWARE OF IT NOW.
MS. MORRIS: EXCUSE ME. THIS MAY BE A GOOD TIME TO STATE FOR THE RECORD THAT THE CITY AND COUNTY OF SAN FRANCISCO JOINS IN ALL OBJECTIONS BY ALL OTHER PLAINTIFFS UNTIL WE STATE OTHERWISE.

BY MR. QUINLIVAN:

Q. DR. PAUL, ARE YOU AWARE NOW THAT DR. HASKELL GAVE A PRESENTATION TO THE NATIONAL ABORTION FEDERATION IN 1992 ABOUT THE INTACT D&E PROCEDURE?

A. I'M AWARE NOW, YES.

Q. SO, IT'S BEEN ROUGHLY 11 AND A HALF YEARS SINCE DR. HASKELL GAVE THAT PRESENTATION IN 1992; IS THAT RIGHT?

A. YES.

Q. AND AM I CORRECT THAT IN THOSE 11 AND A HALF YEARS YOU ARE AWARE OF NO RANDOMIZED CLINICAL TRIAL WHICH HAS EVALUATED THE SAFETY OF THE INTACT D&E PROCEDURES SPECIFICALLY?

A. THAT'S RIGHT.

Q. AND IN THOSE 11 AND A HALF YEARS, YOU ARE AWARE OF NO RANDOMIZED CLINICAL TRIALS THAT HAVE COMPARED THE SAFETY OF THE INTACT D&E PROCEDURE WITH WHAT YOU'VE SAID IS A DISARTICULATION D&E PROCEDURE?

A. WELL, I DON'T KNOW IF IN THE RANDOMIZED TRIAL THAT DR. GRIMES DID --

THE REPORTER: I'M SORRY?

THE WITNESS: I WASN'T ALLOWED TO TALK ABOUT THAT.

BY MR. QUINLIVAN:

Q. WELL, LET ME --

THE COURT: DO YOU WISH TO OPEN THE DOOR?

MR. QUINLIVAN: I WILL RESERVE ON THAT, YOUR HONOR, AND PERHAPS THINK ABOUT THAT DURING THE BREAK.

BY MR. QUINLIVAN:

Q. LET ME JUST ASK YOU GENERALLY. ARE YOU AWARE OF ANY PUBLISHED PEER-REVIEWED ARTICLES THAT HAVE SPECIFICALLY CONSIDERED THE SAFETY OF THE INTACT D&E PROCEDURE?

A. NOT AS SPECIFICALLY IDENTIFIED, ALTHOUGH I DID TESTIFY THAT I BELIEVED THAT AN INTACT PROCEDURE JUST BECAUSE OF THE VARIANCE OF D&E WOULD HAVE BEEN INCLUDED IN THE GOVERNMENT STUDIES, JPSA STUDIES, AND SO FORTH.

Q. I APPRECIATE THAT, DR. PAUL, AND JUST TO CLARIFY, MY QUESTION IS SOLELY LIMITED TO A SPECIFIC CONSIDERATION OF THE SAFETY OF THE INTACT D&E PROCEDURE.

ARE YOU AWARE OF ANY PUBLISHED PEER-REVIEWED ARTICLES SPECIFICALLY CONSIDERING THE SAFETY OF THAT PROCEDURE?

A. NO.

Q. NOW, DR. PAUL, YOU TESTIFIED THAT ONE OF THE REASONS YOU BELIEVE THE INTACT D&E PROCEDURE IS SAFER THAN DISARTICULATION D&E IS THAT THERE ARE FEWER INSTRUMENT PASSES, CORRECT?

A. THAT'S RIGHT.

Q. YOU ALSO THINK THE INTACT D&E PROCEDURE IS SAFER BECAUSE IT'S SOMETIMES FASTER THAN A DISARTICULATION D&E, CORRECT?

A. THAT'S RIGHT.

Q. AND YOU ALSO THINK IT IS SAFER BECAUSE THERE IS LESS RISK OF HAVING RETAINED FETAL PARTS OR TISSUE, CORRECT?

A. THAT'S RIGHT.

Q. IS IT FAIR TO SAY THAT YOUR JUDGMENT THAT THE INTACT D&E

PROCEDURE IS SAFER THAN THE DISARTICULATION D&E PROCEDURE IS BASED ON YOUR INTUITION AND YOUR CLINICAL EXPERIENCE?

A. ON MY CLINICAL EXPERIENCE AND THE CLINICAL EXPERIENCE OF ALL OF THE PHYSICIANS WITH WHOM I HAVE SPOKEN.

Q. ARE YOU ABLE TO QUANTIFY IN ANY WAY THE ADVANTAGE YOU BELIEVE THAT THE INTACT D&E PROCEDURE HAS OVER DISARTICULATION D&E?

A. TO QUANTIFY IT, NO.

Q. DO YOU CONSIDER THAT DISARTICULATION D&E'S ARE GENERALLY SAFE?

A. YES.

Q. AND IN YOUR EXPERIENCE, HOW MANY COMPLICATIONS HAVE YOU HAD WITH THE DISARTICULATION D&E PROCEDURE?

A. I DON'T RECALL EXACTLY.

I DO KNOW THAT THE TWO CASES OF PERFORATIONS I HAD WERE WITH DISARTICULATION D&E.

Q. IT'S TRUE, DR. PAUL, THAT WITH RESPECT TO PLANNED PARENTHOOD GOLDEN GATE, YOU DON'T RECORD ON YOUR FORMS WHETHER OR NOT THE PROCEDURE WAS PERFORMED INTACT OR NOT; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. SO, WOULD YOU BE -- STRIKE THAT.

DR. PAUL, IT'S TRUE, ISN'T IT, THAT THERE ARE EXAMPLES IN THE MEDICAL LITERATURE WHERE PHYSICIANS HAVE THOUGHT THAT A PARTICULAR PROCEDURE WAS SAFE AND EFFECTIVE

BASED ON INTUITION AND CLINICAL EXPERIENCE AND WHEN THAT PROCEDURE WAS SUBJECTED TO STUDY, THEIR JUDGMENT WAS PROVEN WRONG?

A. YES.

Q. AND A GOOD EXAMPLE OF THAT WAS THE CASE OF ELECTRONIC FETAL MONITORING?

A. THAT IS AN EXAMPLE I GAVE IN MY DEPOSITION, YES.

Q. CAN YOU TELL US WHAT ELECTRONIC FETAL MONITORING IS?

A. IT'S THE MONITORING OF THE HEARTBEAT OF THE FETUS BY ELECTRONIC MEANS DURING LABOR.

Q. AND PRIOR TO THE USE OF ELECTRONIC FETAL MONITORING, WHAT TYPE OF PROCEDURE WAS USED BY THE MEDICAL COMMUNITY?

A. PRIMARILY AUSCULTATION WITH A STETHOSCOPE.

Q. HOW OFTEN WAS THE AUSCULTATION WITH THE STETHOSCOPE DONE?

A. I AM NOT SURE. IT OCCURRED BEFORE I BECAME A PHYSICIAN.

Q. IS IT FAIR TO SAY THAT IN THE 1960'S, AND 1970'S, ELECTRONIC FETAL MONITORING WAS INTRODUCED WITH THE IDEA THAT IT WOULD HELP CLINICIANS DIAGNOSE FETAL HYPOXIA AND THAT IT WOULD HAVE ADVANTAGES OVER AUSCULTATION?

A. I AM NOT SURE IF THAT WAS THE EXACT REASON WHY THE COMPANIES THAT HAD THE ELECTRONIC FETAL MONITORS INTRODUCED.

Q. IS IT FAIR TO SAY THAT AT LEAST BY THE 1970'S THERE WAS WIDE USE OF ELECTRONIC FETAL MONITORING IN THE UNITED STATES?

A. YES.

Q. WHEN IT WAS SUBJECTED TO STUDY, IT TURNED OUT THAT

ELECTRONIC FETAL MONITORING ACTUALLY LED TO HIGHER CESAREAN SECTION RATES; ISN'T THAT RIGHT?

A. UNIVERSAL USE OF ELECTRONIC FETAL MONITORING, YES.

Q. THAT WAS NOT SOMETHING THAT ANYONE HAD THOUGHT OF PRIOR TO THOSE STUDIES BEING CONDUCTED; ISN'T THAT RIGHT?

A. PEOPLE MIGHT HAVE THOUGHT ABOUT IT, BUT THEY DIDN'T KNOW IT.

Q. DR. PAUL, WOULD YOU AGREE THAT IF A PARTICULAR ABORTION PROCEDURE LED TO A HIGHER RATE OF CERVICAL INCOMPETENCE, THEN OTHER PROCEDURES THAT THAT WOULD BE A COMPLICATION OF THE FIRST PROCEDURE?

A. IF THAT WERE PROVED, YES.

Q. AND IF YOU WANTED TO LOOK AT THE OUTCOME OF CERVICAL INCOMPETENCE, YOU WOULD HAVE TO FOLLOW WOMEN THROUGH THEIR NEXT PREGNANCY TO DETERMINE WHETHER THERE WAS ANY KIND OF DIFFERENCE IN RATES; ISN'T THAT RIGHT?

A. YES.

Q. JUST TO BE CLEAR, YOU YOURSELF ARE NOT AWARE OF ANY DATA THAT HAS CONSIDERED WHETHER THE INTACT D&E PROCEDURE MIGHT LEAD TO HIGHER RATES OF CERVICAL INCOMPETENCE AS COMPARED TO OTHER PROCEDURES, ARE YOU?

A. NO.

Q. HAVE YOU YOURSELF FOLLOWED UP WITH WOMEN WHO HAVE UNDERGONE AN INTACT D&E THROUGH THEIR NEXT PREGNANCY TO DETERMINE WHETHER THEIR MIGHT BE HIGHER RATES OF CERVICAL INCOMPETENCE?

A. WELL, I DON'T DO PRENATAL CARE ANYMORE, SO I WOULD NOT HAVE SEEN THEM IN THE NEXT PREGNANCY IF THEY CARRIED TO TERM.

Q. THE ANSWER IS "NO"?

A. NO.

Q. IS IT ALSO -- WOULD YOU AGREE THAT IF A PARTICULAR ABORTION PROCEDURE LED TO A HIGHER TERM OF PRETERM --

THE REPORTER: I'M SORRY. CAN YOU START AGAIN?

BY MR. QUINLIVAN:

Q. WOULD YOU AGREE THAT IF A PARTICULAR ABORTION PROCEDURE LED TO A HIGHER RATE OF PRE-TERMED DELIVERIES THAN OTHER ABORTION PROCEDURES THAN THAT WOULD ALSO BE A COMPLICATION?

A. YES. IF YOU REALLY KNEW THAT. IF THE COMPLICATION IS AN ODD TERM TO USE, GENERALLY THAT IS KIND OF WHAT WE CALL LONG-TERM SEQUELAE, IT IS DIFFERENT THAN THE KIND OF COMPLICATIONS THAT ARE TYPICALLY MEASURED AFTER AN ABORTION PROCEDURE.

AS YOU CAN SEE FROM THE JPSA STUDY, THAT'S NOT A COMPLICATION THAT WAS EVER LOOKED AT. SO I JUST WANT TO BE CLEAR ON OUR DEFINITIONS OF COMPLICATION.

Q. UNDERSTOOD.

AND I GUESS MY QUESTION IS, THERE CAN BE COMPLICATIONS THAT OCCUR POTENTIALLY MONTHS OR YEARS AFTER THE ABORTION PROCEDURE, NOT JUST RIGHT WHEN THE ABORTION PROCEDURE TAKES PLACE; ISN'T THAT RIGHT?

A. THERE IS NO EVIDENCE THAT THERE IS LONG-TERM ADVERSE

SEQUELAE AFTER AN ABORTION.

Q. THAT'S MY -- YOU ANTICIPATED MY QUESTION.

ARE YOU AWARE OF ANY DATA AS TO WHETHER THERE MIGHT BE AN INCREASED RISK OF PRE-TERM DELIVERIES WITH THE INTACT D&E PROCEDURE AS COMPARED TO OTHER AVAILABLE PROCEDURES?

A. THAT'S NOT BEEN LOOKED AT SPECIFICALLY, NO.

Q. GIVEN WHAT YOU JUST TESTIFIED WHEN I ASKED YOU THE QUESTION ABOUT CERVICAL INCOMPETENCE, YOU HAVEN'T FOLLOWED THROUGH WITH WOMEN WHO HAVE UNDERGONE THE INTACT D&E PROCEDURES TO SEE IF THAT HAS LED TO A HIGHER RATE OF PRE-TERMED DELIVERIES, HAVE YOU?

A. NO. AS I SAY, I PROBABLY WOULDN'T EVEN REMEMBER WHICH ONES HAD INTACT AND WHICH HAD DISARTICULATION D&E BECAUSE I DON'T SPECIFICALLY NOTE IT ON THE CHART.

Q. DR. PAUL, YOU MENTIONED THAT IT WOULD BE HARD TO CONSTRUCT A RANDOMIZED CONTROLLED TRIAL TESTING THE INTACT D&E PROCEDURE WITH SAY A DISARTICULATION D&E.

WAS THAT YOUR TESTIMONY?

A. YES. I BELIEVE IT WOULD BE HARD TO DO.

Q. IT'S NOT YOUR TESTIMONY IT WOULD BE IMPOSSIBLE TO DO THAT, IS IT?

A. I THINK IT WOULD BE PRETTY INFEASIBLE.

Q. RANDOMIZED CONTROLLED TRIALS ARE, OF COURSE, NOT THE ONLY FORM OF STUDY THAT MEDICAL RESEARCHERS LOOK AT; ISN'T THAT RIGHT?

A. THAT'S RIGHT.
Q. YOU COULD, FOR EXAMPLE, DO A HISTORICAL COHORT STUDY COMPARING THE EXPERIENCE WITH INTACT D&E'S AS COMPARED TO DISARTICULATION D&E'S, COULD YOU NOT?
A. IN A HISTORICAL COHORT STUDY, YOU STILL HAVE TO IDENTIFY SOME SOURCE THAT -- WHERE IT WAS CLEAR THAT IT WAS AN INTACT D&E. IN MY EXPERIENCE, IT IS NOT USUALLY SO DISTINCTLY NOTED.
SO, HISTORICALLY IT MIGHT BE HARD TO JUST GO TO A MEDICAL RECORD AND DETERMINE WHETHER, IN FACT, THE DELIVERY WAS DONE BY DISARTICULATION OR AS AN INTACT DELIVERY.
Q. BUT IF SOME PHYSICIANS WHO DID USE OR DID PERFORM INTACT D&E'S DID ACTUALLY RECORD THAT IN THEIR RECORDS, THEN YOU WOULD BE ABLE TO DO A HISTORICAL COHORT STUDY COMPARING INTACT D&E'S WITH DISARTICULATE D&E'S?
A. YES, YOU COULD.
THE COURT: MR. QUINLIVAN, WE ARE APPROACHING THE BREAK TIME. IS THIS A GOOD TIME?
MR. QUINLIVAN: IT IS A GOOD TIME.
THE COURT: WE WILL BREAK FOR 15 MINUTES.
(RECESS TAKEN AT 11:45 A.M.)
(PROCEEDINGS RESUMED AT 12:00 P.M.)
BY MR. QUINLIVAN:
Q. DR. PAUL, THERE ARE OTHER EXAMPLES IN THE FIELDS -- IN THE FIELD OF OBSTETRICS AND GYNECOLOGY WHERE A PROCEDURE THAT WAS THOUGHT TO BE SAFE HAVE PROVEN TO BE -- OR HAS PROVEN TO HAVE

COMPLICATION RATES AFTER SUBJECTED TO STUDIES; ISN'T THAT RIGHT?

A. CAN YOU GIVE ME AN EXAMPLE?

Q. WELL, CAN YOU TELL ME WHAT AN EPISIOTOMY IS?

A. YES. THAT'S WHEN YOU INCISE THE OPENING OF THE VAGINA SO THAT YOU HAVE MORE ROOM TO ALLOW THE DELIVERY OF THE FETUS.

Q. AND IS IT TRUE THAT, SAY, 20 YEARS AGO IT WAS THOUGHT THAT EPISIOTOMIES SHOULD BE ROUTINELY GIVEN TO WOMEN WHO WERE DELIVERING A BABY?

A. EPISIOTOMIES WERE COMMON 20 YEARS AGO, YES.

Q. AND WHEN IT WAS SUBJECTED TO STUDY, IT IS CORRECT, ISN'T IT, THAT THE EPISIOTOMIES ACTUALLY HAD A HIGHER COMPLICATION RATE THAN WAS ORIGINALLY THOUGHT; ISN'T THAT RIGHT?

A. YES, THE LITERATURE HAS SHOWN THAT IT IS NOT NECESSARY TO DO ROUTINE EPISIOTOMY NOW.

Q. AND, IN FACT, IN THE UNITED STATES TODAY, EPISIOTOMIES ARE NOT ROUTINE, CORRECT?

A. I HAVEN'T DONE PRENATAL -- I MEAN, DELIVERY SINCE 1998. AND AT THAT TIME THE EPISIOTOMY WAS OR WASN'T DONE DEPENDING ON WHAT WE WERE PRESENTED WITH AT THE TIME OF DELIVERY.

Q. THANK YOU.

WHEN YOU TALKED ABOUT THE INTACT D&E PROCEDURE IN SITUATIONS IN WHICH THE FETUS DID NOT DELIVER ENTIRELY, YOU SAID THERE WAS ONE OF TWO WAYS TO GET THE CALVARIUM OUT; IS THAT RIGHT?

A. THERE IS. EITHER I DISARTICULATED IT AT THE NECK, OR -- IN WHICH CASE IT WOULDN'T BE AN INTACT DELIVERY, OR KEPT THE FETUS INTACT AND COLLAPSED THE SKULL WITH MY FORCEPS.

Q. AND JUST SO I AM CLEAR, WHEN YOU ARE TALKING ABOUT THE CALVARIUM, YOU'RE TALKING ABOUT THE FETUS' HEAD, RIGHT?

A. THAT'S RIGHT.

Q. ALL RIGHT. CAN YOU TELL ME HOW YOU WOULD DISARTICULATE THE FETUS' HEAD IN COMPLETING AN INTACT D&E PROCEDURE?

A. I WOULD NOT DISARTICULATE THE HEAD IN AN INTACT D&E PROCEDURE.

Q. OKAY. I APOLOGIZE. YOU SAID YOU WOULD DISARTICULATE AT THE NECK; IS THAT CORRECT?

A. NOT -- THEN I SAID, "BUT THAT WOULD NOT BE AN INTACT."

Q. THAT WOULD NOT BE AN INTACT?

A. THAT'S RIGHT.

Q. UNDERSTOOD.

A. SO, I WAS TELLING YOU WHAT WOULD HAPPEN IF I WAS PRESENTED WITH THAT SITUATION OF HAVING DELIVERED EVERYTHING TO THE HEAD, RIGHT? THERE ARE TWO THINGS THAT YOU CAN DO. ONE WOULD RESULT IN AN INTACT.

Q. AND WHY WOULD THE HEAD -- IF YOU HAD DISARTICULATED AT THE NECK, WHY WOULD THAT NOT BE AN INTACT PROCEDURE?

A. BECAUSE THE FETUS IS NOT BROUGHT OUT INTACT OR RELATIVELY INTACT.

Q. AND IN COLLAPSING THE SKULL, HOW WOULD YOU GO ABOUT DOING

THAT IN COMPLETING AN INTACT PROCEDURE?

A. I DO IT WITH FORCEPS, BY OPENING AND CLOSING THE FORCEPS UNTIL THE SKULL COLLAPSES.

Q. AND DO YOU HAVE TO PUT THE FORCEPS INTO THE CERVICAL OS TO COLLAPSE THE SKULL?

A. YES.

Q. AND IS IT POSSIBLE THAT IN PUTTING THE FORCEPS INTO THE CERVICAL OS TO COLLAPSE THE SKULL YOU MIGHT CAUSE A PERFORATION? IS THAT A POSSIBILITY?

A. THAT WOULD BE PRETTY UNUSUAL. PERFORATIONS OF THE UTERINE WALL OCCUR MOST OFTEN AT THE TOP OF THE UTERUS. IT CAN OCCUR LOWER. BUT IT WOULD BE UNUSUAL, BECAUSE YOU ARE RIGHT THERE, AND YOU ARE JUST AT THE SKULL, AND YOU ARE JUST OPENING AND CLOSING IT AROUND THE SKULL. YOU ARE NOT MOVING THE FORCEPS THROUGHOUT THE UTERUS AS YOU DO IN A DISARTICULATION D&E.

SO I THINK THE CHANCES OF PERFORATION WOULD BE QUITE LOW.

Q. YOU MENTIONED EARLIER -- WE TALKED ABOUT WHAT YOU PERCEIVED TO BE THE INCREASED OR THE SAFETY ADVANTAGE OF INTACT D&E OVER A DISARTICULATION D&E. DO YOU CONSIDER THAT RISK TO BE SIMILAR TO THE ADVANTAGES YOU SAID ABOUT D&E VERSUS LABOR INDUCTION? I AM TRYING TO GET A SENSE OF HOW YOU QUANTIFY THE ADVANTAGES OF AN INTACT D&E PROCEDURE.

A. I THINK I ALREADY TESTIFIED THAT I DON'T -- IT IS NOT QUANTIFIED.

Q. DR. PAUL, WE TALKED OR YOU TALKED EARLIER TODAY ABOUT THE -- IT IS CALLED THE JPSA STUDIES FROM THE 1970'S, RIGHT?

AND YOU TESTIFIED THAT THOSE STUDIES SHOWS THAT D&E IS SAFER THAN LABOR INDUCTION BY INSTILLATION METHODS DURING THE FIRST HALF OF THE SECOND-TRIMESTER; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. AND THE TABLES THAT WERE IN THE JPSA STUDY WERE ALL FROM THE 1970'S; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. THERE ARE OTHER METHODS OF INDUCTION OTHER THAN THOSE INSTILLATIONS METHODS THAT WERE USED IN THE 1970'S; IS THAT RIGHT?

A. YES.

Q. VAGINAL OR ORAL PROSTAGLANDIN AGENTS ARE ONE FORM OF INDUCTION THAT WAS NOT CONSIDERED IN THAT STUDY; IS THAT RIGHT?

A. COULD I SEE THE TABLE AGAIN THAT YOU ARE REFERRING TO, BECAUSE CDC DID COLLECT DATA ON VAGINAL PROSTAGLANDINS THAT THEY LUMPED INTO A CATEGORY CALLED "OTHER." SO I WOULD NEED TO KNOW WHETHER THE TABLE YOU ARE REFERRING TO HAD THAT "OTHER" CATEGORY. AND I AM NOT GOING TO DO IT OFF THE TOP OF MY HEAD.

Q. DR. PAUL, I AM DIRECTING YOUR ATTENTION TO LEARNED TREATISE 15. LOOKING AT THE TABLE, I BELIEVE IT WAS TABLE SEVEN THAT WE WERE LOOKING AT EARLIER. IS THERE A CATEGORY OF "OTHER"?

A. I AM SORRY. I DON'T KNOW WHAT THE "LEARNED TREATISE 15" IS. WHAT IS THE TITLE OF THAT?

Q. I AM SORRY. THIS IS THE BINKIN ARTICLE. I AM SORRY.
A. OH.
THE COURT: IT IS THE LAST PAGE.
THE WITNESS: THANK YOU. OKAY.
BY MR. QUINLIVAN:
Q. DOES THE "OTHER" CATEGORY APPEAR IN THAT TABLE?
A. NO.
Q. AND OXYTOCIN IS ANOTHER METHOD OF LABOR INDUCTION THAT A PHYSICIAN MIGHT USE; IS THAT RIGHT?
A. THAT'S RIGHT.
Q. IN FACT, THE INSTILLATION METHODS THAT WERE ANALYZED IN THE JPSA STUDY I THINK YOU TESTIFIED ARE THE OLDER METHODS OF LABOR INDUCTION; IS THAT RIGHT?
A. YES. THEY ARE STILL USED, BUT IN A VERY SMALL PERCENTAGE OF CASES.
Q. AND JUST TO BE CLEAR, WHEN YOU TESTIFIED AS TO THE COMPARATIVE SAFETY OF D&E VERSUS LABOR INDUCTION BASED ON THOSE STUDIES, YOU WERE REFERRING TO THE OLDER METHODS OF LABOR INSTILLATION; IS THAT RIGHT?
A. IN RELATION TO THE JPSA --
Q. YES.
A. -- MORBIDITY STUDIES, YES.
Q. YES. THANK YOU.
AND I BELIEVE YOU MENTIONED THE AUTRY STUDY WHICH COMPARED THE NEWER METHODS OF LABOR INDUCTION WITH D&E; IS THAT

CORRECT?

A. THAT'S RIGHT.

Q. THE AUTRY STUDY WAS A RETROSPECTIVE COHORT STUDY, CORRECT?

A. THAT'S RIGHT.

Q. AND IT'S FAIR TO SAY THAT THE AUTRY ARTICLE SUFFERS FROM SOME METHODOLOGICAL FLAWS; ISN'T THAT RIGHT?

A. YES, ALL STUDIES DO.

Q. I APPRECIATE THAT, DOCTOR, BUT I AM ASKING YOU SPECIFICALLY ABOUT THE AUTRY ARTICLE. DOES IT SUFFER FROM SOME METHODOLOGICAL FLAWS?

A. YES.

Q. OKAY. AND WHAT IS THE PRIMARY METHODOLOGICAL FLAW OF THAT STUDY?

A. SELECTION BIAS.

Q. AND CAN YOU TELL US AGAIN WHAT "SELECTION BIAS" IS?

A. WELL, WHEN YOU DON'T RANDOMIZE WOMEN INTO TREATMENT GROUPS, THEN YOU CAN HAVE SOME FACTORS THAT ARE DIFFERENT THAN THE TWO GROUPS THAT YOU ARE TRYING TO COMPARE.

Q. AND WAS ONE ASPECT OF THE SELECTION BIAS THAT THE MEAN GESTATIONAL AGES THAT WERE BEING COMPARED IN THE AUTRY ARTICLE WERE DIFFERENT?

A. YES. THERE WAS ABOUT A TWO-WEEK DIFFERENCE, BUT THEY DID DO WHAT IS CALLED A MULTIPLE REGRESSION ANALYSIS WITH THE DIFFERENCE IN COMPLICATION RATES REMAINING AT THE CONTROL FOR THE GESTATIONAL AGE.

SO IT CERTAINLY DID NOT ACCOUNT FOR ALL OF THE FINDINGS.

Q. IS IT FAIR TO SAY, THOUGH, THAT A STUDY THAT COMPARES DIFFERENT ABORTION TECHNIQUES WHERE THE TWO GROUPS OF WOMEN HAVE DIFFERENT MEAN GESTATIONAL AGES, THAT THAT STUDY HAS SOME METHODOLOGICAL LIMITATIONS?

A. CAN YOU REPEAT THAT?

Q. SURE. IS IT FAIR TO SAY THAT A STUDY THAT COMPARES DIFFERENT ABORTION TECHNIQUES WHERE THE WOMEN IN EACH GROUP HAVE DIFFERENT MEAN GESTATIONAL AGES, THAT THAT STUDY HAS SOME METHODOLOGICAL LIMITATIONS?

A. YES, BUT YOU TRY TO CONTROL FOR ANALYSIS. AS I SAID, THEY DID THAT THROUGH MULTIPLE REGRESSION IN THIS STUDY.

Q. GOING BACK TO THE JPSA STUDY, YOU TESTIFIED THAT YOU BELIEVED THAT THE JPSA STUDY WITHIN THE CATEGORY OF D&E WAS INCLUDING SOME INTACT D&E PROCEDURES; IS THAT RIGHT?

A. YES.

Q. DO YOU KNOW THAT FOR A FACT?

A. I DON'T KNOW IT FOR A FACT. I JUST THINK IF YOU HAVE A QUARTER OF A MILLION WOMEN INCLUDED IN A STUDY AND GIVEN THAT YOU CAN'T PREDICT WHETHER, IN FACT, THE FETUS IS GOING TO DELIVER INTACT OR NOT, THERE IS NO WAY YOU CAN STUDY THAT MANY WOMEN AND HAVE EVERY D&E BE DISARTICULATION D&E. I THINK IT IS INFEASIBLE.

Q. YOU -- YOUR TEXTBOOK ON ABORTION METHODS I BELIEVE YOU

MENTIONED HAS A SECTION ENTITLED "INTACT D&E"; IS THAT CORRECT?
A. YES, IT DOES.
Q. AND I BELIEVE WHEN I ASKED YOU EARLIER ABOUT THE DR. HASKELL STUDY OR THE DR. HASKELL STUDY TO THE NATIONAL ABORTION FEDERATION FROM 1992, PRIOR TO THAT PRESENTATION, ARE YOU AWARE OF ANY REFERENCE TO "INTACT D&E" IN THE MEDICAL LITERATURE?
A. NO.
Q. DR. PAUL, YOU TESTIFIED ABOUT WHY YOU FEAR THAT IN PERFORMING AN INTACT D&E -- OR IN PERFORMING ANY D&E PROCEDURE YOU MIGHT BE SUBJECT TO LIABILITY UNDER THE ACT. IF A PHYSICIAN WERE TO GIVE AN INJECTION OF DIGOXIN OR POTASSIUM CHLORIDE TO ENSURE FETAL DEMISE PRIOR TO DOING A D&E PROCEDURE, WOULD THEY BE SUBJECT TO OR WOULD THEY BE VIOLATING THE ACT, IN YOUR VIEW?
A. NO, THEY WOULDN'T BE VIOLATING THE ACT. THEY CERTAINLY -- YOU KNOW, DIGOXIN HAS NOT REALLY BEEN FOUND TO BE EFFECTIVE, AND IT CARRIES RISK, SO I AM NOT SURE WHY YOU WOULD BRING THAT UP.
Q. WELL, LET ME ASK YOU: IN YOUR TEXTBOOK, YOU HAVE A SECTION ENTITLED: "FETICIDAL PROCEDURES," DON'T YOU?
A. YES.
Q. AND THE FETICIDAL PROCEDURES THAT ARE DESCRIBED IN YOUR TEXTBOOK INCLUDE INJECTIONS OF DIGOXIN OR INJECTIONS OF POTASSIUM CHLORIDE; ISN'T THAT RIGHT?
A. THAT'S RIGHT.

Q. AND THE STUDIES THAT YOU HAVE REVIEWED ABOUT DIGOXIN INJECTIONS HAVE GENERALLY SHOWN THAT THEY ARE SAFE; ISN'T THAT RIGHT?

A. GENERALLY. I KNOW OF ONE ARTICLE, WHICH I THINK I TESTIFIED TO IN MY DEPOSITION, THAT DR. DREY IS REVIEWING, THAT SHE MENTIONED TO ME. IT WAS A CASE, I BELIEVE, OF A CARDIAC COMPLICATION AFTER DIGOXIN ADMINISTRATION.

MS. GARTNER: YOUR HONOR, THIS SUBJECT IS OUTSIDE THE SCOPE OF THE DIRECT. I DON'T KNOW HOW STRICT YOU ARE GOING TO BE.

THE COURT: IS SHE ON YOUR LIST, AS WELL?

MS. GARTNER: YES.

THE COURT: ON YOUR LIST.

MR. QUINLIVAN: NO.

THE COURT: ALL RIGHT. THEN, YOU ARE LIMITED TO THE SCOPE. UNLESS YOU CROSS-DESIGNATED HER, THEN YOU MAY HAVE ALL THE LEEWAY YOU WISH.

MR. QUINLIVAN: OKAY.

THE COURT: AND CAN I ASK YOU, DOCTOR, TO SPELL THE NAME OF THE DOCTOR YOU JUST MENTIONED?

THE WITNESS: DR. DREY, D-R-E-Y. SHE IS TESTIFYING LATER.

BY MR. QUINLIVAN:

Q. DR. PAUL, I BELIEVE IN THE EXHIBIT BOOK I WOULD LIKE YOU TO TAKE A LOOK AT DEFENDANT'S EXHIBIT A-81.

THE COURT: DO YOU HAVE IT? I AM NOT SO SURE SHE HAS AN EXHIBIT BOOK.

MR. QUINLIVAN: OH, LET ME -- SORRY, YOUR HONOR. I THOUGHT THEY WERE OFF TO THE SIDE.

THE COURT: DO YOU HAVE AN EXTRA COPY OF IT?

MR. QUINLIVAN: I AM GOING TO GET IT, YOUR HONOR.

I CAN EXPLAIN WE ONLY RECEIVED THE REDACTED VERSION OF THIS THIS MORNING.

THE COURT: THAT IS WHY YOU DON'T HAVE IT?

MR. QUINLIVAN: THAT'S RIGHT.

THE COURT: HOW WOULD YOU LIKE TO PROCEED?

MR. QUINLIVAN: I HAVE A COPY FOR THE WITNESS AND FOR YOUR HONOR.

THE COURT: OKAY.

DOES OPPOSING COUNSEL HAVE A COPY?

MS. GARTNER: WE HAVE A COPY.

THE COURT: ALL RIGHT.

MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DR. PAUL, I AM SHOWING YOU WHAT HAS BEEN MARKED AS DEFENDANT'S EXHIBIT A-81. I WOULD LIKE TO ASK YOU TO REVIEW THAT DOCUMENT AND TO TELL ME IF IT REVEALS THAT IT WAS AN INTACT D&E PROCEDURE THAT WAS USED.

MS. GARTNER: YOUR HONOR, WE OBJECT ON THE GROUNDS THAT HE HASN'T LAID THE FOUNDATION THAT THIS WITNESS IS FAMILIAR WITH THIS DOCUMENT.

THE COURT: YOU DO NEED TO BEFORE YOU ASK HER QUESTIONS. YOU MAY AS WELL DO IT BEFORE SHE REVIEWS IT.

MR. QUINLIVAN: THAT'S FINE.

BY MR. QUINLIVAN:

Q. DR. PAUL, I AM SHOWING YOU WHAT HAS BEEN MARKED AS DEFENSE EXHIBIT A-81. HAVE YOU EVER SEEN THIS DOCUMENT BEFORE?

A. YES.

Q. CAN YOU TELL ME WHAT IT IS?

A. IT'S A MEDICAL RECORD FROM PLANNED PARENTHOOD GOLDEN GATE.

Q. IF IT YOU LOOK AT THE BOTTOM RIGHT-HAND CORNER THERE IS A NOTATION "PPGG" AND THE FIRST PAGE 000282. DO YOU UNDERSTAND "PPGG" TO BE PLANNED PARENTHOOD -- PLANNED PARENTHOOD GOLDEN GATE?

A. YES.

Q. AND IS THIS MEDICAL RECORD PREPARED IN THE NORMAL COURSE OF BUSINESS AT PLANNED PARENTHOOD GOLDEN GATE?

A. YES.

Q. AND IS IT PREPARED CONTEMPORANEOUSLY WITH THE MEDICAL PROCEDURE THAT IS BEING PERFORMED?

A. BEFORE, DURING, AFTER.

Q. DR. PAUL, I WOULD LIKE TO ASK YOU TO REVIEW THAT DOCUMENT, AND TELL ME, IF YOU CAN, WHETHER IT REVEALS THAT AN INTACT D&E

PROCEDURE WAS PERFORMED?

A. IT REVEALS THAT AN INTACT D&E PROCEDURE WAS NOT PERFORMED.

Q. AND CAN YOU POINT ME TO THE PAGE WHICH -- OR PAGES WHICH REVEAL THAT?

A. ARE THEY NUMBERED?

THE COURT: IF YOU WOULD JUST USE WHAT WE REFER TO AS THE BATES NUMBER. THAT'S THE NUMBERS FOLLOWING THE "PPGG."

THE WITNESS: OKAY.

THE COURT: JUST REFER TO THE LAST THREE DIGITS.

THE WITNESS: OKAY. FIRST OF ALL, THIS IS MY HANDWRITING, SO I PERFORMED THIS PROCEDURE.

BY MR. QUINLIVAN:

Q. DO YOU -- SITTING HERE TODAY, DO YOU RECALL SPECIFICALLY THIS PARTICULAR PROCEDURE?

A. NO, ONLY AS I HAVE IN THE MEDICAL RECORDS, IT IS MY HANDWRITING. I KNOW I DID THIS PROCEDURE.

BUT, UNFORTUNATELY, MY COPY DOES NOT HAVE THAT NUMBER ON ALL THE PAGES SO --

Q. ON SOME OF THE PAGES IT IS ACTUALLY -- YOU WILL FIND IT AT DIFFERENT PARTS ON DIFFERENT PAGES.

A. OH, I SEE.

Q. SOMETIMES IT'S IN THE CENTER BOTTOM.

A. OKAY. THEN, I STILL DON'T SEE IT. BUT IT WOULD BE 000289 IS THE ONE FOLLOWING 288.

Q. AND WHAT PART OF THAT RECORD TELLS YOU THAT AN INTACT D&E

PROCEDURE WAS NOT PERFORMED?

A. IT SAYS:

"CALVARIUM TRAPPED IN FUNDUS-UNABLE TO EXTRACT.

CALVARIUM TRAPPED IN FUNDUS," WHICH IS THE TOP OF THE UTERUS. "UNABLE TO EXTRACT." SO I HAD DELIVERED ALL OF THE REST OF THE PREGNANCY EXCEPT FOR THE HEAD, WHICH GOT TRAPPED IN THE TOP OF THE UTERUS, AND I WAS UNABLE TO EXTRACT IT.

SO IT IS ONE OF THE FEW RECORDS I CAN LOOK AT AND ACTUALLY SAY I KNOW IT WAS NOT INTACT.

Q. THANK YOU. THANK YOU, DOCTOR.

DR. PAUL, IS IT FAIR TO SAY THAT WHEN YOU BEGIN ANY D&E PROCEDURE, YOU DON'T KNOW WHETHER IT'S GOING TO RESULT IN AN INTACT DELIVERY?

A. THAT'S RIGHT.

Q. AT WHAT POINT ARE YOU ABLE TO DETERMINE WHEN THE FETUS WILL BE ABLE TO BE DELIVERED INTACT?

A. WHEN I EXTRACT THE FETUS.

Q. IS IT FAIR TO SAY THAT AT THAT POINT IN TIME HOW THE D&E OR DISARTICULATION D&E PROCEEDS AND HOW AN INTACT D&E PROCEEDS ARE VERY DIFFERENT?

A. IN WHAT RESPECTS?

Q. WELL, LET ME ASK YOU A MORE SPECIFIC QUESTION. DO YOU USE A SUCTION CANNULA WHEN YOU PERFORM AN INTACT D&E PROCEDURE?

A. AS I TESTIFIED EARLIER, I SOMETIMES USE A SUCTION CANNULA

TO EVACUATE THE AMNIOTIC FLUID OR SOMETIMES I DRAIN THE FLUID.
Q. DO YOU USE A SUCTION CANNULA FOR ANY OTHER REASON WHEN PERFORMING AN INTACT D&E PROCEDURE?
A. I USE A SUCTION CANNULA AFTER EXTRACTING THE FETUS TO REMOVE ANY PLACENTA.
Q. DR. PAUL, I BELIEVE YOU TESTIFIED THAT AT PLANNED PARENTHOOD GOLDEN GATE THE CLINICS PERFORM ABORTIONS UP TO 18 WEEKS, SIX DAYS GESTATIONAL AGE?
A. THAT'S RIGHT.
Q. AND IN YOUR PREVIOUS EMPLOYMENT YOU PERFORMED ABORTIONS AT HIGHER GESTATIONAL AGES?
A. DURING RESIDENCY.
YOU MEAN, BY D&E?
Q. BY D&E, YES.
A. YES.
Q. IN PERFORMING A D&E AT 20 WEEKS GESTATIONAL AGE OR ABOVE, HAVE YOU EVER --
MR. QUINLIVAN: STRIKE THAT.
BY MR. QUINLIVAN:
Q. IN PERFORMING AN INTACT D&E AT -- I AM SORRY.
IN PERFORMING A D&E AT 20 WEEKS GESTATIONAL AGE AND ABOVE, IN YOUR PREVIOUS CAPACITY, WAS THERE EVER A TIME WHEN YOU SAW ANY INDICATION THAT THE FETUS WAS EXPERIENCING PAIN?
A. I HAVE NO IDEA WHAT THAT MEANS.
MS. GARTNER: THIS IS OUTSIDE THE SCOPE OF THE

DIRECT, AND DR. PAUL SPECIFICALLY TESTIFIED IN HER DEPOSITION THAT SHE WAS NOT GOING TO BE TESTIFYING ABOUT THIS SUBJECT.

THE COURT: SUSTAINED.

MR. QUINLIVAN: SUSTAINED?

THE COURT: YES.

MR. QUINLIVAN: NOTHING FURTHER.

THE COURT: ALL RIGHT. THANK YOU.

ANY REDIRECT?

MS. GARTNER: I DO HAVE ONE QUESTION, YOUR HONOR.

REDIRECT EXAMINATION

BY MS. GARTNER:

Q. DR. PAUL, WITH RESPECT TO THE MEDICAL CHART THAT YOU JUST REVIEWED, IS IT YOUR TESTIMONY THAT THE CALVARIUM -- WHAT WAS THE EXACT LANGUAGE THAT WAS USED IN THAT MEDICAL CHART TO DESCRIBE THE CALVARIUM?

A. "CALVARIUM TRAPPED IN FUNDUS."

Q. AND IS THAT SOMETHING THAT MAKES THE -- WHEN THAT OCCURS, DOES THAT MAKE THE PROCEDURE MORE DIFFICULT TO COMPLETE?

A. ABSOLUTELY. IT IS ACTUALLY ONE OF THE SCARIEST THINGS I SEE HAPPEN DURING A D&E.

Q. IN THIS PARTICULAR SITUATION, WHAT DID YOU DO TO DELIVER THE HEAD, THE CALVARIUM?

A. WHAT YOU DON'T WANT TO DO IS TO BE REACHING HIGH UP WITH YOUR FORCEPS TO TRY AND BRING DOWN THE CALVARIUM THAT IS DETACHED AND TRAPPED AT THE FUNDUS, BECAUSE YOU REALLY HAVE A

PERFORATION RISK WHEN YOU DO THAT. SO WHAT I DID WAS TO GIVE PITOCIN, AND SENT THE WOMAN TO THE RECOVERY ROOM AND GAVE HER PITOCIN FOR AWHILE. IT CONTRACTS THE UTERUS AND BRINGS THE PREGNANCY ELEMENTS DOWN TO MY FORCEPS IN A WAY THAT I CAN EXTRACT IT SAFELY. AND THAT IS, IN FACT, WHAT WE DID.

Q. AND WHAT IS PITOCIN?

A. PITOCIN IS AN AGENT THAT'S USED ALSO IN INDUCTION ABORTIONS TO CAUSE CONTRACTIONS TO HELP BRING THE PREGNANCY OUT.

Q. AND THE SITUATION WHERE THAT CALVARIUM IS TRAPPED HIGH UP IN THE FUNDUS, WOULD THAT EVER OCCUR --

MR. QUINLIVAN: YOUR HONOR, I HAVE AN OBJECTION. IT WAS MY UNDERSTANDING THAT THE ONLY WAY THAT THESE RECORDS WOULD BE USED IS IF THEY REVEALED AN INTACT PROCEDURE.

WHEN DR. PAUL TESTIFIED THAT THIS RECORD DID NOT EVINCE OR REVEAL AN INTACT PROCEDURE, I CEASED MY QUESTIONING ABOUT IT. SO I DON'T BELIEVE PLAINTIFFS ARE ENTITLED TO ASK QUESTIONS ABOUT IT. AND I WOULD ASK THAT THIS LINE OF QUESTIONING BE -- LINE OF QUESTIONING BE STRICKEN FROM THE RECORD.

MS. GARTNER: YOUR HONOR, MY UNDERSTANDING OF YOUR RULING -- AND I MAY HAVE MISUNDERSTOOD IT -- WAS THAT THE DOCUMENTS, THE MEDICAL RECORDS COULD ONLY BE INTRODUCED INTO EVIDENCE IN THE CASE IF THEY SPECIFICALLY REVEALED THE EXISTENCE OF AN INTACT PROCEDURE. WE WOULD NOT HAVE EVEN BROUGHT THIS RECORD TO DR. PAUL'S ATTENTION. THE GOVERNMENT

DID.

BUT I THINK ACTUALLY THIS PROCEDURE REVEALED POTENTIALLY ANOTHER ADVANTAGE OF INTACT EXTRACTION VERSUS DISARTICULATION D&E, IN THAT AN INTACT EXTRACTION -- THIS COMPLICATION WOULDN'T OCCUR --

THE COURT: I CAN CLARIFY. MY RULING WAS A THRESHOLD RULING I WOULD ONLY ALLOW INTO EVIDENCE THOSE MEDICAL RECORDS THAT SHOWED THAT AN INTACT PROCEDURE WAS USED. HOWEVER, IT CERTAINLY -- SINCE YOU OPENED THE QUESTIONING ON THIS PARTICULAR DOCUMENT, IF YOU WISH TO PROCEED FURTHER ON IT, YOU MAY DO SO.

I DON'T QUITE KNOW WHY THIS ONE WAS SHOWN AT ALL, BUT SINCE YOU HAVE ALREADY OPENED THE DOOR, I WILL ALLOW YOU TO ASK QUESTIONS ON THIS PARTICULAR DOCUMENT.

MS. GARTNER: THANK YOU, YOUR HONOR.

BY MS. GARTNER:

Q. DR. PAUL, IN ABORTIONS, D&E ABORTIONS IN WHICH YOU ARE ABLE TO EXTRACT THE FETUS INTACT TO THE POINT WHERE THE CALVARIUM LODGES AT THE CERVIX, DO YOU EVER ENCOUNTER THE SITUATION WHERE THE CALVARIUM BECOMES TRAPPED IN THE FUNDUS OF THE UTERUS?

A. NO.

Q. IS THAT AN ADDITIONAL SAFETY ADVANTAGE IN YOUR OPINION OF AN INTACT EXTRACTION DURING A D&E PROCEDURE?

A. ABSOLUTELY. ONE OF THE PERFORATIONS I HAD WAS EXACTLY WHEN I HAD TO GO AFTER A TRAPPED CALVARIUM. I REMEMBER IT.

Q. THANK YOU.

THE COURT: DID YOU WANT TO ASK FOLLOW UP ON THAT?

MR. QUINLIVAN: I DO, JUST VERY BRIEFLY, YOUR HONOR.

RECROSS-EXAMINATION

BY MR. QUINLIVAN:

Q. DR. PAUL, IF YOU COULD DIRECT YOUR ATTENTION TO THE PAGE THAT HAS BEEN MARKED OR BATES-STAMPED PPGG000291?

A. OKAY.

Q. MIDWAY THROUGH THE PAGE -- OH, LET HE ASK YOU FIRST: IS THAT YOUR HANDWRITING?

A. YES.

Q. MIDWAY THROUGH THE PAGE IT LOOKS -- IS THAT AN A WITH THEN THE WORDS "EXAM"?

A. YES.

Q. AND AM I CORRECT THAT IT THEN SAYS:

"NO CERVICAL LACERATIONS. NO BLEEDING EVIDENT AT MOMENT -- AT THE MOMENT"?

A. YES.

Q. AND IS THERE ANY EVIDENCE THAT THERE WAS A CERVICAL LACERATION DURING THIS PROCEDURE?

A. NO, THERE WASN'T.

MR. QUINLIVAN: NOTHING FURTHER, YOUR HONOR.

THE COURT: ALL RIGHT.

BEFORE I FORGET, MS. MORRIS, YOU KNOW, I OVERLOOKED AFTER THE EXAMINATION. I FORGET WHAT WE DECIDED WITH REGARD TO

THE CITY AND COUNTY OF SAN FRANCISCO. I NEGLECTED TO ASK YOU IF YOU WANTED TO DO ANY FOLLOW-UP QUESTIONS AFTER MS. GARTNER HAD DIRECT EXAMINATION.

WHAT ARRANGEMENTS HAVE YOU ALL MADE IN THAT REGARD? ARE YOU GOING TO TAKE SOME WITNESSES?

MS. MORRIS: THE ATTORNEYS FOR PLANNED PARENTHOOD ARE PUTTING ON ALL THE WITNESSES IN THEIR CASE-IN-CHIEF ON DIRECT. I HOPE TO PUT ON DR. DREY JUST FOR PURPOSES OF BEING OUR PERCIPIENT WITNESS TO ESTABLISH THE FACTS OF THE CITY AND COUNTY OF SAN FRANCISCO AS IT RELATES TO SAN FRANCISCO GENERAL HOSPITAL.

I KNOW THAT YOU SAID EARLIER THAT YOU ONLY WANTED ONE ATTORNEY PER WITNESS. WE ARE HOPING THAT I CAN PUT HER ON DIRECT FOR PERCIPIENT PURPOSES, AND PLANNED PARENTHOOD CAN PUT HER ON FOR EXPERT PURPOSES.

THE COURT: DOES THAT MEAN YOU WON'T BE QUESTIONING ON DIRECT THE OTHER WITNESSES DESIGNATED BY PLAINTIFFS?

MS. MORRIS: YES, THAT'S CORRECT.

THE COURT: ALL RIGHT. THEN I WILL -- ALL RIGHT. THANK YOU.

ALL RIGHT. PLEASE CALL YOUR NEXT WITNESS.

MS. KRASNOFF: YOUR HONOR, THE PLAINTIFFS CALL SUELLEN CRAIG.

THE COURT: ALL RIGHT. AND, MS. ADLER, YOU WILL BE HANDLING THE EXAMINATION?

MS. KRASNOFF: I'M MS. KRASNOFF.

THE COURT: MS. KRASNOFF, YOU WILL BE HANDLING THE EXAMINATION?

MS. KRASNOFF: YES.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

SUELLEN CRAIG

CALLED AS A WITNESS FOR THE PLAINTIFFS, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

THE WITNESS: YES.

THE CLERK: PLEASE STATE YOUR NAME FOR THE RECORD.

THE WITNESS: SUELLEN CRAIG.

THE CLERK: SPELL YOUR LAST NAME.

THE WITNESS: C-R-A-I-G.

DIRECT EXAMINATION

BY MS. KRASNOFF:

Q. MS. CRAIG, WHAT IS YOUR CURRENT POSITION?

A. I AM SENIOR VICE PRESIDENT FOR THE EXECUTIVE OFFICE OF PLANNED PARENTHOOD FEDERATION OF AMERICA.

Q. AND IS IT OKAY IF I REFER TO THAT ORGANIZATION BY THE ACRONYM "PPFA"?

A. YES.

Q. HOW LONG HAVE YOU BEEN WITH PPFA?

A. I HAVE BEEN THERE ALMOST SEVEN YEARS.

Q. HOW LONG HAVE YOU HELD YOUR CURRENT POSITION?

A. A LITTLE OVER A YEAR.

Q. IN YOUR CURRENT POSITION, WHAT ARE YOUR JOB RESPONSIBILITIES?

A. MY JOB RESPONSIBILITIES IN THE GENERAL FORM ARE TO PROVIDE LEADERSHIP TO THE STAFF WHO WORK WITH THE PRESIDENT OF PPFA, THE BOARD OF DIRECTORS AND THE AFFILIATES.

Q. WOULD IT BE FAIR TO SAY THAT YOU ARE FAMILIAR WITH THE OPERATIONS OF PPFA?

A. YES, I AM.

Q. AND PRIOR TO YOUR CURRENT POSITION WHAT POSITION DID YOU HOLD?

A. I WAS VICE PRESIDENT FOR AFFILIATE SERVICES AT PPFA.

Q. AND HOW LONG WERE YOU VICE PRESIDENT FOR AFFILIATE SERVICES?

A. APPROXIMATELY SIX YEARS.

Q. WHAT WERE YOUR JOB RESPONSIBILITIES IN THAT JOB?

A. LARGELY THE SAME, EXCEPT IT WAS MUCH MORE DIRECTED AT THE AFFILIATES.

Q. WHAT IS PPFA? HOW WOULD YOU DESCRIBE IT?

A. PPFA IS A NONPROFIT ORGANIZATION WHOSE JOB REALLY IS -- SORRY. IT'S A NONPROFIT ORGANIZATION THAT IS PROVIDING LEADERSHIP IN THE FIELD OF REPRODUCTIVE HEALTH CARE.

Q. AND WHERE IS PPFA HEADQUARTERED?

A. NEW YORK CITY.

Q. DOES IT HAVE OTHER OFFICES?

A. YES. WE HAVE DOMESTIC OFFICES IN CHICAGO, SAN FRANCISCO,

HOUSTON, MIAMI, WASHINGTON, D.C. AND PHILADELPHIA.

Q. DO THEY HAVE INTERNATIONAL OFFICES, AS WELL?

A. YES.

Q. WHERE ARE THOSE?

A. THEY ARE IN BANGKOK. OUR LATIN AMERICAN OFFICE IS ACTUALLY IN MIAMI, FLORIDA, AND NAIROBI.

Q. IS THAT IT?

A. YES, THAT'S IT.

Q. HOW MANY PEOPLE WORK FOR PPFA?

A. APPROXIMATELY 300.

Q. DOES PPFA HAVE A STATED MISSION?

A. YES. OUR MISSION REALLY IS TO PROVIDE -- HELP PROVIDE ACCESS OR ASSURE ACCESS TO REPRODUCTIVE HEALTH CARE FOR MEN AND WOMEN WITH PRIVACY AND CONFIDENTIALITY.

Q. DOES PPFA ITSELF PROVIDE MEDICAL SERVICES?

A. NO, WE DO NOT.

Q. WHO PROVIDES THOSE SERVICES?

A. OUR AFFILIATES.

Q. HOW MANY MEMBER AFFILIATES DOES PPFA HAVE?

A. AT THE MOMENT WE ARE 123.

Q. WHERE ARE THEY LOCATED?

A. THEY ARE LOCATED IN EVERY STATE OF THE UNION PLUS THE DISTRICT OF COLUMBIA.

Q. AND HOW MANY HEALTH CENTERS DO THOSE AFFILIATES OPERATE?

A. APPROXIMATELY 866.

Q. IS PLANNED PARENTHOOD GOLDEN GATE ONE OF PPFA'S MEMBER AFFILIATES?

A. YES, IT IS.

Q. AND WHEN I SAY "A MEMBER AFFILIATE OF PPFA," WHAT DOES IT MEAN TO YOU TO BE A MEMBER AFFILIATE OF PPFA?

A. AN AFFILIATE OF PPFA PROVIDES -- IS SEPARATELY INCORPORATED NONPROFIT ORGANIZATION WITH ITS OWN CEO, ITS OWN BOARD OF DIRECTORS. IT PROVIDES A GENERAL MEDICAL AND EDUCATIONAL SERVICES TO ITS COMMUNITY OR COMMUNITIES.

Q. AND YOU SAID THE NATIONAL ORGANIZATION DOESN'T PROVIDE MEDICAL SERVICES. WHAT DO THEY DO DIFFERENTLY FROM THE MEMBER AFFILIATES?

A. IT DOES TWO THINGS. WE PROVIDE SUPPORT AND LEADERSHIP TO THE AFFILIATES. AND WE ALSO DO THINGS ON A NATIONAL BASIS THAT AFFILIATES CAN'T DO INDIVIDUALLY OR IN SMALLER GROUPS, SUCH AS ADVOCACY.

Q. ARE THERE ANY REQUIREMENTS THAT THE ORGANIZATION HAS TO MEET IN ORDER TO BE A PPFA MEMBER AFFILIATE?

A. YES, WE HAVE STANDARDS OF AFFILIATION IN OUR NATIONAL BYLAWS.

Q. ARE YOU FAMILIAR WITH THE BYLAWS OF PPFA?

A. YES, I AM.

MS. KRASNOFF: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. KRASNOFF:

Q. MS. CRAIG, I AM HANDING YOU WHAT IS MARKED AS EXHIBIT 27.

MS. CRAIG, ARE THOSE THE CURRENT BYLAWS OF PPFA?

A. YES, THEY ARE.

Q. AND ARE THOSE PREPARED IN THE ORDINARY COURSE OF BUSINESS OF PPFA?

A. YES, THEY ARE.

MS. KRASNOFF: YOUR HONOR, I WOULD LIKE TO MOVE THOSE BYLAWS, EXHIBIT 27, INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. CLARK: NO OBJECTION.

THE COURT: THEY WILL BE ADMITTED.

THE CLERK: 27 INTO EVIDENCE.

(PLAINTIFF'S EXHIBIT 27
WAS RECEIVED IN EVIDENCE.)

BY MS. KRASNOFF:

Q. MS. CRAIG, YOU MENTIONED THAT THE AFFILIATES NEED TO MEET THE STANDARDS OF AFFILIATION THAT ARE IN THE BYLAWS. WHAT ARE THOSE?

A. THOSE ARE THE REQUIREMENTS FOR -- THAT AFFILIATES NEED TO MEET AND CONTINUE TO MEET IN ORDER TO BE ABLE TO CARRY THE NAME "PLANNED PARENTHOOD."

Q. ARE THERE ANY REQUIREMENTS THAT AFFILIATES MUST FOLLOW THAT DO NOT APPEAR -- I'M SORRY. ARE THERE ANY REQUIREMENTS THAT AFFILIATES NEED TO MEET THAT DO NOT APPEAR IN THE BYLAWS; THAT

THEY NEED TO MEET IN ORDER TO CARRY THE PLANNED PARENTHOOD NAME?

A. NO.

MS. KRASNOFF: MAY I APPROACH AGAIN?

THE COURT: YES.

BY MS. KRASNOFF:

Q. I AM GOING TO HAND YOU EXHIBIT NUMBER 26, WHICH IS A FACT SHEET OF PLANNED PARENTHOOD FEDERATION OF AMERICA ENTITLED "PLANNED PARENTHOOD SERVICES, 2002."

ARE YOU FAMILIAR WITH THAT DOCUMENT?

A. YES, I AM.

Q. AND IS THIS A TRUE AND CORRECT COPY OF A FACT SHEET FROM PLANNED PARENTHOOD FEDERATION OF AMERICA?

A. APPEARS TO BE.

Q. AND IS IT A DOCUMENT THAT PPFA PREPARES IN ITS ORDINARY COURSE OF BUSINESS?

A. YES.

MS. KRASNOFF: YOUR HONOR, WE WOULD LIKE TO MOVE THE FACT SHEET INTO EVIDENCE, AS WELL, EXHIBIT 26.

MS. CLARK: YOUR HONOR, WE OBJECT ON HEARSAY GROUNDS AND ON RELEVANCE GROUNDS.

THE COURT: ALL RIGHT. WHAT PARTICULAR HEARSAY EXCEPTION ARE YOU RELYING ON, COUNSEL?

MS. KRASNOFF: IT IS A BUSINESS RECORD OF PLANNED PARENTHOOD. MS. CRAIG IS FAMILIAR AND AN APPROPRIATE WITNESS

TO SAY IT IS A DOCUMENT PREPARED BY PPFA.

THE COURT: AND WITH REGARD TO THE RELEVANCE OBJECTION?

MS. KRASNOFF: YOUR HONOR, IT GOES TO JUST PPFA'S STANDING, WHO IT IS, THE SERVICES THAT ITS AFFILIATES PROVIDE. AND INCLUDED IN THERE IS THE NUMBER OF ABORTIONS IT PROVIDES, FOR EXAMPLE.

THE COURT: AND YOU HAVE YET ANOTHER OBJECTION?

MS. CLARK: AND OUR LAST OBJECTION IS THAT THIS DOCUMENT WAS NOT DISCLOSED UNDER RULE 26 INITIAL DISCLOSURES. FIRST TIME WE SAW THIS WAS ON THEIR EXHIBIT LIST A WEEK OR TWO AGO.

THE COURT: ALL RIGHT. I THINK THAT IS SUFFICIENT NOTICE FOR THIS KIND OF EXHIBIT. I WILL ALLOW IT IN AS A BUSINESS RECORD.

THE CLERK: TWENTY-SIX INTO EVIDENCE.

THE COURT: YES.

(PLAINTIFF'S EXHIBIT 26
WAS RECEIVED IN EVIDENCE.)

BY MS. KRASNOFF:

Q. MS. CRAIG, YOU CAN REFER TO THAT DOCUMENT IF IT HELPS YOU.

WHAT ARE THE MOST FREQUENT SERVICES PROVIDED BY A PLANNED PARENTHOOD MEMBER AFFILIATE?

A. THE MOST FREQUENT ARE CONTRACEPTIVE SERVICES, WHICH ARE ABOUT 2 MILLION A YEAR. THE OTHER ONES THAT ARE AS -- ARE NOT

QUITE AS FREQUENT. ABOUT A MILLION A YEAR ARE PREGNANCY TESTS, BREAST EXAMS AND PROCEDURES FOR SEXUALLY-TRANSMITTED INFECTIONS.

Q. DO ALL PPFA MEMBER AFFILIATES PROVIDE THE SAME MEDICAL SERVICES?

A. NO, THEY DO NOT.

Q. DO SOME PPFA AFFILIATES PROVIDE ABORTION SERVICES?

A. YES, THEY DO.

Q. AND DO YOU KNOW HOW MANY OF THE PPF -- OF THE 123 MEMBER AFFILIATES PROVIDE ABORTION SERVICES?

A. AROUND 70.

Q. DO YOU KNOW HOW MANY OF THOSE 70 PROVIDE ABORTION SERVICES AFTER 13.6 WEEKS, AS MEASURED FROM THE FIRST DAY OF THE WOMEN'S LAST MENSTRUAL PERIOD?

A. APPROXIMATELY HALF.

Q. DO YOU KNOW WHAT THE LATEST GESTATIONAL AGE WHICH ANY PPFA MEMBER AFFILIATE PERFORMS ABORTIONS?

A. TWENTY-FOUR WEEKS.

Q. IN 2002, HOW MANY ABORTIONS DID PPFA MEMBER AFFILIATES PERFORM?

A. APPROXIMATELY 227,000, WHICH IS ABOUT 5 PERCENT OF OUR SERVICES.

Q. AND HOW MANY OF THOSE ABORTIONS WERE AFTER 13.6 WEEKS LMP?

A. ABOUT 12,000.

Q. DOES PPFA HAVE ANY REQUIREMENTS THAT THE AFFILIATES MUST

FOLLOW RELATED TO THE PROVISION OF THEIR MEDICAL SERVICES?

A. YES, WE HAVE MEDICAL STANDARDS AND GUIDELINES.

Q. WHAT ARE THE MEDICAL STANDARDS AND GUIDELINES.

A. BASICALLY WHAT IT SAYS THEY ARE. THEY ARE BOTH STANDARDS THAT ARE MUST DO'S FOR OUR AFFILIATES, AND THE GUIDELINES ARE SHOULD DO'S.

Q. WHO WRITES THOSE STANDARDS AND GUIDELINES?

A. THOSE ARE WRITTEN BY THE MEDICAL DIVISION AT PPFA.

Q. DOES THE MEDICAL DIVISION AT PPFA INCLUDE LICENSED MEDICAL PERSONNEL?

A. YES, THE VICE PRESIDENT FOR MEDICAL SERVICES IS AN OB/GYN. AND OTHER STAFF INCLUDE NURSES AND NURSE PRACTITIONERS.

Q. HAVE YOU EVER WORKED IN OR OVERSEEN THE MEDICAL DIVISION?

A. NO, I HAVE NOT.

Q. DO YOU KNOW HOW PPFA ASSURES THAT THE AFFILIATES ARE MEETING THE MEDICAL STANDARDS AND GUIDELINES UNDER STANDARDS OF AFFILIATION?

A. YES, WE HAVE AN ACCREDITATION PROCESS.

Q. AND ARE YOU FAMILIAR WITH THAT PROCESS?

A. YES, I AM, BECAUSE I USED TO SUPERVISE THAT DEPARTMENT.

Q. COULD YOU TELL US WHAT HAPPENS IN THAT PROCESS?

A. YES. APPROXIMATELY EVERY FOUR YEARS A TEAM OF PEOPLE GO TO AN AFFILIATE TO LOOK AT ALL KINDS OF RECORDS: PERSONNEL RECORDS, MEDICAL RECORDS, GENERAL BUSINESS RECORDS, AND WATCH THE SERVICES THAT ARE BEING PROVIDED, AS WELL.

Q. ARE PHYSICIANS INVOLVED IN THAT ACCREDITATION REVIEW PROCESS?

A. IF THE AFFILIATE HAS PROVIDED SURGICAL SERVICES, A PHYSICIAN IS INCLUDED.

Q. AND WHAT IS THE ROLE OF THE PHYSICIAN?

A. TO -- MOSTLY TO WATCH THE SURGICAL SERVICES.

Q. YOU MENTIONED THAT THE PROCESS INCLUDES A REVIEW OF MEDICAL RECORDS? WHAT IS DONE WITH THE MEDICAL RECORDS DURING THE ACCREDITATION PROCESS?

A. DURING THE ACCREDITATION PROCESS THE RECORDS ARE PULLED AT RANDOM. THE ARE REVIEWED, AND THEN TURNED BACK TO THE AFFILIATE.

Q. ARE THEY EVER COPIED?

A. NO.

Q. ARE THEY EVER REMOVED FROM THE PREMISES OF THE AFFILIATE?

A. NO.

Q. AND OTHER THAN THIS PROCESS WE WERE JUST TALKING ABOUT MEETING THE STANDARDS OF AFFILIATION, IF SOMEONE FROM PPFA SOUGHT MEDICAL RECORDS FROM A MEMBER AFFILIATE, IS THAT AFFILIATE UNDER ANY OBLIGATION TO PROVIDE THEM TO PPFA?

A. NO, OTHER THAN THE STANDARDS OF AFFILIATION.

MS. KRASNOFF: I HAVE NO FURTHER QUESTIONS FOR MS. CRAIG.

THE COURT: ALL RIGHT, CROSS-EXAMINATION?

CROSS-EXAMINATION

BY MS. CLARK:

Q. MS. CRAIG, MY NAME IS KAIJA CLARK. I DON'T THINK I HAVE MET YOU BEFORE.

A. NO.

Q. MS. CRAIG, DID YOU HAVE ANY ROLE IN RESPONDING TO THE GOVERNMENT'S REQUEST FOR DISCOVERY IN THIS CASE?

A. YES.

Q. I WOULD LIKE TO SHOW YOU WHAT HAS BEEN MARKED AS DEFENDANT'S A-41.

MS. CLARK: MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. CLARK:

Q. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. YES, I HAVE.

Q. WHAT IS IT?

A. IT'S MY AFFIDAVIT FOR THIS CASE.

Q. HAVE YOU SEEN THE ENTIRE DOCUMENT?

A. YES, I HAVE.

Q. IF YOU TURN TO THE VERY LAST PAGE?

A. YES.

Q. IS THAT YOUR SIGNATURE ON THE LAST PAGE?

A. YES, IT IS.

Q. AND YOU DECLARED UNDER PENALTY OF PERJURY THAT THIS SUPPLEMENTAL RESPONSES TO PLANNED PARENTHOOD FEDERATION OF AMERICA'S RESPONSES AND OBJECTIONS TO DEFENDANT'S FIRST SET OF

INTERROGATORIES AND DOCUMENT REQUESTS WERE TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE AND BELIEF; IS THAT CORRECT?

A. THAT'S CORRECT.

MS. CLARK: YOUR HONOR, DEFENDANT MOVES INTO EVIDENCE DEFENDANT'S EXHIBIT A-41, SPECIFICALLY INTERROGATORY REQUESTS TWO, THREE, NINE, 10, 11, IN RESPONSES TO DOCUMENT REQUESTS NUMBER 21, 22, AND 23.

THE COURT: ALL RIGHT. ANY OBJECTION?

MS. KRASNOFF: YOUR HONOR, WE HAVE NO OBJECTION TO MOVING INTERROGATORIES INTO EVIDENCE. DOCUMENT REQUESTS WE DON'T BELIEVE ARE PROPERLY ADMISSIBLE IN EVIDENCE, THE RESPONSES TO THEM, NOR DID MS. CRAIG VERIFY THEM. SHE IS ONLY UNDER A REQUIREMENT TO VERIFY THE INTERROGATORIES.

THE COURT: ALL RIGHT. WHICH OF THESE ARE INTERROGATORIES?

MS. CLARK: THE ONES AT THE BEGINNING ARE THE INTERROGATORIES. AND THEN, AS YOU MOVE TOWARDS THE BACK --

THE COURT: OF THE ONES THAT YOU WISH THE COURT TO REVIEW, WHICH ONES ARE INTERROGATORIES FOR WHICH VERIFIED RESPONSES WERE PROVIDED?

MS. CLARK: IS THAT QUESTION DIRECTED TO ME?

THE COURT: YES.

MS. CLARK: OH. IT WAS MY UNDERSTANDING THE VERIFICATION ON THE VERY LAST PAGE, IT STATES THAT THE -- THAT BOTH THE INTERROGATORIES AND DOCUMENT REQUESTS WERE VERIFIED,

BUT THE INTERROGATORIES THAT WE ARE SEEKING TO ADMIT NOW, AND OUR POSITION IS WERE VERIFIED INCLUDE NUMBERS TWO, THREE, NINE, 10 AND 11.

THE COURT: THOSE ARE INTERROGATORY RESPONSES.

MS. CLARK: YES.

THE COURT: ALL RIGHT. THOSE WILL BE ADMITTED.

THE CLERK: THE WHOLE DOCUMENT OR JUST THAT PORTION?

THE COURT: WELL, WE WILL ADMIT THE WHOLE DOCUMENT, BUT THOSE ARE THE ONLY ONES I AM GOING TO REVIEW.

THE CLERK: A-41 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-41
WAS RECEIVED IN EVIDENCE.)

MS. CLARK: YOUR HONOR, MAY I APPROACH THE WITNESS AGAIN?

THE COURT: YES.

BY MS. CLARK:

Q. I HAVE JUST SHOWED YOU WHAT HAS BEEN MARKED AS DEFENDANT'S EXHIBIT A-43. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. YES.

Q. AND WHAT IS THIS DOCUMENT?

A. THIS DOCUMENT IS A CORRECTION OF THE NAME OF ONE OF THE ORGANIZATIONS THAT WAS IN A PREVIOUS DOCUMENT.

Q. IS THIS DOCUMENT THE "PLAINTIFF'S SECOND SUPPLEMENTAL RESPONSES AND OBJECTIONS TO DEFENDANTS FIRST SET OF INTERROGATORIES AND DOCUMENT REQUESTS TO PLANNED PARENTHOOD

FEDERATION OF AMERICA"?

IS THAT WHAT THIS DOCUMENT IS?

A. IS IT THE SECOND?

Q. WELL, I AM LOOKING AT DEFENDANT'S EXHIBIT A-43; IS THAT CORRECT, ON THE FIRST PAGE?

A. YES.

Q. AND THE TITLE OF THIS DOCUMENT IS:

"PLAINTIFF'S SECOND SUPPLEMENTAL RESPONSES AND OBJECTIONS TO DEFENDANT'S FIRST SET OF INTERROGATORIES AND DOCUMENT REQUESTS TO PLANNED PARENTHOOD FEDERATION OF AMERICA"?

A. YES. THAT IS WHAT IT SAYS.

Q. AND THAT IS WHAT THIS DOCUMENT IS; IS THAT CORRECT?

A. I BELIEVE SO, BUT BECAUSE THAT IS WHAT IT SAYS.

Q. IF YOU TURN TO THE THIRD TO LAST PAGE.

A. YES.

Q. IS THAT YOUR SIGNATURE?

A. YES, THAT IS MY SIGNATURE.

Q. AND IN THE THIRD SENTENCE DOES IT STATE:

"BASED ON THE INFORMATION AVAILABLE TO ME, I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING SUPPLEMENTAL RESPONSES TO PLANNED PARENTHOOD FEDERATION OF AMERICA'S SECOND SUPPLEMENTAL RESPONSES AND OBJECTIONS TO DEFENDANT'S FIRST SET OF INTERROGATORIES AND DOCUMENT REQUESTS ARE TRUE AND

CORRECT"?

A. YES.

Q. AND DO YOU BELIEVE THAT THIS DOCUMENT IS TRUE AND CORRECT?

A. YES.

MS. CLARK: ALL RIGHT. YOUR HONOR, DEFENDANT MOVES INTO EVIDENCE DEFENDANT'S EXHIBIT A-43, SPECIFICALLY INTERROGATORY RESPONSE NUMBER 2.

THE COURT: ANY OBJECTION?

MS. KRASNOFF: NO, YOUR HONOR.

THE COURT: ALL RIGHT. ADMITTED.

THE CLERK: A-43 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-43
WAS RECEIVED IN EVIDENCE.)

BY MS. CLARK:

Q. MS. CRAIG, WHAT WAS YOUR ROLE IN RESPONDING TO THE GOVERNMENT'S REQUEST FOR DISCOVERY?

A. WHAT WAS MY ROLE?

Q. YES.

A. TO REVIEW THE INTERROGATORIES, TO LOOK THEM THROUGH. COUNSEL DID THE RESEARCH ON THEM. I SPOKE WITH COUNSEL ABOUT QUESTIONS I HAD. I REVIEWED THEM CAREFULLY, AND THEN I SIGNED THEM.

Q. AND DID YOU COLLECT ANY DOCUMENTS IN CONNECTION WITH THE GOVERNMENT'S REQUEST FOR DISCOVERY?

A. DID I COLLECT ANY?

Q. YES.

A. PERSONALLY?

Q. YES.

A. NO.

Q. DID YOU DIRECT ANYONE TO COLLECT ANY DOCUMENTS?

A. NO.

Q. DID YOU SEE ANY DOCUMENTS BEFORE THEY WERE PRODUCED TO THE GOVERNMENT IN DISCOVERY?

A. I WOULD HAVE TO GO BACK THROUGH BOTH OF THESE JUST TO BE SURE. I AM NOT SURE ABOUT THAT, TO ANSWER THAT QUESTION.

Q. LET'S SEE IF I CAN MAKE IT A LITTLE EASIER. WHEN -- DO YOU UNDERSTAND THAT PLANNED PARENTHOOD AND PLANNED PARENTHOOD GOLDEN GATE PRODUCED CERTAIN DOCUMENTS IN RESPONSE TO THE GOVERNMENT'S REQUEST FOR DISCOVERY?

A. YES.

Q. AND WERE YOU AWARE OF THE DOCUMENTS THAT WERE BEING PRODUCED IN RESPONSE TO THE DEFENDANT'S REQUEST FOR DISCOVERY?

A. NO, I WAS NOT.

Q. DID YOU SEE ANY OF THE DOCUMENTS -- DID YOU SEE ANY OF THE DOCUMENTS BEFORE THEY WERE PRODUCED?

A. NO, I DID NOT.

Q. AND EVEN THOUGH YOU SIGNED THOSE VERIFICATION -- THE TWO VERIFICATIONS WE JUST WENT THROUGH, YOU HADN'T LOOKED THROUGH ANY OF THE DOCUMENTS THAT WERE PRODUCED?

MS. KRASNOFF: YOUR HONOR, I OBJECT ON RELEVANCE AND

THE SUGGESTION OF THIS WITNESS. THERE WAS NO REQUIREMENT UNDER FEDERAL RULES THAT MS. CRAIG OR THE WITNESS TO VERIFY INTERROGATORIES --

THE COURT: I UNDERSTAND WHAT ARE YOU TRYING TO ESTABLISH.

MS. KRASNOFF: -- THAT SHE WAS INVOLVED IN THE DOCUMENT --

THE COURT: ALL RIGHT. I UNDERSTAND.

MS. CLARK: I AM TRYING TO ESTABLISH A FOUNDATION FOR CERTAIN DOCUMENTS.

THE COURT: OVERRULED.

MS. CLARK: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: ALL RIGHT.

BY MS. CLARK:

Q. MS. CRAIG, I HAVE NOW JUST SHOWED YOU WHAT HAS BEEN MARKED AS DEFENDANT'S A-27.

A. YES.

Q. THIS DOCUMENT IS BATES-STAMP LABELED PPFA001284 TO 1285; IS THAT CORRECT?

A. YES.

Q. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. NO, I HAVE NOT.

Q. DO YOU HAVE AN UNDERSTANDING THAT THIS DOCUMENT WAS PRODUCED BY PLANNED PARENTHOOD TO THE GOVERNMENT IN DISCOVERY?

A. I WAS NOT AWARE THAT THIS HAD BEEN PROVIDED SINCE I HAVE

NOT SEEN IT BEFORE.

Q. DO YOU KNOW HOW COUNSEL FOR PLANNED PARENTHOOD OBTAINED THIS DOCUMENT?

A. NO, I DO NOT.

Q. THE DOCUMENT REFLECTS THAT KAREN SHEA IS A CLINICAL SERVICE MANAGER FOR PLANNED PARENTHOOD FEDERATION OF AMERICA; IS THAT CORRECT?

A. YES.

Q. AND DO YOU KNOW KAREN SHEA TO, IN FACT, BE THE CLINICAL SERVICE MANAGER FOR PLANNED PARENTHOOD FEDERATION OF AMERICA?

A. I DON'T KNOW HER EXACT TITLE.

Q. DO YOU KNOW KAREN SHEA?

A. YES, I DO.

Q. DO YOU HAVE ANY REASON TO BELIEVE THAT CLINICAL SERVICE MANAGER FOR PLANNED PARENTHOOD FEDERATION OF AMERICA IS NOT HER TITLE?

A. I HAVE NO REASON TO BELIEVE IT'S NOT. I JUST DON'T KNOW.

Q. AND IS KAREN SHEA -- DOES SHE WORK FOR PLANNED PARENTHOOD FEDERATION OF AMERICA?

A. YES, SHE DOES.

Q. AND WHAT DO YOU UNDERSTAND HER JOB DUTIES TO BE WITH PLANNED PARENTHOOD FEDERATION OF AMERICA?

A. SHE IS IN THE MEDICAL DIVISION. AND BEYOND THAT, I AM NOT SURE WHAT HER SPECIFIC JOB DUTIES ARE.

Q. WOULD SHE BE INVOLVED IN OVERSEEING THE MEDICAL PROTOCOLS

TO BE FOLLOWED BY THE PPFA MEMBER AFFILIATES, IF YOU KNOW?
A. I DON'T KNOW THAT SHE OVERSEES THEM.
Q. DO YOU KNOW IF SHE IS INVOLVED WITH THE MEDICAL PROTOCOLS?
A. I WOULD SUSPECT SHE IS.
MS. CLARK: YOUR HONOR, DEFENDANT WOULD MOVE TO --
MOVE TO ADMIT DEFENDANT'S EXHIBIT A-27 INTO EVIDENCE ON THE GROUND THAT THIS IS AN ADMISSION. IT'S A STATEMENT MADE BY A PERSON WHO WORKS FOR PPFA. IT IS BEING OFFERED BY THE GOVERNMENT AGAINST PLANNED PARENTHOOD FEDERATION OF AMERICA.
THE COURT: ADMISSION IS NOT -- IT TAKES A LITTLE BIT MORE THAN SIMPLY BEING A PPFA EMPLOYEE TO BE DEEMED AN ADMISSION AGAINST THE ORGANIZATION.
MS. CLARK: WELL, I GUESS ON THE SECOND GROUND WE WOULD ALSO MOVE TO ADMIT IT FOR THE LIMITED PURPOSE THAT IT IS -- WE ARE NOT OFFERING IT FOR THE TRUTH OF THE MATTER, BUT THAT WE ARE OFFERING IT FOR THE FACT THAT THE STATEMENT WAS MADE IN THIS E-MAIL.
THE COURT: AND WHAT IS THE RELEVANCE OF THE FACT THAT THE STATEMENT WAS MADE IF NOT FOR THE TRUTH OF THE MATTER?
MS. CLARK: WELL, THE RELEVANCE OF THE STATEMENT IS WE ARE NOT OFFERING IT FOR THE TRUTH THAT THE D&X PROCEDURE AS SET FORTH IN THE DOCUMENT IS, IN FACT, WHAT THE D&X PROCEDURE IS OR THAT THE INTACT D&E PROCEDURE AS SET FORTH IN THAT DOCUMENT IS WHAT THE INTACT D&E PROCEDURE IS, BUT FOR THE FACT THAT AN EMPLOYEE OF PPFA, IN FACT, MADE THOSE STATEMENTS AND

MADE THOSE -- AND DISTINGUISHED IT IN THAT WAY.

THE COURT: NO. NO. IT IS HEARSAY. I AM NOT GOING TO ALLOW IT IN.

NO, IT IS NOT ADMITTED.

MS. CLARK: MAY I APPROACH?

BY MS. CLARK:

Q. I NOW HAVE SHOWN YOU WHAT HAS BEEN MARKED AS DEFENDANT'S A-34.

A. YES.

Q. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. NO, I HAVE NOT.

Q. THIS IS BATES-STAMP LABELED "PPFA1397 THROUGH 1401"; IS THAT CORRECT?

A. MINE SAYS "THROUGH 1404."

Q. LET ME TAKE A LOOK AT THAT DOCUMENT.

THE COURT: AS DOES MINE.

BY MS. CLARK:

Q. "THROUGH 1404," SORRY.

DO YOU UNDERSTAND THAT THIS DOCUMENT WAS PRODUCED IN DISCOVERY TO THE GOVERNMENT?

A. SINCE I HAVEN'T SEEN IT, NO.

Q. HAVE YOU HEARD OF CAPS BEFORE?

A. YES, I HAVE.

Q. WHAT IS CAPS?

A. CAPS IS AN INFORMAL GROUPING OF AFFILIATES, ALL OF WHOM

PROVIDE ABORTIONS. IT'S -- THE ACRONYM IS "CONSORTIUM OF ABORTION PROVIDERS."

Q. I MIGHT BE ABLE TO HELP YOU OUT. WOULD IT BE CONSORTIUM OF PLANNED PARENTHOOD ABORTION PROVIDERS"; IS THAT WHAT "CAPS" STANDS FOR?

A. THAT IS NOT THE ACRONYM, NO.

Q. I AM SORRY. WE NEED TO -- OKAY. IS IT THE CONSORTIUM OF ABORTION PROVIDERS?

A. YES, I BELIEVE SO.

MS. CLARK: MAY I APPROACH, AGAIN?

THE COURT: YES.

BY MS. CLARK:

Q. AND I HAVE JUST SHOWED YOU WHAT HAS BEEN MARKED AS GOVERNMENT EXHIBIT A-24. AND YOU SEE ON THAT DOCUMENT IT IS:

"CAPS PROJECT/CONSORTIUM OF PLANNED PARENTHOOD ABORTION PROVIDERS?" IS THAT CORRECT?

A. THAT IS WHAT IT SAYS.

Q. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. I PROBABLY HAVE.

Q. AND WHY DO YOU SAY THAT YOU PROBABLY HAVE?

A. BECAUSE THIS WOULD BE THE KIND OF THING THAT WOULD BE SENT WIDELY FOR PEOPLE TO READ AND SEE.

Q. AND IS THIS -- WHEN IT TALKS ABOUT THE CONSORTIUM OF PLANNED PARENTHOOD ABORTION PROVIDERS, IS THIS THE SAME THING WHERE IT SAYS "CAPS PROJECT," THE CAPS THAT IS DISCUSSED ON

WHAT HAS BEEN MARKED AS DEFENDANT'S A-34, WHERE IT SAYS "CAPS SURVEY" AT THE BOTTOM LEFT-HAND CORNER?

A. ARE YOU ASKING IS IT THE SAME GROUP OF PEOPLE PUT THESE TWO DOCUMENTS TOGETHER?

Q. I'M ASKING IS "CAPS" THE SAME THING BOTH IN A-24 AND A-34?

A. IT APPEARS TO BE, BECAUSE I HAVE NEVER SEEN THE SURVEY ITSELF, BUT I WOULD ASSUME THAT THAT IS THE CASE.

Q. WERE YOU FAMILIAR WITH A CAPS SURVEY BEING PERFORMED AMONG THE PPFA OR AMONG THE PLANNED PARENTHOOD MEMBER AFFILIATES?

A. NO, I WAS NOT.

Q. IF YOU REVIEWED THE MATERIAL IN DEFENDANT'S EXHIBIT A-34, THIS SETS FORTH THE GESTATIONAL RANGE OF SERVICES FOR ABORTION SERVICES AND PATIENT VOLUME; IS THAT CORRECT, FOR THE VARIOUS PLANNED PARENTHOOD MEMBER AFFILIATES ACROSS THE COUNTRY?

A. YES.

Q. AND AS YOU LOOK THROUGH THIS, DO YOU UNDERSTAND THIS INFORMATION PROVIDED IN THE DOCUMENT TO BE ACCURATE AND CORRECT?

A. I WOULD HAVE NO WAY TO VERIFY THAT.

Q. MS. CRAIG, ARE YOU FAMILIAR WITH -- ARE YOU FAMILIAR WITH THE PROTOCOLS FOR USE OF CHEMICAL AGENTS IN ORDER TO EFFECT INTRAUTERINE DEMISE OF THE VARIOUS PPFA MEMBER AFFILIATES?

A. NO, I AM NOT.

MS. CLARK: JUST ONE MOMENT.

NO FURTHER QUESTIONS.

THE COURT: ALL RIGHT.

MS. KRASNOFF?

MS. KRASNOFF: NO, YOUR HONOR.

THE COURT: THANK YOU, MS. CRAIG. YOU ARE EXCUSED.

ALL RIGHT. WE HAVE TIME TO START ONE LAST WITNESS.

MS. PARKER: DO YOU WANT TO DO THAT, YOUR HONOR, OR DO YOU WANT US TO PUT ON --

THE COURT: NO. WE ARE GOING TO GO. WE HAVE A LITTLE TIME.

MS. PARKER: WE WOULD LIKE TO CALL DR. KATHARINE SHEEHAN.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

DR. KATHARINE SHEEHAN

CALLED AS A WITNESS FOR THE PLAINTIFFS, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

THE WITNESS: I DO.

THE CLERK: TAKE THE STAND.

PLEASE STATE YOUR NAME FOR THE COURT.

THE WITNESS: MY NAME IS KATHARINE SHEEHAN.

THE CLERK: WOULD YOU PLEASE SPELL KATHARINE?

THE WITNESS: K-A-T-H-A-R-I-N-E.

THE CLERK: WOULD YOU PLEASE SPELL YOUR LAST NAME?

THE WITNESS: S-H DOUBLE E H-A-N.

THE COURT: ALL RIGHT, MS. PARKER.

DIRECT EXAMINATION

BY MS. PARKER:

Q. GOOD MORNING, DR. SHEEHAN. HAVE YOU COME TO COURT TODAY PREPARED TO PROVIDE YOUR OPINIONS ABOUT THE PARTIAL-BIRTH ABORTION BAN ACT AND ITS IMPACT ON YOUR PRACTICE?

A. I HAVE.

Q. BEFORE WE GET INTO YOUR OPINIONS, I WOULD LIKE TO DO A COUPLE OF BACKGROUND QUESTIONS; IS THAT OKAY?

ARE YOU A PHYSICIAN?

A. I AM.

Q. IN WHAT FIELDS?

A. I'M TRAINED IN OB AND GYN.

Q. ARE THERE ANY OTHER FIELDS IN WHICH YOU PRACTICE OR ARE TRAINED?

A. I DID A SUBSPECIALTY FELLOWSHIP IN REPRODUCTIVE ENDOCRINOLOGY.

Q. AND WHAT IS REPRODUCTIVE ENDOCRINOLOGY?

A. THAT IS THE SPECIALITY REGARDING HORMONES AND HAVING TO DO WITH REPRODUCTION, MALE AND FEMALE REPRODUCTION.

Q. AND YOU INDICATE THAT YOUR WERE TRAINED IN OBSTETRICS; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. DO YOU WITH CURRENTLY PRACTICE OBSTETRICS?

A. I DON'T.

Q. AND WHY IS THAT?

A. I FOUND THAT DURING MY TRAINING THAT I REALLY ENJOINED

TAKING CARE OF WOMEN. I ENJOYED THE ACTUAL PRACTICE OF MEDICINE FOR WOMEN AND THEREFORE FOCUSED MORE ON GYNECOLOGY. IT ALSO ALLOWED ME A LITTLE BIT MORE TIME TO RAISE MY FAMILY.

Q. ARE YOU BOARD CERTIFIED?

A. I AM.

Q. IN WHAT AREAS?

A. OB/GYN.

Q. AND WHAT IS YOUR CURRENT POSITION?

A. I'M CURRENTLY FULL-TIME MEDICAL DIRECTOR OF THE PLANNED PARENTHOOD AFFILIATE OF SAN DIEGO AND RIVERSIDE COUNTIES.

Q. AND HOW LONG HAVE YOU HELD THAT POSITION?

A. SINCE 1981.

Q. SO CLOSE TO OVER 20 YEARS?

A. CORRECT.

Q. CAN YOU TELL ME A LITTLE BIT ABOUT PLANNED PARENTHOOD SAN DIEGO RIVERSIDE COUNTIES? FIRST OF ALL, HOW MANY HEALTH CARE CENTERS DOES THAT AFFILIATE HAVE?

A. WE HAVE SEVENTEEN HEALTH CARE CENTERS.

Q. AND WHERE ARE THEY LOCATED?

A. THEY ARE SPREAD THROUGHOUT THE COUNTIES OF SAN DIEGO AND RIVERSIDE.

Q. AND WHAT TYPES OF PATIENTS DOES PLANNED PARENTHOOD SAN DIEGO RIVERSIDE COUNTY SERVE?

A. WE SEE PRIMARILY YOUNG HEALTHY PEOPLE FOR THEIR CONTRACEPTIVE NEEDS, EVALUATING PAP SMEARS FOR WOMEN AND

EVALUATING ABNORMAL PAP SMEARS. WE ALSO SEE YOUNG MEN FOR CONTRACEPTION AND FOR STD TESTING. WE HAVE AN HIV SCREENING PROGRAM.

WE ALSO HAVE A MIDLIFE PROGRAM, WHICH IS FOR WOMEN OF MIDDLE AGE. WE HAVE A PRENATAL PROGRAM. WE HAVE A STERILIZATION PROGRAM FOR BOTH MEN AND WOMEN. AND WE HAVE SIGNIFICANT ABORTION PROGRAM.

Q. AND HOW MANY PATIENTS DOES PLANNED PARENTHOOD SAN DIEGO RIVERSIDE COUNTY SEE EACH YEAR?

A. WE SEE OVER A HUNDRED THOUSAND PATIENTS.

Q. AND AS MEDICAL REQUEST DIRECTOR, ARE YOU IN CHARGE OF -- WHAT DOES YOUR POSITION ENTAIL?

A. I AM RESPONSIBLE FOR ALL THE MEDICAL CARE THAT IS PROVIDED AT THE AFFILIATE. I SUPERVISE ALL THE PHYSICIANS AND THE MIDLEVEL CLINICIANS WHICH ARE NURSE PRACTITIONERS, NURSE MIDWIVES, PHYSICIANS ASSISTANTS.

Q. SO YOU OVERSEE ALL THE MEDICAL CARE AND YOU SUPERVISE THE VARIOUS PHYSICIANS?

A. CORRECT, AND I AM RESPONSIBLE FOR THE MEDICAL PROTOCOLS OF THE OPERATION, THE STANDARDS THAT WE OPERATE UNDER.

Q. HOW MANY PHYSICIANS DOES PLANNED PARENTHOOD SAN DIEGO HAVE THAT YOU SUPERVISE OR OVERSEE?

A. WE HAVE APPROXIMATELY 11 OR 12.

Q. AND WHAT ABOUT THE OTHER MEDICAL PERSONNEL THAT YOU WERE JUST TALKING ABOUT?

A. WE HAVE OVER -- PROBABLY OVER A HUNDRED MIDLEVEL POSITIONS AND SOME PART-TIME POSITIONS.

Q. DOES PLANNED PARENTHOOD SAN DIEGO RIVERSIDE COUNTY OFFER ABORTIONS?

A. YES.

Q. DOES IT DO SO AT ALL OF THE 17 HEALTH CENTERS?

A. NO. WE PROVIDE ABORTION SERVICES ONLY AT THREE OF THE CENTERS, SURGICAL ABORTION SERVICES. I SHOULD SAY WE PROVIDE MEDICAL ABORTION SERVICES AT ALL THE FAMILY PLANNING CENTERS.

Q. TO WHAT GESTATIONAL AGE DO YOU PROVIDE MEDICAL ABORTIONS?

A. WE PROVIDE MEDICAL ABORTION UP TO SIXTY-THREE DAYS OR NINE WEEKS.

Q. AND YOU SAID YOU PROVIDE THOSE AT ALL OF THE FAMILY PLANNING?

A. FAMILY PLANNING.

Q. AND WHAT DO YOU MEAN BY MEDICAL ABORTIONS?

A. I MEAN, ABORTIONS THAT ARE INDUCED BY GIVING THE WOMEN MEDICINE, USUALLY MIFEPRISTONE.

Q. AND YOU INDICATED THAT YOU PROVIDE SURGICAL ABORTIONS AT THREE OF THE HEALTH CARE CENTERS; IS THAT RIGHT?

A. CORRECT.

Q. AND WHAT DO YOU MEAN BY "SURGICAL ABORTIONS"?

A. I MEAN ABORTIONS THAT ARE PROVIDED AS -- BY THE MEANS OF SURGERY.

Q. AND UP TO WHAT GESTATIONAL AGE DOES PLANNED PARENTHOOD SAN

DIEGO RIVERSIDE COUNTY PROVIDE SURGICAL ABORTIONS?

A. WE PROVIDE IT UP TO ANOTHER TWENTY-FOUR WEEKS.

Q. AS PART OF THE SURGICAL ABORTIONS THAT YOU PROVIDE, DO YOU PROVIDE THOSE DUE TO THE PRESENCE OF A FETAL ANOMALY?

A. WE FREQUENTLY DO THAT.

Q. AND WHY DO YOU DO THAT?

A. OUR AFFILIATE HAS BECOME BASICALLY THE MAIN REFERRAL CENTER FOR ALL OF CALIFORNIA SOUTH OF L.A. FOR FEW ANOMALIES. WE RECEIVE REFERRALS FROM THE KAISER-PERMANENTE GROUP. WE RECEIVE THEM FROM THE LARGEST MEDICAL GROUPS IN THAT AREA. EVEN UCSD REFERS SOME OF THEIR CASES TO US.

SO WE HAVE BECOME BASICALLY THE PRIMARY SOURCE FOR FETAL ANOMALY TERMINATIONS IN THAT AREA.

WE ARE THE ONLY CENTER THAT GOES PAST 18 WEEKS IN THE AREA.

Q. AND THAT IS THE ONLY CENTER FOR ALL CIRCUMSTANCES, INCLUDING FETAL ANOMALIES, OR JUST THE FETAL ANOMALIES PAST 18 WEEKS?

A. I'M SORRY. I DON'T UNDERSTAND.

Q. WELL, YOU INDICATED YOU ARE THE ONLY CENTER THAT PROVIDES ABORTIONS AFTER 18 WEEKS GESTATION IN THE SAN DIEGO AREA; IS THAT RIGHT?

A. THERE IS ONE OTHER PROVIDER WHO WILL GO PAST 18 WEEKS FOR FETAL ANOMALIES.

Q. AND DO YOU KNOW WHAT PERCENT OF THE SECOND-TRIMESTER

ABORTIONS THAT ARE PERFORMED AT PLANNED PARENTHOOD SAN DIEGO ARE FOR FETAL ANOMALIES?

A. SINCE WE ARE BECOMING THE SOLE REFERRAL SOURCE, OUR NUMBERS ARE DEFINITELY INCREASING. I WOULD SAY IT IS IN THE RANGE OF 15 TO 20, AND POSSIBLY 25 PERCENT.

Q. AND WHAT TYPE OF FETAL ANOMALIES ARE REFERRED TO PLANNED PARENTHOOD SAN DIEGO?

A. IT'S ACROSS THE BOARD. WE HAVE HAD THREE CASES OF CONJOINED TWINS, WE HAVE ANENCEPHALY, POTTER'S SYNDROME, WHICH IS A CONDITION WHERE THE KIDNEYS DON'T DEVELOP. WE HAVE CERTAIN -- DOWNS SYNDROME IS THE MOST COMMON, MANY OTHER GENETICALLY-ABNORMAL PREGNANCIES.

Q. WHAT IS ANENCEPHALY?

A. ANENCEPHALY IS WHEN THE BRAIN DOESN'T DEVELOP.

Q. AND ARE ALL THOSE FETAL ANOMALIES THAT YOU JUST MENTIONED CHROMOSOMAL?

A. NO. SOME OF THEM ARE STRUCTURAL, SUCH AS THE RENAL AGENESIS, POTTER'S SYNDROME.

Q. WHAT IS RENAL AGENESIS?

A. THAT'S WHERE THE KIDNEYS DON'T DEVELOP.

Q. AND ARE SOME OF THEM STRUCTURAL?

A. YES.

Q. AND COULD YOU GIVE US SOME EXAMPLES OF STRUCTURAL FETAL ANOMALIES THAT YOUR AFFILIATE DEALS WITH OR SEES?

A. THE LACK OF DEVELOPMENT OF THE KIDNEYS WOULD BE ONE EXAMPLE

OF THAT. ANOTHER EXAMPLE WOULD BE A CONDITION CALLED AMNIOTIC BANDS, WHEN THERE IS NOT ENOUGH AMNIOTIC FLUID IN THE UTERUS AND SO THE MEMBRANE BECOMES BANDS, AND THEY CUT OFF THE CIRCULATION FOR THE FETAL LIMBS AND SO THERE IS NO DEVELOPMENT OF THE HANDS OR THE FEET. THERE IS -- BASICALLY THE CIRCULATION IS CUT OFF, AND SO THE LIMBS DON'T DEVELOP.

Q. AND YOU ALSO INDICATED YOU HAD RECENTLY SEEN THREE CASES OF CONJOINED TWINS?

A. I HAVE.

Q. ARE THERE ANY OTHER STRUCTURAL FETAL ANOMALIES THAT YOUR AFFILIATES HAVE SEEN?

A. WE HAVE SEEN NUMEROUS STRUCTURAL ANOMALIES. JUST LAST WEEK I SAW A WOMAN WITH SEVERAL ANOMALIES, WHICH WERE CARDIAC MALFORMATIONS, HAND MALFORMATIONS AND FORMATIONS OF THE BONES OF THE FACE.

Q. ARE SOME OF THESE ANOMALIES FATAL?

A. ABSOLUTELY.

Q. GIVE ME SOME EXAMPLES OF SOME OF THE ONES WHICH YOU'VE SEEN THAT ARE FATAL?

A. POTTER'S SYNDROME IS INCOMPATIBLE WITH LIFE. ANENCEPHALY IS INCOMPATIBLE WITH LIFE. THIS ONE THAT I JUST MENTIONED WITH THE CARDIAC MALFORMATIONS AND CYSTIC KIDNEYS IS INCOMPATIBLE WITH LIFE.

Q. SO IN ADDITION TO SURGICAL ABORTIONS, DOES PLANNED PARENTHOOD SAN DIEGO AFFILIATE OFFER INDUCTION ABORTIONS?

A. WE DON'T OFFER INDUCTION ABORTIONS.
Q. AND WHY IS THAT?
A. WE DON'T HAVE THE PHYSICIAN TIME IT REQUIRES KEEPING A PHYSICIAN AT THE HOSPITAL FOR MANY HOURS, AND WE JUST DON'T HAVE THE MANPOWER.
Q. NOW, YOU INDICATED THAT YOU SUPERVISE 11 PHYSICIANS AT THE AFFILIATE. DO ALL OF THOSE PHYSICIANS PERFORM ABORTIONS?
A. NO, TWO OF THEM DO VASECTOMY.
Q. BUT THE REMAINING NINE DO?
A. YES.
Q. AND DO ALL OF THOSE PHYSICIANS PERFORM SECOND-TRIMESTER ABORTIONS?
A. NO, THEY DON'T.
Q. HOW MANY DO?
A. THREE.
Q. DO YOU PERFORM SECOND-TRIMESTER ABORTIONS?
A. I DO.
Q. IS THAT A SIGNIFICANT PART OF YOUR CLINICAL PRACTICE?
A. IT IS.
Q. AND UP TO WHAT GESTATIONAL AGE DO YOU PROVIDE SECOND-TRIMESTER ABORTIONS?
A. UP TO 24 WEEKS.
Q. HOW DO YOU ASCERTAIN THAT GESTATIONAL AGE?
A. THE ASCERTAINMENT OF GESTATIONAL AGE IS NOT A HUNDRED PERCENT ACCURATE SCIENCE, BUT IT STARTS WITH THE WOMAN'S

HISTORY OF HER LAST MENSTRUAL PERIOD, AS WAS MENTIONED EARLIER TODAY, AND AN EXAMINATION AND ALSO AN ULTRASOUND EVALUATION.

Q. DO YOU USE ANY PARTICULAR MEASUREMENTS TO DETERMINE THAT IT'S UP TO 24 WEEKS?

A. WE USE AS MANY MEASUREMENTS AS WE CAN MAKE USING THE ULTRASOUND. THE PRIMARY ONES ARE BIPARIETAL DIAMETER. WE HAVE DIAMETER CIRCUMFERENCE AND THE FETAL LENGTH -- I AM SORRY -- FEMUR LENGTH, F-E-M-U-R.

Q. WHAT IS THE BIPARIETAL DIAMETER?

A. THAT'S THE DISTANCE --

THE COURT: WHY DON'T YOU SPELL THAT WORD?

THE WITNESS: B-I-P-A-R-I-E-T-A-L. THE PARIETAL BONES ARE ON EITHER SIDE OF THE HEAD. THE BIPARIETAL DIAMETER IS FROM THIS SIDE OF THE HEAD.

BY MS. PARKER:

Q. AND UP TO WHAT BIPARIETAL DIAMETER DO YOU OFFER SECOND-TRIMESTER ABORTIONS?

A. WE GO UP TO 56 WEEKS.

Q. AND DOES YOUR AFFILIATE EVER GO BEYOND 24 WEEKS?

A. NO.

Q. AND WHY IS THAT?

A. IT HAS BEEN AN INTERPRETATION BASED ON THE VIABILITY ISSUE.

Q. SO YOU INDICATED THAT -- LET ME BACK UP. WHAT TYPES OF ABORTIONS DO YOU OFFER IN THE SECOND-TRIMESTER AT YOUR AFFILIATE?

A. WE PROVIDE ABORTIONS BY SUCTION UP UNTIL ABOUT 16 WEEKS, AND THEN DILATION AND EVACUATION AFTER THAT.

Q. AND WHAT TYPES DO YOU OFFER, DO YOU PERSONALLY PERFORM?

A. BOTH OF THEM.

Q. AND APPROXIMATELY HOW MANY SURGICAL ABORTIONS HAVE YOU PERFORMED IN YOUR CAREER?

A. IT'S A DIFFICULT THING TO TRY TO COMPUTE, BUT I WOULD GUESS AROUND 30,000 ABORTIONS IN MY CAREER.

Q. AND HOW MANY OF THOSE WERE IN THE SECOND-TRIMESTER?

A. I WOULD SAY APPROXIMATELY 30 PERCENT OF THEM.

Q. YOU SAID 30 PERCENT?

A. RIGHT.

Q. SO IT WOULD BE ABOUT 9,000?

A. YES.

Q. DO YOU HAVE CLINICAL EXPERIENCE PERFORMING INDUCTIONS?

A. I DO, DURING MY RESIDENCY.

Q. DO YOU CURRENTLY PERFORM INDUCTION ABORTIONS?

A. NO.

Q. AND WHY IS THAT?

A. AS I MENTIONED BEFORE, WE JUST DON'T HAVE THE TIME TO SEND SOMEBODY TO THE HOSPITAL FOR HOURS AT A TIME.

Q. AND YOU DID DO SO DURING YOUR RESIDENCY?

A. I DID.

Q. APPROXIMATELY HOW MANY INDUCTION ABORTIONS DID YOU DO DURING YOUR RESIDENCY?

A. I WOULD SAY APPROXIMATELY 300.

Q. SO IN ADDITION TO SERVING AS THE MEDICAL DIRECTOR OF PLANNED PARENTHOOD SAN DIEGO, DO YOU HAVE ANY RESPONSIBILITIES WITH REGARD TO PLANNED PARENTHOOD FEDERATION OF AMERICA?

A. I DO IN THAT I SIT ON THE NATIONAL -- I HAVE SAT ON THE NATIONAL MEDICAL COMMITTEE, WHICH IS AN ADVISORY COMMITTEE MADE UP OF EXPERTS WHO ADVISE THE PLANNED PARENTHOOD FEDERATION BOARD ON THE MEDICAL POLICY.

AND I ALSO SERVE AS AN AFFILIATE REVIEWER.

Q. AND WHAT DO YOU DO AS AN AFFILIATE REVIEWER?

A. TWICE A YEAR I SERVE ON A GROUP OF PEOPLE WHO GO TO THE AFFILIATES AND REVIEW THE AFFILIATES' PERFORMANCE PRIMARILY IN THE MEDICAL FIELD. SUELLEN CRAIG'S TESTIMONY MENTIONED THE MANY DIFFERENT FACTORS THAT ARE LOOKED AT AT THE AFFILIATES TO ASCERTAIN IF THEY ARE PROVIDING EXCELLENT SERVICES THAT MEET THE STANDARDS OF THE FEDERATION.

BUT THE PHYSICIAN GOES ON THIS COMMITTEE BASICALLY TO REVIEW THE MEDICAL SERVICES THAT ARE BEING PROVIDED AT THE AFFILIATE.

Q. IS THAT PART OF THE ACCREDITATION PROCESS THAT THE PLANNED PARENTHOOD FEDERATION DOES AT EACH OF THE AFFILIATES?

A. THAT'S CORRECT.

Q. IT IS THE MEDICAL ASPECT OF THAT?

A. CORRECT.

Q. AND YOU ARE PART OF THAT COMMITTEE?

A. CORRECT.

Q. SO IN ADDITION TO THOSE TWO SORT OF RESPONSIBILITIES, MEDICAL DIRECTOR AND SERVING ON THE MEDICAL COMMITTEE FOR PLANNED PARENTHOOD FEDERATION, DO YOU DO ANYTHING ELSE IN YOUR PROFESSIONAL CAPACITY?

A. I HAVE A SMALL PRIVATE PRACTICE, AS WELL.

Q. OKAY. WHY DON'T YOU TELL US A LITTLE BIT ABOUT THAT, AS WELL?

A. I HAVE A VERY NICE SMALL PRIVATE PRACTICE FOR ABOUT 12 YEARS IN AN AREA NEAR SAN DIEGO. AND WHEN I WAS ASKED TO GO BACK TO THE AFFILIATES AS A FULL-TIME MEDICAL DIRECTOR IN 1997, I REQUESTED THAT I BE ALLOWED SOME TIME TO CONTINUE MY PRIVATE PRACTICE. SO ONE DAY A WEEK I SEE MY OWN PRIVATE PATIENTS.

Q. WHAT SERVICES DO YOU OFFER IN THAT PRACTICE?

A. GENERAL GYNECOLOGY.

Q. DO YOU DO ANYTHING ELSE PROFESSIONALLY? DO YOU TEACH?

A. THANK YOU. I AM ON THE FACULTY AT UCSD. I AM A CLINICAL FACULTY MEMBER AT UNIVERSITY OF CALIFORNIA SAN DIEGO. AND I TEACH THE RESIDENTS IN THE REPRODUCTIVE MEDICINE PROGRAM. PRIMARILY WE TEACH THEM ABORTION PROVISION. WE ALSO HAVE SOME RESIDENTS WHO CHOOSE NOT TO GO THROUGH THE ABORTION PROGRAM, AND THEY DO FAMILY PLANNING SERVICES.

I ALSO TEACH THE NAVY RESIDENTS IN OB/GYN WHO COME TO LEARN ABORTION SERVICES.

Q. AND THE NAVAL RESIDENTS, WHERE DO THEY COME FROM?

A. THE U.S. NAVY HAS A RESIDENCY PROGRAM IN SAN DIEGO AT THE NAVAL HOSPITAL.

Q. DOES THE U.S. NAVY HAVE A MEDICAL SCHOOL IN SAN DIEGO?

A. NO.

Q. WHERE IS THAT LOCATED?

A. BETHESDA, MARYLAND.

Q. DO YOU DO THE TRAINING AT THE HOSPITALS OR DO YOU DO THAT AT PLANNED PARENTHOOD'S CLINICS OR HEALTH CENTERS?

A. I DO THAT AT THE PLANNED PARENTHOOD CENTERS.

Q. AND WHAT DO YOU TRAIN THE REPRODUCTIVE MEDICINE RESIDENTS IN?

A. PRIMARILY IN FIRST AND SECOND-TRIMESTER ABORTION CARE, BUT ALSO IN FAMILY PLANNING.

Q. DO YOU TRAIN THEM HOW TO PERFORM ABORTIONS?

A. YES.

Q. AND WHAT PARTICULAR METHODS OF ABORTIONS?

A. WE TRAIN THEM IN THE PROVISION OF MEDICAL ABORTION, AND EARLY SURGICAL ABORTION, WHICH WE ALSO CALL MANUAL VACUUM ABORTION. AND WE USE SUCTION ASPIRATION AND DILATION AND EVACUATION.

MS. PARKER: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. PARKER:

Q. DR. SHEEHAN, I SHOW YOU WHAT HAS BEEN MARKED EXHIBIT 66. DO YOU SEE THAT?

A. I DO.
Q. AND WHAT IS THAT?
A. THIS IS MY C.V.
Q. DID YOU PREPARE IT?
A. I DID.
Q. IS IT CURRENT?
A. IT IS.
Q. IS THE INFORMATION IN IT ACCURATE AND CORRECT?
A. IT SHOULD BE.
MS. PARKER: I WOULD LIKE TO OFFER EXHIBIT 66 INTO EVIDENCE.
THE COURT: ANY OBJECTION?
MR. SIMPSON: NO OBJECTION, YOUR HONOR.
THE COURT: ADMITTED.
THE CLERK: SIXTY-SIX INTO EVIDENCE.
(PLAINTIFF'S EXHIBIT 66
WAS RECEIVED IN EVIDENCE.)
MS. PARKER: AND, YOUR HONOR, I WOULD LIKE TO MOVE TO QUALIFY DR. SHEEHAN AS AN EXPERT WITNESS IN THE AREAS OF GYNECOLOGY, AND ALL AREAS OF ABORTION PRACTICE.
THE COURT: ANY OBJECTION?
MR. SIMPSON: YOUR HONOR, SUBJECT TO OUR QUESTIONING HER FURTHER ON CROSS-EXAMINATION --
THE COURT: DO YOU WISH TO QUESTION HER NOW?
MR. SIMPSON: NO, NOT IN VOIR DIRE; SIMPLY IN

RELATION TO HER QUALIFICATIONS ON CROSS. WE HAVE NO OBJECTION TO ADMITTING HER AS AN EXPERT.

THE COURT: ALL RIGHT. SHE WILL BE ADMITTED.

MS. PARKER: YOU WANT ME TO MOVE ON?

THE COURT: YES.

BY MS. PARKER:

Q. DR. SHEEHAN, YOU INDICATED YOU WERE HERE TO PROVIDE YOUR OPINIONS ON THE PARTIAL-BIRTH ABORTION BAN ACT AND THE IMPACT ON YOUR PRACTICE; IS THAT RIGHT?

A. CORRECT.

Q. CAN YOU GIVE US A GENERAL OVERVIEW OF WHAT THOSE OPINIONS ARE GOING TO BE?

A. MY OPINION IS THAT THE ACT COULD STRONGLY INHIBIT THE WAY I NORMALLY PRACTICE ABORTION CARE FOR MY PATIENTS IN THE LATER PART OF THE SECOND-TRIMESTER.

Q. AND DO YOU HAVE ANY OPINIONS ABOUT THE OVERALL SAFETY OF THE PROCEDURES THAT APPEAR TO BE BANNED BY THE ACT?

A. I FEEL STRONGLY THAT ABORTION CARE AS WE PROVIDE IT IN OUR AFFILIATE, WHICH IS TO PROVIDE THE SAFEST POSSIBLE D&E CARE, OFTEN WOULD VIOLATE THE UNDERSTANDING OR MY UNDERSTANDING OF THIS ACT.

Q. SO YOU INDICATED THAT YOU USE DILATATION AND EXTRACTION IN THE SECOND-TRIMESTER; IS THAT CORRECT?

A. CORRECT.

Q. AND DO YOU HAVE A GOAL WHEN YOU PERFORM THAT PARTICULAR

PROCEDURE?

A. MY GOAL IS TO COMPLETE THE TERMINATION OF THE PREGNANCY AS QUICKLY AND SAFELY FOR THE WOMAN AS POSSIBLE.

Q. AND HOW DO YOU DO THAT? HOW DO YOU ATTEMPT TO ACHIEVE THAT?

A. ONE OF THE CRUCIAL THINGS ABOUT DILATION AND EXTRACTION IS TO PROVIDE ACCURATE CERVICAL DILATION. AND THIS IS ACCOMPLISHED OVER ONE OR TWO DAYS BEFORE THE PROCEDURE BY USING OSMOTIC DILATORS TO ACHIEVE ADEQUATE DILATION FOR THE PROCEDURE. AND THEN, THE PROCEDURE ITSELF IS DONE AS QUICKLY WITH AS FEW PASSES WITH THE FORCEPS AS POSSIBLE, AND TO GET THE PROCEDURE DONE QUICKLY.

Q. AND WHAT IS THE PURPOSE OF DOING IT WITH AS FEW INSTRUMENT PASSES AS POSSIBLE?

A. I THINK THE CRUCIAL THING TO UNDERSTAND ABOUT D&E IS THAT YOU ARE PUTTING INSTRUMENTS THROUGH A SMALL APERTURE, WHICH IS THE CERVIX, INTO THE UTERUS. IT IS A TOTALLY BLIND PROCEDURE. WE DO HAVE ULTRASOUND AVAILABLE DURING THE PROCEDURE TO HELP GUIDE US, BUT IT IS NOT A PERFECT ADJUNCT. YOU'RE PUTTING LARGE FORCEPS INTO A BLIND SPACE TO TRY TO EXTRACT FETAL PARTS THAT ARE LARGER THAN THE APERTURE OF THE CERVIX. IT IS A VERY RISKY CONDITION, POTENTIALLY, BECAUSE IF THE FORCEPS CLOSES ON, YOU KNOW, THE WALL OF THE UTERUS OR PERFORATES THROUGH THE WALL OF THE UTERUS AND CLOSES ON SOME OTHER ORGAN OF THE WOMAN, THERE ARE SERIOUS COMPLICATIONS AND SERIOUS THINGS HAPPEN AFTER

THAT. SO, IT'S -- IT JUST MAKES SENSE TO MAKE THAT KIND OF MANEUVER AS INFREQUENTLY AS POSSIBLE.

Q. AND WHAT DO YOU TRY TO ACCOMPLISH SO YOU CAN DO AS FEW MANEUVERS AS POSSIBLE?

A. THE ESSENTIAL THING IS ADEQUATE CERVICAL DILATION.

Q. AND THE PURPOSE OF ADEQUATE CERVICAL DILATION IS FOR WHAT PURPOSE?

A. THE PURPOSE OF ADEQUATE CERVICAL DILATION IS SO THAT I HAVE ADEQUATE ROOM TO PUT MY FORCEPS IN AND MAKE THE FEWEST AMOUNT OF PASSES TO BE ABLE TO EXTRACT THE FETAL TISSUE.

Q. AND YOU INDICATED THERE WERE SOME COMPLICATIONS. I THINK THAT IS THE WORD YOU USED. THE MORE TIMES YOU INTRODUCE THE INSTRUMENTS INTO THE UTERUS; IS THAT RIGHT?

A. CORRECT.

Q. AND COULD YOU DESCRIBE WHAT SOME OF THOSE COULD BE?

A. WELL, THE MAIN THING IS ALLOWING THE FORCEPS TO GO PAST THE WALL OF THE UTERUS. AS THE PREGNANCY GETS FURTHER ALONG IN GESTATION, THE WALL GETS THINNER AND THINNER SO IT IS ACTUALLY POSSIBLE TO HAVE PUT THE FORCEPS THROUGH THE WALL AND NOT BE ABSOLUTELY CERTAIN THAT YOU KNOW WHERE YOU ARE.

IT IS ALSO POSSIBLE TO CLOSE DOWN THOSE -- THAT INSTRUMENT ON TISSUE THAT ISN'T ACTUALLY FETAL TISSUE, AND THEN WHEN YOU PUT TRACTION ON IT, YOU CAN ACTUALLY INJURE THE UTERUS OR INJURE OTHER ORGANS IN THE WOMAN.

Q. WHAT HAPPENS WHEN THAT OCCURS?

A. ONE HOPEFULLY NOTICES IT RIGHT AWAY; KNOW THAT YOU HAVE GOT A COMPLICATION. YOU HAVE TO TRANSPORT THE WOMAN TO THE HOSPITAL AND PERFORM AN OPEN SURGERY TO EVALUATE THE SITUATION AND FIX IT.

Q. AND SO THAT'S --

THE COURT: EXCUSE ME. CAN I ASK A QUESTION? DO YOU USE THE ULTRASOUND WITH EVERY PROCEDURE, EVERY D&E PROCEDURE?

THE WITNESS: I DO.

THE COURT: IS THAT STANDARD?

THE WITNESS: I DON'T BELIEVE IT IS STANDARD. I THINK IN OUR AFFILIATE IT IS STANDARD, BUT WHEN I GO AROUND AND REVIEW OTHER AFFILIATES, IT IS NOT.

BY MS. PARKER:

Q. YOU INDICATED ONE OF THE REASONS WHY YOU WANT TO HAVE AS FEW INSTRUMENT PASSES AS POSSIBLE WAS TO REDUCE THE RISK OF PERFORATION OR LACERATION?

A. YES.

Q. ARE THERE ANY -- ARE THERE OTHER REASONS THAT YOU WANT TO HAVE AS FEW INSTRUMENT PASSES AS POSSIBLE?

A. THE OTHER THING I WOULD SAY IS THAT IF I CAN DO THE PROCEDURE AS QUICKLY AND WITH AS FEW PASSES AS POSSIBLE THEN IT REDUCES THE ANESTHESIA TIME. OUR PATIENTS ARE DEEPLY SEDATED TO THE POINT OF ACTUALLY BEING ASLEEP. AND THIS IS A POTENTIALLY RISKY SITUATION FOR THE WOMAN THAT IF SHE CAN'T

BREATHE FOR HERSELF OR IF SHE WERE TO VOMIT AND ASPIRATE THE CONTENTS OF HER STOMACH, THIS CAN BE A POTENTIALLY FATAL CONDITION.

SO WE TRY TO HAVE THE WOMAN UNDER ANESTHESIA AS SHORT OF A TIME AS POSSIBLE. SO COMPLETING THE PROCEDURE AS FAST AS POSSIBLE WITH AS FEW PASSES AS POSSIBLE IS DESIRABLE.

Q. AND ARE THERE OTHER REASONS THAT YOU CAN THINK OF WHY YOU WANT TO HAVE AS FEW INSTRUMENT PASSES IN THE UTERUS AS POSSIBLE?

A. WELL, EACH TIME YOU PASS IN AND OUT OF THE UTERUS YOU HAVE THE POTENTIAL OF ACTUALLY CUTTING THE CERVIX WITH ANY OF THE SHARP PARTS THAT MIGHT BE COMING OUT OF THE UTERUS, SO YOU POTENTIALLY RAISE YOUR RISK OF LACERATION.

Q. SO I WOULD LIKE TO TALK ABOUT HOW YOU PERFORM A D&E IN THE LATE SECOND --

THE COURT: MS. PARKER, THIS MAY BE AN APPROPRIATE TIME FOR US TO END --

MS. PARKER: OKAY.

THE COURT: -- FOR THE DAY.

ALL RIGHT. SO DR. SHEEHAN, YOU ARE EXCUSED FOR NOW, AND WE WILL SEE YOU TOMORROW MORNING AT 8:30.

THE WITNESS: THANK YOU.

THE COURT: ALL RIGHT. SINCE IT IS 1:30, IT IS TIME FOR US TO ADJOURN. I WOULD LIKE BEFORE I EXCUSE YOU ALL TO JUST REVISIT THE QUESTION OF THE MEDICAL RECORDS. THEY WERE

INTRODUCED BY THE DEFENDANT. THERE WASN'T AN OBJECTION FROM THE PLAINTIFFS. I UNDERSTAND THERE IS NO -- THERE HAS BEEN NO ATTEMPT TO MOVE THIS PARTICULAR RECORD -- WE ARE TALKING ABOUT A-81 -- INTO EVIDENCE. AND I ALLOWED PLAINTIFFS TO GO FORWARD SINCE YOU OPENED THE DOOR.

BUT I ACTUALLY DID NOT EXPECT TO SEE IN THIS PROCEEDING ANY OF THE RECORDS EXCEPT THOSE THAT WE TALKED ABOUT ON FRIDAY THAT -- AND I BELIEVE YOU ALL INDICATED TO ME THAT THERE WERE APPROXIMATELY FIVE OF THE RECORDS THAT, IN FACT, DID REFER TO INTACT, AN INTACT PROCEDURE. SO I AM A LITTLE BIT AT A LOSS AS TO WHY THIS DOCUMENT WAS EVEN USED FOR THIS PROCEEDING.

MR. QUINLIVAN: YOUR HONOR, I CAN SPEAK TO THAT. IT TURNS OUT WHEN WE REVIEWED THOSE DOCUMENTS WE FOUND THREE THAT THERE WAS SOME INDICATION THAT IT MIGHT HAVE BEEN AN INTACT PROCEDURE. I WAS -- I QUESTIONED DR. PAUL TO SEE IF WE WERE CORRECT IN THAT. SHE MADE IT CLEAR THAT IT WAS NOT, AND THEREFORE, WE DIDN'T.

THE COURT: OKAY.

MR. QUINLIVAN: IN OTHER WORDS, THERE WERE THREE WHERE WE -- THERE WAS -- WE THOUGHT THAT THE INDICATION IN THE MEDICAL RECORD DID INDICATE THAT IT WAS AN INTACT.

THE COURT: AND THERE ARE FIVE OTHERS --

MR. QUINLIVAN: NO. NO. IT IS JUST THOSE THREE.

THE COURT: JUST THOSE THREE?

MR. QUINLIVAN: AND WELL, NOW, JUST TWO.

THE COURT: OKAY. ALL RIGHT. ARE THE OTHER TWO AMBIGUOUS, AS WELL?

IF YOU NEED TO ASK THE WITNESS IN ORDER TO ESTABLISH IF THEY ARE, INDEED, REFLECTIVE OF AN INTACT PROCEDURE, I WILL PERMIT YOU TO DO THAT. THERE IS NO OTHER WAY TO GET THAT AS EVIDENCE.

IF THE ANSWER IS IT IS NOT AN INTACT, I WILL NOT ALLOW ANY QUESTION BY EITHER SIDE ON THE PARTICULAR RECORDS.

MR. QUINLIVAN: YOUR HONOR, I CEASED MY QUESTIONING WITH DR. PAUL.

THE COURT: AND I DIDN'T UNDERSTAND WHAT IT WAS YOU WERE GETTING AT AT THAT POINT. NOW THAT YOU EXPLAINED I UNDERSTAND. ALL RIGHT.

MS. PARKER: YES. ONE OTHER, IF WE MIGHT, YOUR HONOR. I AM LITTLE CONCERNED THAT BECAUSE OF THE SCHEDULING OF THE PHYSICIANS IN OUR CASE, THAT WE MAY HAVE DAYS WHERE WE ARE NOT GOING TO TAKE UP THE FULL DAY.

IS THAT GOING TO BE -- I JUST WANT TO RAISE THAT ISSUE.

THE COURT: IT COMES OFF YOUR TIME.

MS. PARKER: WELL, IT IS THE REST OF OUR TIME FOR THAT DAY THAT WILL GET COUNTED AGAINST US IF WE DON'T HAVE A WITNESS AVAILABLE AT THAT POINT?

THE COURT: YES.

MS. PARKER: OKAY. WE HADN'T UNDERSTOOD THAT.

THE COURT: WE CAN TALK ABOUT IT. I MEAN, I UNDERSTAND SCHEDULING IS A REAL DIFFICULTY AND WE CAN TALK ABOUT THAT. IF BOTH SIDES ANTICIPATE HAVING THE SAME PROBLEM. BUT THERE IS A LIMITED AMOUNT OF TIME THAT I SET ASIDE TO DO THIS.

MS. PARKER: NO, WE UNDERSTAND.

THE COURT: AND BOTH OF YOU HAVE A LIMITED TIME TO MAKE THE PRESENTATION. IF THAT IS NOT AFFECTED BY THE DOWN TIME, THEN IT'S FINE WITH ME.

MR. QUINLIVAN: I THINK, YOUR HONOR, IT IS OUR ANTICIPATION, AS WELL. I BELIEVE WE ARE IN AGREEMENT THAT IN TERMS OF THE TESTIMONY OF THE EXPERTS IN THIS CASE, THAT WILL NOT EXTEND BEYOND THE THREE WEEKS THAT YOU HAVE ALLOCATED. GIVEN THAT WE HAVE AT LEAST FOUR OF OUR EXPERTS WHO WILL BE TESTIFYING IN ALL THREE TRIALS, WE HAVE TO ALLOT THEM SPECIFIC DAYS.

AND SO, WHILE WE ALSO MAY HAVE A DAY THAT MAY END EARLY, WE DO NOT ANTICIPATE THAT THIS TRIAL WILL BLEED INTO A FOURTH WEEK.

MS. PARKER: YES, THAT'S OUR UNDERSTANDING. WE HAVE EXCHANGED OUR SCHEDULES OF OUR WITNESSES. BUT IT LOOKS FROM LOOKING AT THE SCHEDULE THAT WE MAY HAVE DAYS THAT WE ARE GOING TO COMPLETE WELL BEFORE 1:30.

THE COURT: THAT WOULD BE FINE. AS LONG AS YOU ALL

KNOW WHAT THE CONCLUSION DATE IS, IT IS FINE.

MS. GARTNER: YOUR HONOR, ON THAT, MAY I RAISE ONE ADDITIONAL QUESTION ON THAT? IT MAY BE THAT THIS COMING FRIDAY THAT WE WOULD END QUITE SIGNIFICANTLY BEFORE 1:30. AND BECAUSE OF THE SCHEDULING OF OUR WITNESSES, WE ACTUALLY HAVE SEVERAL WITNESSES THAT WILL BE AVAILABLE TO TESTIFY MONDAY AND TUESDAY, BUT NONE OF THEM WERE AVAILABLE TO COME ON FRIDAY. AND WE WERE WONDERING IF YOUR HONOR WOULD INDULGE US AND END QUITE EARLY ON FRIDAY, BUT POSSIBLY GO AN ADDITIONAL HOUR OR TWO ON MONDAY TO ACCOMMODATE THAT SCHEDULE.

THE COURT: I HAVE TO TALK TO THE COURT REPORTER. YOU ALL REQUESTED DAILY TRANSCRIPTS. WE NEED TO BE ABLE TO ENSURE THEY WOULD HAVE THE TIME TO DO THAT. I WOULD BE WILLING TO DO THAT.

MS. GARTNER: THANK YOU, YOUR HONOR.

THE COURT: SO WE CAN TALK ABOUT THAT A LITTLE BIT MORE ON THURSDAY WHEN YOU KNOW WHAT YOUR SCHEDULE IS GOING TO BE.

MS. GARTNER: ALL RIGHT. THANK YOU, YOUR HONOR.

THE COURT: ALL RIGHT. WE ARE ADJOURNED UNTIL TOMORROW MORNING AT 8:30.

(WHEREUPON, PROCEEDINGS WERE ADJOURNED AT 1:31 P.M.)

I N D E X