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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. JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT.	NO. C 03-4872 PJH FRIDAY, APRIL 16, 2004 SAN FRANCISCO, CALIFORNIA

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS:
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(APPEARANCES CONTINUED ON NEXT PAGE)

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

1 PLANNED PARENTHOOD FEDERATION OF AMERICA
2 1780 MASSACHUSETTS AVENUE, N.W. WASHINGTON, D.C. 200036
3 BY: HELENE T. KRASNOFF, ESQUIRE
4
5
6 FOR INTERVENOR PLAINTIFFS CITY AND COUNTY OF SAN FRANCISCO: OFFICE OF THE CITY ATTORNEY
7 1390 MARKET STREET, SUITE 1008 SAN FRANCISCO, CALIFORNIA 94102
BY: KATHLEEN SUZANNE MORRIS,
8 ALEETA MARIE VAN RUNKLE, DEPUTY CITY ATTORNEYS
9
10 FOR DEFENDANT: U.S. DEPARTMENT OF JUSTICE
20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
11 WASHINGTON, D.C. 20530
BY: MARK THOMAS QUINLIVAN
12 W. SCOTT SIMPSON,
KAIJA MARIE CLARK,
13 PREEYA NORONHA,
ASSISTANT U.S. ATTORNEYS
14
15
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1 FRIDAY, APRIL 16, 2004 8:30 A.M.
2
3 P R O C E E D I N G S
4 THE COURT: ALL RIGHT. GOOD MORNING. ARE WE READY
5 FOR OUR LAST WITNESS OF THE TRIAL?
6 MR. SIMPSON: YOUR HONOR, IF WE MAY, WE HAVE ONE
7 MATTER TO BRING UP THAT MS. CLARK WILL TAKE CARE OF.
8 THE COURT: THAT'S FINE.
9 MS. CLARK: YOUR HONOR, WITH THE CLOSE OF OUR CASE,
10 WE WOULD LIKE TO MOVE TO ADMIT DEFENDANT'S A-40; MOVE INTO
11 EVIDENCE EXHIBIT A-40.
12 THE COURT: WHAT IS IT?
13 MS. CLARK: IT IS A LETTER FROM MS. KRASNOFF TO ME
14 IN THE COURSE OF DISCOVERY, AND WE MOVE TO ADMIT IT AS A PARTY
15 ADMISSION.
16 THE COURT: MS. KRASNOFF IS NOT A PARTY TO THIS.
17 MS. CLARK: RIGHT. IT WAS WRITTEN IN THE COURSE OF
18 DISCOVERY AS WE WERE RESOLVING SOME DISCOVERY DISPUTES AND SOME
19 INTERROGATORY DISPUTES. AND THIS WAS WRITTEN IN RESPONSE --
20 EXCUSE ME -- TO OUR DISCOVERY DISPUTE.
21 THE COURT: OKAY. ARE YOU ALL PREPARED TO ARGUE IT
22 NOW OR DO YOU WANT TO DO IT LATER?
23 MS. KRASNOFF: WE CAN DO IT. YOUR HONOR, WE -- WE
24 DON'T BELIEVE THIS IS AN ADMISSION OF A PARTY. WE WENT BACK
25 AND FORTH ON SEVERAL LETTERS THAT I WROTE THAT MAKES CLEAR THAT

1 WE VIEWED THIS INFORMATION AS OUTSIDE THE DISCOVERY REQUEST,
2 BUT WE AGREED TO PROVIDE IT, ANYWAY.
3 MOREOVER, SOME OF THIS INFORMATION WAS INCLUDED IN
4 THE STIPULATION. IF YOU RECALL THE PRETRIAL WE HAD THAT LITTLE
5 STIPULATION BETWEEN THE PARTIES.
6 THE INFORMATION WE WERE WILLING TO PROVIDE TO THE
7 COURT AND WE WERE WILLING TO STIPULATE TO WAS INCLUDED THEREIN.
8 AND I CAN LOOK FOR THE LETTER WHICH DISCUSSES THAT WE BELIEVE
9 THAT THESE THINGS ARE OUTSIDE OF THE SCOPE OF DISCOVERY.
10 BUT I AM SURE THAT WE MADE THAT REPRESENTATION PRIOR
11 TO PROVIDING THIS INFORMATION, THAT WE WOULD DO IT TO RESOLVE
12 THE DISPUTES BETWEEN THE PARTIES, BUT WE NONETHELESS VIEWED IT
13 OUTSIDE THE DISCOVERY REQUEST AND WERE PROVIDING IT, ANYWAY,
14 AND, THEREFORE, IT IS NOT AN ADMISSION.
15 THE COURT: WELL, OBVIOUSLY, SOME OF WHAT IS
16 CONTAINED IN THIS LETTER IS CONTAINED IN THE JOINT STIPULATION.
17 MS. CLARK: YES. I AGREE WITH THAT REPRESENTATION
18 OF COUNSEL THAT SOME WAS AGREED TO BE IN A STIPULATION.
19 NONETHELESS, WE THINK THAT A LETTER WRITTEN BY COUNSEL TO US IN
20 THE COURSE OF RESOLVING DISCOVERY DISPUTES ON PLANNED
21 PARENTHOOD'S LETTERHEAD IS A TRUTHFUL STATEMENT OFFERED BY THE
22 PARTY. AND, IN PARTICULAR, WE WOULD LIKE TO MAKE AN OFFER OF
23 PROOF WITH RESPECT TO THE THIRD RESPONSE, WHICH IS THE
24 PROTOCOLS FOR THE USE OF THE CHEMICAL AGENT IN ORDER TO EFFECT
25 INTRAUTERINE DEMISE OF THE THREE PPFA MEMBER AFFILIATES

1 IDENTIFIED IN RESPONSE TO INTERROGATORY NUMBER 2.
2 AND THEN, IT GOES ON TO SAY:
3 "PLANNED PARENTHOOD OF KANSAS AND MID-MISSOURI
4 OFFERS AN INJECTION A CHEMICAL AGENT IN ORDER TO
5 EFFECT INTRAUTERINE DEMISE TO WOMEN WHO ARE BELIEVED
6 TO HAVE A GESTATIONAL AGE OF 21 WEEKS LMP OR GREATER
7 PRIOR TO THE PROCEDURE."
8 IT ALSO SETS FORTH THAT:
9 "PLANNED PARENTHOOD LOS ANGELES OFFERS AN
10 INJECTION OF A CHEMICAL AGENT IN ORDER TO EFFECT
11 INTRAUTERINE DEMISE TO WOMEN WHO ARE BELIEVED TO
12 HAVE A GESTATION AGE OF 20 WEEKS LMP OR GREATER
13 PRIOR TO THE PROCEDURE."
14 AND, THIRD, IT GOES ON TO SAY:
15 "PLANNED PARENTHOOD OF SAN DIEGO AND RIVERSIDE
16 COUNTIES OFFERS AN INJECTION OF A CHEMICAL AGENT IN
17 ORDER TO EFFECT INTRAUTERINE DEMISE TO WOMEN WHO ARE
18 BELIEVED TO HAVE A GESTATIONAL AGE OF 22 WEEKS LMP
19 OR GREATER PRIOR TO THE PROCEDURE."
20 AND FOR PLAINTIFFS NOW TO ASSERT THAT THIS ISN'T
21 TRUTHFUL OR THIS ISN'T SOMETHING THAT THE COURT CAN TAKE FOR
22 THE TRUTH OF THE MATTER, WHEN THIS WAS PROVIDED IN THE COURSE
23 OF DISCOVERY, WE DON'T THINK IT IS APPROPRIATE AND THIS SHOULD
24 CONSTITUTE AN ADMISSION BY A PARTY.
25 WE CERTAINLY, YOU KNOW, DON'T THINK WE SHOULD HAVE

1 TO CALL THE WRITER OF THE LETTER TO THE STAND TO GET IT OFFERED
2 AS TRUTHFUL AND AS A TRUTHFUL STATEMENT. AND WE THINK THIS
3 PART OF THE EXHIBIT SHOULD COME IN AS ITSELF AN ADMISSION.
4 THE COURT: IS THIS THE ONLY PORTION THAT IS AT
5 ISSUE?
6 MS. CLARK: THAT IS THE ONLY PORTION THAT IS AT
7 ISSUE.
8 THE COURT: THAT'S THE ONLY PORTION THAT YOU ARE
9 ATTEMPTING TO GET IN?
10 MS. CLARK: WE MOVE TO GET THE WHOLE THING IN, BUT
11 THAT IS WHAT WE ARE GOING FOR. WE WOULD SETTLE FOR THAT PART
12 OF THE DOCUMENT.
13 THE COURT: ALL RIGHT. MS. KRASNOFF?
14 MS. KRASNOFF: WELL, FIRST OF ALL THEIR DISCOVERY
15 REQUEST DIDN'T ASK FOR THE NUMBER OF ABORTIONS IN WHICH DIGOXIN
16 WAS USED AND WHICH AFFILIATES USE IT. AND IT DID NOT ASK WHEN
17 IT WAS USED. WE AGREE THAT THERE WERE LENGTHY NEGOTIATIONS TO
18 AVOID THE MOTION TO COMPEL WE ACTUALLY ENDED UP HAVING.
19 BUT, IN ADDITION, THERE IS NO FOUNDATION FOR --
20 THESE ARE SOMEWHAT CONCLUSORY STATEMENTS WHICH I PROVIDED TO
21 MS. CLARK.
22 DR. SHEEHAN WAS HERE TO DISCUSS THE SPECIFICS OF SAN
23 DIEGO AND RIVERSIDE COUNTY. IF DEFENDANT WANTED THE FULL
24 INFORMATION ABOUT THESE OTHER AFFILIATES, THEY COULD HAVE
25 SOUGHT THEIR DEPOSITIONS OR CALLED THEM AS WITNESSES.

1 WE FEEL THAT THERE IS A LACK OF FOUNDATION AS TO IN
2 ALL CASES, WHICH WOMEN HAS IT BEEN REJECTED. WE FEEL LIKE
3 THESE ARE SOMEWHAT CONCLUSORY AND SOME WAYS MISREPRESENT
4 PERHAPS THE SITUATION.
5 IN ADDITION, WE THINK TO BE AN ADMISSION IT HAS TO
6 BE CONTRARY TO OUR POSITION AT TRIAL, AND WE DON'T SEE HOW,
7 ESPECIALLY WITHOUT ANY FOUNDATION, THIS HAS BEEN ESTABLISHED TO
8 BE CONTRARY.
9 MS. CLARK: WE ARE OFFERING IT AGAINST THE
10 PLAINTIFFS. THEY DON'T WANT IT IN, AND WE ARE OFFERING IT
11 AGAINST THEM. I DON'T KNOW HOW THAT CAN'T BE OFFERED AS BEING
12 OFFERED AGAINST THEM. THEY ARE OBJECTING TO THE ADMISSION OF
13 THIS. WE ARE OFFERING IT AGAINST THEM. I DON'T UNDERSTAND
14 THAT PART. AND TO THE EXTENT --
15 THE COURT: I AM NOT CLEAR. DR. SHEEHAN, I BELIEVE,
16 IS THE ONLY PLANNED PARENTHOOD DOCTOR FROM RIVERSIDE --
17 MS. KRASNOFF: FROM THESE THREE AFFILIATES.
18 THE COURT: -- THAT TESTIFIED ASIDE FROM GOLDEN
19 GATE. I DON'T KNOW WHO TESTIFIED FROM PLANNED PARENTHOOD
20 GOLDEN GATE. AND THEY TESTIFIED IN GREAT DETAIL. AND I DO
21 HAVE SOME CONCERNS EXACTLY ABOUT WHAT THIS MEANS, WHAT THE
22 OFFER OF AN INJECTION MEANS AND UNDER WHAT CIRCUMSTANCES IT IS
23 OFFERED GIVEN DR. SHEEHAN'S TESTIMONY.
24 SO I WOULD ACTUALLY LIKE TO -- I DON'T KNOW WHAT TO
25 MAKE OF THIS WITHOUT HAVING SOME CONTEXT FOR THESE PARTICULAR

1 QUESTIONS. AND YOU SAY THAT THIS IS -- YOU SUBMITTED AN
2 INTERROGATORY THAT ASKED SPECIFICALLY FOR THIS INFORMATION?
3 MS. CLARK: NO. WE SENT -- THERE IS APPROXIMATELY
4 24, 25 INITIAL INTERROGATORIES. AND WE WENT BACK AND FORTH
5 WITH THE PARTIES. I THINK SOME WERE UNCLEAR. SOME THE
6 OBJECTION WAS RELEVANCE. THERE IS A SERIES OF DIFFERENT
7 OBJECTIONS.
8 AND IN THE COURSE OF -- I DON'T REMEMBER THE
9 SPECIFIC OBJECTIONS -- BUT IN THE COURSE OF TRYING TO RESOLVE
10 THE DISCOVERY DISPUTE, ONE OF THE LETTERS THAT HAD BEEN WRITTEN
11 TO THE PLAINTIFFS, BECAUSE WE HAD ASKED FOR DOCUMENTS ABOUT
12 CHEMICAL INJECTIONS THAT WERE OFFERED TO PATIENTS.
13 WE HAD ASKED IN THE COURSE OF LETTERS GOING BACK AND
14 FORTH FOR PLANNED PARENTHOOD TO TELL US WHAT THE PROTOCOL WAS
15 FOR USE OF THE CHEMICAL AGENT AT THE VARIOUS AFFILIATES THAT
16 USE THE CHEMICAL AGENT.
17 THIS IS TO THE BEST OF MY RECOLLECTION WAS THAT IN
18 THE COURSE OF DISCOVERY THERE WASN'T A SPECIFIC REQUEST FOR THE
19 PROTOCOL FOR USE OF A CHEMICAL AGENT. BUT THIS WAS ONE OF THE
20 REQUESTS WE HAD OVER THE SERIES OF LETTERS GOING BACK AND FORTH
21 AND SEEKING TO AVOID THE MOTION TO COMPEL.
22 AND IN RESPONSE TO THOSE LETTERS THIS IS A RESPONSE
23 I RECEIVED FROM MS. KRASNOFF. AND TO THE EXTENT THAT THEY
24 ASSERT NOW THAT THESE MAY OR MAY NOT BE THE CASE OF WHAT
25 HAPPENS AT KANSAS, MID-MISSOURI OR LOS ANGELES, THAT THEY DON'T

1 OFFER A CHEMICAL INJECTION, I GUESS I DON'T QUITE KNOW WHAT TO
2 MAKE OF THAT WHEN THIS IS A LETTER WE RECEIVED FROM COUNSEL
3 THAT IS SIGNED.
4 THE COURT: WELL, THE PROBLEM IS INTERROGATORY
5 RESPONSES ARE VERIFIED BY THE ACTUAL PARTY. AND WE HAVE SEEN
6 AND ADMITTED AND REFERRED TO MANY OF THOSE. THIS IS NOT THE
7 SAME THING. THIS IS A LETTER IN NEGOTIATION BETWEEN COUNSEL.
8 IT WOULD SEEM TO ME THAT IF YOU WANTED TO RELY UPON
9 THE EVIDENCE YOU WOULD HAVE SOUGHT A RESPONSE TO THE
10 INTERROGATORY ITSELF SIGNED BY A REPRESENTATIVE OF THE PARTY
11 AND NOT SIMPLY COUNSEL.
12 MS. CLARK: SURE.
13 THE COURT: THAT IS ONE OF THE PROBLEMS. THE OTHER
14 PROBLEM IS THE ISSUE RAISED BY MS. KRASNOFF THAT THERE HASN'T
15 BEEN ANYONE HERE WHO CAN PROVIDE ANY CONTEXT FOR THIS ANSWER.
16 AND I WOULDN'T EXACTLY KNOW WHAT TO DO WITH THIS
17 RESPONSE, EVEN IF YOU WERE TO ARGUE THE SIGNIFICANCE OF IT AS
18 EVIDENCE, IN YOUR CLOSING, GIVEN THAT THERE HAS BEEN NO
19 TESTIMONY ON IT.
20 AND THEN, YOU HAVE SUBMITTED TO ME, WHICH INDICATES
21 THAT YOU DID DO SOME -- MADE SOME EFFORT AT COMPROMISING. YOU
22 SUBMITTED A STIPULATION OF FACTS ABOUT WHICH THERE WAS NO
23 DISPUTE. I WONDER WHY WASN'T THIS INCLUDED IN THAT IF IT WAS
24 SOMETHING YOU WANTED TO RELY UPON WITHOUT HAVING TO PRESENT
25 EVIDENCE?

1 MS. CLARK: WELL, WE DID ASK FOR A STIPULATION ON
2 THIS AS WELL, AND --
3 THE COURT: DID YOU GET A STIPULATION ON IT?
4 MS. CLARK: NO, WE DID NOT GET IT. THAT IS WHY WE
5 ARE MOVING TO OFFER IT AS AN ADMISSION. WE THOUGHT THAT IT WAS
6 INAPPROPRIATE THAT THE PLAINTIFF WOULD NOT STIPULATE TO THESE
7 FACTS WHEN THEY HAD REPRESENTED TO THIS AND SENT IT TO US. AND
8 AS WE WERE GETTING OUR EXHIBITS READY FOR TRIAL WE REQUESTED
9 THAT IT WOULD BE VERIFIED, AND WERE SURPRISED THAT COUNSEL
10 WOULDN'T VERIFY IT.
11 AND SO NOW WE ARE LOOKING TO MOVE IT AS A PARTY
12 ADMISSION. AND, YOU KNOW, WE DON'T THINK IT IS APPROPRIATE TO
13 CALL COUNSEL TO THE STAND TO ASK HOW SHE OBTAINED THIS
14 INFORMATION AND WHETHER IN GIVING IT TO US SHE BELIEVED IT WAS,
15 IN FACT, TRUTHFUL. IF WE WERE PRESSED TO DO THAT, WE WOULD BE
16 READY TO CALL COUNSEL TO THE STAND AND ASK WHY THEY PROVIDED
17 THIS INFORMATION TO US.
18 THE COURT: OKAY. RESPONSE?
19 MS. KRASNOFF: YOUR HONOR, THERE IS NO QUESTION I
20 DON'T HAVE -- WE DIDN'T HAVE ANY NOTICE THIS WAS GOING TO COME
21 UP THIS MORNING. I DON'T HAVE MY PREVIOUS LETTER AND I DON'T
22 HAVE OUR DISCOVERY REQUESTS, BUT I AM QUITE CLEAR THERE WERE
23 TWO DISCOVERY REQUESTS.
24 THEY ASKED FOR WHICH MEMBER AFFILIATE UTILIZES A
25 CHEMICAL INJECTION TO CAUSE FETAL DEMISE AND THE NUMBER OF

1 ABORTIONS IN WHICH CHEMICAL AGENTS WERE USED. WE ANSWERED BOTH
2 OF THOSE QUESTIONS. THEY WERE VERIFIED. THERE WERE PROTRACTED
3 NEGOTIATIONS AROUND THESE DISCOVERY REQUESTS. AND ONE THING
4 THAT I AGREED IN THE COURSE OF THIS TO DO WAS TO TRY TO OBTAIN
5 THIS INFORMATION.
6 MY LETTER WAS VERY CLEAR THAT WE VIEWED IT AS
7 OUTSIDE THE SCOPE OF DISCOVERY.
8 THE COURT: OKAY. I AM GOING TO NEED TO SEE THE
9 DISCOVERY REQUEST AND THE LETTERS BEFORE I CAN MAKE A DECISION
10 ON THIS. SO FOR TODAY'S PURPOSES, YOU MAY NOT REFER TO THIS.
11 HOWEVER, I WILL OBVIOUSLY LEAVE THE RECORD OPEN TO
12 ALLOW THIS EVIDENCE IN IF YOU'RE ABLE TO ESTABLISH THAT I
13 SHOULD ONCE I SEE THE LETTERS.
14 MS. KRASNOFF: IT MAY BE NEXT WEEK.
15 THE COURT: WELL, THAT'S OKAY. I DON'T IMAGINE WE
16 WILL RESOLVE IT TODAY. YOU DON'T HAVE TO DO IT TODAY. YOU CAN
17 DO IT NEXT WEEK.
18 IT IS GOING TO TAKE US A WHILE TO PREPARE THE
19 FINDINGS, IN ANY EVENT, AND WE CAN TAKE THIS INTO CONSIDERATION
20 IF I ULTIMATELY GRANT THE GOVERNMENT'S REQUEST.
21 ALL RIGHT. LET'S CALL -- LET'S TAKE OUR LAST
22 WITNESS.
23 MS. PARKER: YOUR HONOR, WE CALL AS OUR LAST
24 WITNESS, DR. STEPHEN CHASEN.
25 THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

1 DR. STEPHEN CHASEN
2 CALLED AS A WITNESS FOR THE PLAINTIFFS, HAVING BEEN DULY SWORN,
3 TESTIFIED AS FOLLOWS:
4 THE WITNESS: YES.
5 THE CLERK: PLEASE TAKE THE STAND.
6 PLEASE STATE YOUR NAME FOR THE COURT.
7 THE WITNESS: FIRST NAME IS STEPHEN, S-T-E-P-H-E-N.
8 MIDDLE INITIAL T. LAST NAME CHASEN, C-H-A-S-E-N.
9 THE CLERK: THANK YOU.
10 DIRECT EXAMINATION
11 BY MS. PARKER:
12 Q. GOOD MORNING, DR. CHASEN.
13 A. GOOD MORNING.
14 Q. ARE YOU A PHYSICIAN?
15 A. YES, I AM.
16 Q. AND WHAT ARE YOUR SPECIALTIES?
17 A. I'M AN OBSTETRICIAN AND GYNECOLOGIST, AND MY SUBSPECIALTY
18 IS MATERNAL FETAL MEDICINE.
19 Q. ARE YOU BOARD CERTIFIED IN THOSE AREAS?
20 A. I AM BOARD CERTIFIED IN BOTH AREAS, YES.
21 Q. WHERE ARE YOU CURRENTLY EMPLOYED?
22 A. I AM A MEMBER OF THE FULL-TIME FACULTY OF THE WEILL MEDICAL
23 COLLEGE OF CORNELL UNIVERSITY.
24 Q. AND WHERE IS THE WEILL MEDICAL COLLEGE, CORNELL, LOCATED?
25 A. IN NEW YORK CITY, MANHATTAN.

1 Q. WHAT POSITION DO YOU HOLD THERE?
2 A. I AM AN ASSOCIATE PROFESSOR OF OBSTETRICS AND GYNECOLOGY.
3 Q. DO YOU HAVE ANY OTHER MEDICAL APPOINTMENTS?
4 A. I HAVE PRIVILEGES AT HOSPITALS. THAT'S MY ACADEMIC
5 APPOINTMENT IS AT THE MEDICAL COLLEGE. I AM AN ATTENDING
6 PHYSICIAN AT THE NEW YORK WEILL CORNELL MEDICAL CENTER, WHICH
7 IS THE TEACHING HOSPITAL OF THE WEILL MEDICAL COLLEGE OF
8 CORNELL UNIVERSITY.
9 AND I AM ALSO -- I ALSO HAVE PRIVILEGES AT FLUSHING
10 HOSPITAL AND MEDICAL CENTER IN QUEENS IN NEW YORK CITY.
11 Q. WHAT POSITION DO YOU HOLD AT NEW YORK WEILL CORNELL MEDICAL
12 CENTER?
13 A. I AM DIRECTOR OF HIGH RISK OBSTETRICS. I AM THE
14 CO-DIRECTOR OF THE OBSTETRICS AND GYNECOLOGY RESIDENCY PROGRAM,
15 AND I AM THE DIRECTOR OF THE MATERNAL FETAL MEDICINE FELLOWSHIP
16 PROGRAM.
17 Q. ARE YOU IN THE SAME DEPARTMENT AS DR. CAROLYN WESTHOFF?
18 A. NO, I AM NOT.
19 Q. WHAT ARE YOUR RESPONSIBILITIES IN YOUR POSITIONS AT THE NEW
20 YORK WEILL CORNELL MEDICAL CENTER?
21 A. MY CLINICAL RESPONSIBILITIES INCLUDE BEING THE ATTENDING
22 AND RESPONSIBLE PHYSICIAN FOR THE HIGH RISK OBSTETRICS CLINIC
23 WHERE WOMEN WHO HAVE -- THEY MAY HAVE MEDICAL PROBLEMS THAT
24 PRECEDE PREGNANCY OR MEDICAL PATIENTS WHO RECEIVE PRENATAL CARE
25 AT THE HIGH RISK OBSTETRICS CLINIC. SOME OF THESE PATIENTS

1 HAVE MEDICAL PROBLEMS THAT PRECEDE PREGNANCY. SOME HAVE
2 COMPLICATIONS THAT ARRIVE DURING PREGNANCY. SOME OF THESE
3 PATIENTS ARE FOUND TO BE CARRYING FETUSES THAT ARE ABNORMAL.
4 AND THESE -- ALL OF THESE WOMEN RECEIVE PRENATAL
5 CARE UNDER MY DIRECT SUPERVISION AT OUR HIGH RISK OBSTETRICS
6 CLINIC.
7 MY CLINICAL RESPONSIBILITIES ALSO INCLUDE
8 SUPERVISING THE CARE OF WOMEN WHO ARE PREGNANT AND ARE
9 HOSPITALIZED FOR REASONS NOT HAVING TO DO WITH DELIVERING A
10 BABY.
11 AGAIN, VARIOUS COMPLICATIONS MAY INCLUDE PRE-TERM
12 LABOR OR OTHER MEDICAL PROBLEMS. MY CLINICAL RESPONSIBILITIES
13 INCLUDE SUPERVISING THE PRENATAL DIAGNOSIS UNIT WHERE WOMEN MAY
14 COME TO HAVE ULTRASOUND WHILE THEY ARE PREGNANT OR TO HAVE
15 PROCEDURES SUCH AS AMNIOCENTESIS OR OTHER TYPES OF PRENATAL
16 DIAGNOSTIC PROCEDURES OR ASSESSMENTS OF FETAL HEALTH.
17 I ALSO SEE WOMEN AS OUTPATIENTS FOR WHOM I AM NOT
18 PROVIDING PRENATAL CARE, BUT AS A CONSULTANT, WOMEN WHO MAY BE
19 PLANNING TO GET PREGNANT, WHO MAY HAVE A COMPLICATED
20 REPRODUCTIVE HISTORY OR MAY HAVE MEDICAL PROBLEMS THAT COULD
21 COMPLICATE PREGNANCY OR WHO ARE FOUND TO HAVE -- TO BE CARRYING
22 A FETUS THAT IS ABNORMAL IN SOME WAY.
23 THOSE ARE MY MAIN CLINICAL RESPONSIBILITIES.
24 Q. IN WHAT SETTINGS DO YOU CURRENTLY TREAT PATIENTS?
25 A. I TREAT INPATIENTS IN THE HOSPITAL. I TREAT OUTPATIENTS IN

1 THE HIGH RISK OBSTETRICS CLINIC, PATIENTS WHO ARE RECEIVING
2 PRENATAL CARE.
3 AND I SEE OUTPATIENTS IN THE PRENATAL DIAGNOSIS UNIT
4 FOR WOMEN, AGAIN, WHO ARE COMING FOR PRENATAL DIAGNOSIS OR
5 WOMEN WHO ARE COMING TO SEE ME AS A CONSULTANT.
6 Q. AND APPROXIMATELY HOW MANY PATIENTS ARE CURRENTLY UNDER
7 YOUR CARE?
8 A. THE PATIENTS UNDER MY DIRECT PRENATAL CARE ARE THOSE
9 PATIENTS IN THE HIGH RISK OBSTETRIC CLINIC. AND AT ANY GIVEN
10 TIME I BELIEVE WE ARE FOLLOWING APPROXIMATELY 50 PATIENTS.
11 AT ANY GIVEN TIME I AM PROBABLY SUPERVISING THE CARE
12 FOR ANYWHERE FROM ONE TO FIVE INPATIENTS, PREGNANT WOMEN WITH
13 COMPLICATIONS REQUIRING PRENATAL ADMISSION TO THE HOSPITAL.
14 AND OUR PRENATAL DIAGNOSIS UNIT HAS AN EXTRAORDINARY HIGH
15 VOLUME. EVERY DAY, PROBABLY, BETWEEN 50 AND 80 WOMEN COME FOR
16 A PROCEDURE, WHETHER IT'S ULTRASOUND OR INVASIVE PROCEDURE. SO
17 I DON'T SEE ALL OF THOSE WOMEN PERSONALLY, BUT I SUPERVISE AND
18 I OVERSEE THEIR CARE.
19 AND IN ANY GIVEN WEEK I PROBABLY SEE BETWEEN FIVE
20 AND TEN WOMEN WHO COME TO SEE ME IN CONSULTATION.
21 Q. WHAT IS THE RANGE OF GYNECOLOGICAL AND OBSTETRIC CARE AND
22 COUNSELING THAT YOU PROVIDE?
23 A. ALL MATTERS OF OBSTETRIC PROCEDURES, INCLUDING PRENATAL
24 CARE, INCLUDING PRENATAL CARE IN BOTH INPATIENT AND OUTPATIENT
25 SETTING, PRENATAL DIAGNOSIS. I DO HAVE SOME LABOR AND DELIVERY

1 COVERAGE RESPONSIBILITIES WHERE I HAVE THE OPPORTUNITY TO
2 DELIVER BABIES BY VAGINAL DELIVERY OR BY C-SECTION. SURGICAL
3 PROCEDURES THAT I DO THAT AREN'T C-SECTION. MOST WOMEN THESE
4 DAYS REQUIRE VAGINAL DELIVERIES THAT HAVE A SURGICAL PROCEDURE
5 COULD INCLUDE A PROCEDURE CALLED "CERVICAL CERCLAGE," WHEREBY A
6 STITCH IS PLACED AROUND THE CERVIX WITH THE INTENT OF
7 PREVENTING A PRE-TERM BIRTH.
8 AND ANOTHER PROCEDURE I DO IS ABORTION, ALMOST ALL
9 OF WHICH ARE IN THE SECOND-TRIMESTER.
10 Q. AND WHY ARE MOST OF THE ABORTIONS YOU PERFORM IN THE
11 SECOND-TRIMESTER?
12 A. ALMOST ALL CASES OF ABORTION I PERFORM FOLLOW THE PRENATAL
13 DIAGNOSIS OF A CERTAIN ABNORMALITY. UNFORTUNATELY, SUCH
14 PRENATAL DIAGNOSIS DON'T OCCUR IN THE FIRST-TRIMESTER. THEY
15 OCCUR IN THE SECOND-TRIMESTER.
16 I DO SOME CASES FOR WOMEN WHO HAVE MEDICAL
17 COMPLICATIONS IN PREGNANCY. AND THE PHYSIOLOGY IN PREGNANCY IS
18 SUCH THAT MOST OF THESE CONDITIONS WILL BECOME MANIFEST OR
19 DETERIORATE AFTER THE FIRST-TRIMESTER.
20 AND THE FINAL REASON IS THAT IN MY HOSPITAL, IN MY
21 DEPARTMENT, THERE ARE ONLY A FEW OF US THAT HAVE THE EXPERTISE
22 TO PERFORM SECOND-TRIMESTER SURGICAL ABORTION. MOST
23 OBSTETRICIANS IN MY DEPARTMENT ARE COMFORTABLE DOING
24 FIRST-TRIMESTER ABORTION. SO THOSE PATIENTS ARE NOT REFERRED
25 TO ME.

1 Q. APPROXIMATELY HOW MANY ABORTIONS DO YOU PERFORM A MONTH?
2 A. USUALLY BETWEEN THREE AND FIVE.
3 Q. AND UP TO WHAT GESTATIONAL AGE DO YOU PERFORM ABORTIONS?
4 A. IN A LIVING FETUS -- AGAIN, I DO SOME ABORTIONS FOLLOWING
5 SPONTANEOUS FETAL DEATH. IN A LIVING FETUS UP TO 23 AND
6 SIX-SEVENTH WEEKS.
7 Q. IS THAT 23 AND SIX-SEVENTHS WEEKS LMP?
8 A. IT'S 23 AND SIX-SEVENTHS WEEKS LMP TO CORRESPOND TO, I
9 GUESS, 21 AND SIX-SEVENTHS WEEKS POSTCONCEPTION.
10 Q. AND WHAT TYPE OF SECOND-TRIMESTER ABORTIONS DO YOU PERFORM?
11 A. I PERFORM DILATION AND EVACUATION.
12 Q. AND IS DILATION AND EVACUATION PROCEDURES BEEN A
13 SIGNIFICANT PART OF YOUR ABORTION PRACTICE?
14 A. GIVEN THAT ESSENTIALLY ALL OF THE ABORTIONS I PERFORM ARE
15 IN THE SECOND-TRIMESTER AND ALMOST ALL OF THEM ARE SURGICAL
16 ABORTION, DILATION AND EVACUATION IS THE PROCEDURE I PERFORM IN
17 ALMOST ALL CASES.
18 Q. HAVE YOU ALSO PERFORMED INDUCTION ABORTIONS IN THE
19 SECOND-TRIMESTER?
20 A. I HAVE.
21 Q. HAVE YOU EVER PERFORMED WHAT HAS BEEN CALLED AN INTACT D&E?
22 A. I PERFORM D&E, AND ONE OF THE VARIATIONS THAT I USE
23 INCLUDES WHAT IS REQUIRED AS AN INTACT D&E.
24 Q. IS THE INTACT D&E VARIATION A SIGNIFICANT OR A PART OF YOUR
25 REGULAR PRACTICE?

1 A. YES, IT IS.
2 Q. IS IT A SIGNIFICANT PART?
3 A. YES, IT IS.
4 Q. YOU ALSO INDICATED THAT YOU TEACH AT WEILL MEDICAL COLLEGE
5 AT CORNELL; IS THAT RIGHT?
6 A. THAT IS CORRECT.
7 Q. WHAT SUBJECTS DO YOU TEACH?
8 A. I TEACH OBSTETRICS, BOTH LOW RISK AND HIGH RISK. AND I
9 TEACH THAT TO MEDICAL STUDENTS, AS WELL AS RESIDENTS IN
10 OBSTETRICS AND GYNECOLOGY. I TEACH HIGH RISK OBSTETRICS TO
11 RESIDENTS AND OBSTETRICS AND GYNECOLOGY AND TO PHYSICIANS WHO
12 HAVE COMPLETED A RESIDENCY IN OB/GYN AND ARE DOING A FELLOWSHIP
13 IN MATERNAL FETAL MEDICINE.
14 I TEACH PRENATAL DIAGNOSIS TO RESIDENTS AND TO
15 MATERNAL FETAL MEDICINE FELLOWS. I TEACH HANDS-ON PROCEDURES
16 LIKE DELIVERIES OR CERCLAGES OR ABORTIONS TO MEDICAL STUDENTS,
17 RESIDENTS AND FELLOWS AT THE MEDICAL COLLEGE.
18 Q. AND DOES YOUR INSTITUTION OFFER ANY TRAINING IN ABORTION
19 PROCEDURES?
20 A. YES, IT DOES.
21 Q. WHAT TYPES?
22 A. MEDICAL ABORTION IN THE FIRST AND SECOND-TRIMESTER, AND
23 SURGICAL ABORTION IN FIRST AND SECOND-TRIMESTER.
24 Q. DOES YOUR INSTITUTIONAL ALSO TEACH INDUCTION ABORTIONS?
25 A. YES, IT DOES.

1 Q. AND IS D&E PROCEDURE TAUGHT?
2 A. YES, IT IS.
3 Q. IS THE INTACT VARIATION OF D&E TAUGHT AT YOUR INSTITUTION?
4 A. YES, IT IS.
5 Q. AND TO HOW MANY MEDICAL STUDENTS OR RESIDENTS ARE ABORTION
6 PROCEDURES TAUGHT?
7 A. THE MEDICAL STUDENTS ROTATE THROUGH AN OB/GYN DEPARTMENT IN
8 THE THIRD YEAR OF MEDICAL SCHOOL. THERE ARE APPROXIMATELY 100
9 STUDENTS A YEAR, ALL OF WHOM WILL ROTATE THROUGH OUR DEPARTMENT
10 AND ALL OF WHOM WILL HAVE THE OPPORTUNITY TO OBSERVE AND
11 PARTICIPATE IN PROCEDURES, INCLUDING SURGICAL ABORTION.
12 THERE ARE 25 RESIDENTS IN OUR RESIDENCY PROGRAM, AND
13 THEY ALL ROTATE PERIODICALLY THROUGH THE GYNECOLOGY SERVICE,
14 INCLUDING PROCEDURES IN THE OPERATING ROOM. AND THE VAST
15 MAJORITY OF THESE RESIDENTS PARTICIPATE IN ABORTION PROCEDURES.
16 Q. DO YOU HAVE ANY RESPONSIBILITIES FOR TRAINING THESE
17 RESIDENTS?
18 A. YES, I DO. I HAVE A LARGE RESPONSIBILITY IN TRAINING THESE
19 RESIDENTS.
20 Q. WHAT IS THAT, ROUGHLY?
21 A. I AM THE CO-DIRECTOR OF THE RESIDENCY PROGRAM, SO I AM ONE
22 OF THE RESPONSIBLE PHYSICIANS FOR THEIR EDUCATION, BOTH IN THE
23 CLINICAL SETTING, AS WELL AS IN THE DIDACTIC SETTING. I HAVE A
24 HUGE ADMINISTRATIVE RESPONSIBILITY FOR SCHEDULING AND THINGS
25 LIKE THAT.

1 AND IN ALMOST ALL OF MY CLINICAL ACTIVITIES IN ALL
2 OF THE SETTINGS I HAVE DESCRIBED I FREQUENTLY HAVE RESIDENTS
3 WITH ME WHO ARE OBSERVING AND LEARNING, WHETHER IT'S ULTRASOUND
4 OR COUNSELING, OR PROVIDING PRENATAL CARE IN LABOR AND DELIVERY
5 AND IN THE OPERATING ROOM.
6 Q. DO YOU SUPERVISE A FELLOWSHIP?
7 A. YES, I DO.
8 Q. WHAT IS THAT FELLOWSHIP?
9 A. THAT IS THE MATERNAL FETAL MEDICINE FELLOWSHIP.
10 Q. HOW DOES YOUR TIME DIVIDE BETWEEN TEACHING AND YOUR OTHER
11 RESPONSIBILITIES?
12 A. WELL, IN ALMOST ALL OF MY CLINICAL RESPONSIBILITIES, AS I
13 HAVE STATED, DOES INVOLVE TEACHING. SO THERE IS A VERY, VERY,
14 VERY SMALL PORTION OF MY ACTIVITY THAT DOESN'T INVOLVE SOME
15 TEACHING.
16 PURELY DIDACTIC TEACHING WHERE I HAVE A GROUP OF
17 RESIDENTS AND STUDENTS OR FELLOWS IN A LECTURE ROOM AND GIVING
18 A PRESENTATION MAY ACCOUNT FOR 10 PERCENT OF MY TIME. PROBABLY
19 ANOTHER 10 PERCENT OF MY TIME IS IN THE ADMINISTRATIVE AND
20 RESEARCH. AND PROBABLY THE OTHER 80 PERCENT OF MY TIME IS
21 DEVOTED TO CLINICAL ACTIVITY. BUT, AGAIN, TEACHING IS A PART
22 OF MOST OF THIS ACTIVITY.
23 Q. DO YOU SERVE ON ANY HOSPITAL COMMITTEES?
24 A. YES, I DO.
25 Q. WHAT ARE THOSE?

1 A. I AM A MEMBER OF THE QUALITY ASSURANCE COMMITTEE FOR THE
2 DEPARTMENT OF OBSTETRICS AND GYNECOLOGY. THIS COMMITTEE IS
3 CHARGED WITH REVIEWING THE MEDICAL CARE OF PATIENTS THAT MAY
4 HAVE HAD COMPLICATIONS OR WHOSE RECORDS HAVE BEEN REFERRED TO
5 MY COMMITTEE FOR REVIEW. IT COULD ARISE FROM A PATIENT
6 COMPLAINT OR A COMPLAINT FROM A PHYSICIAN OR ANOTHER HEALTH
7 CARE PROFESSIONAL.
8 AND THIS COMMITTEE REVIEWS THE MEDICAL CARE AND
9 MAKES RECOMMENDATIONS TO THE HOSPITAL QUALITY ASSURANCE
10 COMMITTEE AND TO THE CHAIRMAN OF MY DEPARTMENT.
11 I AM ALSO A MEMBER OF THE OBSTETRICS PATIENT SAFETY
12 COMMITTEE FOR THE HOSPITAL. AND THIS COMMITTEE IS CHARGED WITH
13 REVIEWING PROTOCOLS AND DEVELOPING AND IMPLEMENTING PROTOCOLS
14 RELATING TO OBSTETRIC CARE TO MAXIMIZE PATIENT SAFETY AND TO
15 ANTICIPATE AND AVOID COMPLICATIONS IN OUR PATIENTS.
16 Q. ARE YOU ALSO A MEMBER OF ANY PROFESSIONAL ASSOCIATIONS?
17 A. I AM. I AM A FELLOW OF THE AMERICAN COLLEGE OF OBSTETRICS
18 AND GYNECOLOGY, OR ACOG. AND I AM A MEMBER OF THE SOCIETY FOR
19 MATERNAL FETAL MEDICINE.
20 Q. HAVE YOU AUTHORED ANY PUBLICATIONS?
21 A. YES, I HAVE.
22 Q. APPROXIMATELY HOW MANY?
23 A. I HAVE AUTHORED OR CO-AUTHORED APPROXIMATELY 30 ARTICLES IN
24 LITERATURE, ALL BUT TWO OR THREE OF WHICH UNDERWENT PEER
25 REVIEW.

1 Q. IN WHAT SUBJECTS WERE THOSE ARTICLES?
2 A. THEY REALLY COMPRISE THE WHOLE BREADTH OF OBSTETRICS. SOME
3 OF THEM RELATE TO MEDICAL OR OBSTETRIC COMPLICATIONS IN
4 PREGNANCY, MULTI-FETAL PREGNANCY: TWINS AND TRIPLETS, PRENATAL
5 DIAGNOSIS OF -- BASED ON ABNORMAL ULTRASOUND, PRENATAL
6 DIAGNOSIS OF DOWNS SYNDROME, GENETIC -- OTHER GENETIC
7 ABNORMALITIES IN PREGNANCY, AS WELL AS ABORTION.
8 Q. DO YOU SOMETIMES PERFORM PEER REVIEW FOR JOURNALS?
9 A. I DO.
10 Q. FOR WHICH JOURNALS?
11 A. I AM A PEER REVIEWER FOR THE AMERICAN JOURNAL OF OBSTETRICS
12 AND GYNECOLOGY, WHICH WE CALL THE GRAY JOURNAL.
13 I AM A PEER REVIEWER FOR OBSTETRICS AND GYNECOLOGY,
14 WHICH WE CALL THE GREEN JOURNAL, THE JOURNAL OF MATERNAL FETAL
15 MEDICINE, THE AMERICAN JOURNAL OF PERINATOLOGY, AND THE
16 INTERNATIONAL JOURNAL OF GYNECOLOGY AND OBSTETRICS, AND SOME
17 OTHER JOURNALS THAT HAVE VARIOUS PERMUTATIONS OF ALL OF THOSE
18 NAMES.
19 Q. HAVE YOU RECEIVED ANY HONORS OR AWARDS FOR TEACHING?
20 A. I HAVE. EVERY YEAR THE GRADUATING CHIEF RESIDENTS IN OUR
21 OBSTETRICS AND GYNECOLOGY PROGRAM RECOGNIZE A FACULTY MEMBER
22 FOR TEACHING. AND I HAVE RECEIVED THAT AWARD ON THREE
23 OCCASIONS: IN 1998 AND 2001 AND 2003.
24 MS. PARKER: YOUR HONOR, MAY I APPROACH THE WITNESS?
25 THE COURT: YES.

1 BY MS. PARKER:
2 Q. DR. CHASEN, I SHOW YOU WHAT HAS BEEN MARKED AS PLAINTIFFS'
3 EXHIBIT 24. DO YOU SEE THAT?
4 A. YES.
5 Q. IS THAT A COPY OF YOUR C.V.?
6 A. YES, IT IS.
7 Q. IS IT TRUE AND CORRECT?
8 A. YES, IT IS.
9 Q. AND IS IT CURRENT?
10 A. IT IS.
11 MS. PARKER: YOUR HONOR, I WOULD LIKE TO OFFER
12 EXHIBIT 24 INTO EVIDENCE.
13 THE COURT: ANY OBJECTION?
14 MS. PARKER: ACTUALLY, I MIGHT NOTE THAT THE
15 EXHIBIT 24 IN THE BINDER CONTAINED HIS EXPERT REPORT, BECAUSE
16 THAT WAS HOW IT WAS INTRODUCED AT THE DEPOSITION, BUT WE ARE
17 ONLY SEEKING TO INTRODUCE THE SEVERAL PAGES THAT CONSTITUTE HIS
18 C.V.
19 THE COURT: LET ME MAKE SURE I HAVE THAT.
20 IS IT TITLED "BIOGRAPHICAL SKETCH"?
21 THE WITNESS: YES.
22 THE COURT: ALL RIGHT. I HAVE THAT.
23 ANY OBJECTION?
24 MR. QUINLIVAN: SUBJECT TO MS. PARKER'S
25 QUALIFICATION THAT THEY ARE ONLY SEEKING THOSE THREE PAGES, WE

1 HAVE NO OBJECTION.
2 THE COURT: THOSE WILL BE ARE TAKEN APART FROM THE
3 OTHER ATTACHMENTS.
4 MS. PARKER: WE HAVE DONE THAT WITH THE FORMAL
5 EXHIBIT, YOUR HONOR.
6 THE COURT: ADMITTED.
7 THE CLERK: TWENTY-FOUR INTO EVIDENCE.
8 (PLAINTIFFS' EXHIBIT 24
9 WAS RECEIVED IN EVIDENCE.)
10 MS. PARKER: AT THIS TIME, YOUR HONOR, WE TENDER
11 DR. CHASEN AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY, MATERNAL
12 FETAL MEDICINE AND ABORTION PRACTICE AND PROCEDURES PURSUANT TO
13 THE FEDERAL RULE OF EVIDENCE 702.
14 THE COURT: ANY OBJECTION?
15 MR. QUINLIVAN: NO OBJECTION, YOUR HONOR.
16 THE COURT: ANY REQUEST TO VOIR DIRE?
17 MR. QUINLIVAN: NO.
18 THE COURT: ALL RIGHT. HE WILL BE ACCEPTED AS
19 QUALIFIED IN THOSE AREAS.
20 BY MS. PARKER:
21 Q. DR. CHASEN, YOU INDICATED THAT THE MAJORITY OF ABORTIONS
22 YOU PERFORM IN THE SECOND-TRIMESTER ARE D&E'S; IS THAT RIGHT?
23 A. THAT IS CORRECT.
24 Q. WHAT IS YOUR GOAL WHEN YOU PERFORM A D&E?
25 A. THE OVERALL GOAL IS TO END THE PREGNANCY, WHICH INVOLVES

1 REMOVING THE FETUS AND THE PLACENTA FROM THE UTERUS AND TO DO
2 SO IN A WAY TO MINIMIZE THE RISK OF COMPLICATIONS TO MY
3 PATIENTS.
4 Q. COULD YOU DESCRIBE BRIEFLY HOW YOU DO THE DILATION PORTION
5 OF THE D&E PROCEDURE?
6 A. THE DILATION PORTION OF THE PROCEDURE IS A COMPONENT OF
7 ALMOST ALL OF THE PROCEDURES I DO. THERE ARE SOME PATIENTS
8 THAT I TREAT THAT MAY HAVE CONDITIONS THAT ALMOST INVARIABLY
9 LEAD TO SPONTANEOUS ABORTION OR VERY, VERY, VERY PREMATURE
10 LABOR.
11 THESE PATIENTS MAY PRESENT WITH ADVANCED DEGREES OF
12 CERVICAL DILATION. SO IN THESE CASES I DON'T DO -- I DON'T DO
13 THIS DILATION PROCEDURE THAT I AM ABOUT TO DESCRIBE.
14 BUT IN THE VAST MAJORITY OF PATIENTS THE DILATION
15 PROCEDURE -- I DO THE DILATION PROCEDURE THAT INVOLVES PLACING
16 THE LAMINARIA IN THE CERVICAL CANAL. AND DEPENDING ON THE
17 GESTATIONAL AGE, PRIMARILY, THAT WILL DICTATE WHETHER I -- HOW
18 MANY PLACEMENTS OF LAMINARIA I WILL USE.
19 Q. HOW MANY SETS OF LAMINARIA DO YOU TYPICALLY USE?
20 A. BROADLY, WITH SOME EXCEPTIONS, AGAIN, PRIOR TO 20 WEEKS IN
21 ALMOST ALL CASES I WILL USE A SINGLE SET OF LAMINARIA.
22 IN ALMOST ALL CASES AFTER 20 WEEKS, I WILL DO -- I
23 WILL DO TWO SETS OF LAMINARIA.
24 Q. WHAT IS THE MAXIMUM NUMBER OF LAMINARIA THAT YOU TYPICALLY
25 USE IN YOUR FIRST SET?

1 A. IN THE FIRST SET -- AND, AGAIN, MY GOAL IN PLACING
2 LAMINARIA IS TO PLACE AS MANY AS WILL FIT IN THE CERVIX WITHOUT
3 FORCING IT IN THERE. AND THIS CAN DEPEND ON FACTORS. THE
4 BIGGEST FACTOR IS PARA OF THE PATIENT. WOMEN THAT HAVE HAD A
5 CERVIX DILATE USUALLY UNDER HAPPIER CIRCUMSTANCES, LIKE IN
6 LABOR, THEIR CERVIXES CAN BE A BIT MORE LAMINARIA.
7 BUT, IN GENERAL, WITH THE FIRST SET OF LAMINARIA,
8 WHICH MAY BE THE ONLY SET IN SOME PATIENTS, ANYWHERE FROM TWO
9 OR THREE UP TO SIX.
10 Q. AND WHEN YOU DO A SECOND SET -- FIRST, HOW FAR AFTER -- HOW
11 MANY HOURS AFTER THE FIRST SET DO YOU TYPICALLY PUT IN THE
12 SECOND SET?
13 A. IN MOST PATIENTS WHO ARE OUTPATIENTS I WILL TYPICALLY DO
14 THEM 24 HOURS APART. IN CERTAIN CIRCUMSTANCES I CAN COMPRESS
15 THAT TIME.
16 Q. HOW MANY DO YOU GENERALLY INSERT IN THE SECOND SET OF
17 LAMINARIA?
18 A. IN MOST CASES I WILL INSERT BETWEEN EIGHT AND TWELVE.
19 LAMINARIA COME IN DIFFERENT SIZES. SO THE LAMINARIA I WILL
20 INSERT ON THE SECOND INSERTION ARE BIGGER THAN THE ONES I WILL
21 INSERT ON THE FIRST INSERTION. BUT IN MOST CASES, EIGHT TO
22 TWELVE.
23 Q. HAVE YOU EVER HAD A PATIENT BECOME INFECTED AS A RESULT OF
24 THE INSERTION OF LAMINARIA?
25 A. THE ONLY CASE THAT I CAN RECALL INVOLVED A PATIENT WHO WAS

1 UNDERGOING D&E BECAUSE OF THE PRE-TERM PREMATURE RUPTURE OF
2 MEMBRANES, OR PPROM.
3 THIS PATIENT WAS UNDERGOING D&E PRECISELY BECAUSE
4 SHE HAD SOME EVIDENCE OF INFECTION ALREADY. SHE HAD CLEAR
5 EVIDENCE OF INFECTION AFTER LAMINARIA INSERTION, BUT I THINK
6 THE INFECTION PRECEDED THE LAMINARIA INSERTION.
7 NO PATIENT WHO DIDN'T HAVE THIS CONDITION HAVE I
8 SEEN AN INFECTION DUE TO LAMINARIA.
9 I START ALL PATIENTS ON ANTIBIOTICS ON THE DAY THAT
10 I INSERT LAMINARIA.
11 Q. CAN YOU BRIEFLY DESCRIBE THE EVACUATION PART OF THE D&E
12 PROCEDURE?
13 A. YES. I WILL TRY TO DO IT BRIEFLY. THE DAY AFTER THE LAST
14 LAMINARIA INSERTION, WHICH BEFORE 20 WEEKS IS USUALLY THE FIRST
15 AND ONLY LAMINARIA INSERTION, PATIENTS ARRIVE IN THE HOSPITAL.
16 THEY ARE TAKEN TO THE OPERATING ROOM.
17 AFTER ANSWERING A WHOLE LOT OF QUESTIONS FROM NURSES
18 AND ANESTHESIOLOGISTS, THEY LIE DOWN. THEY RECEIVE AN
19 INTRAVENOUS LINE. THEY RECEIVE ANESTHESIA. AND, AGAIN, AT THE
20 DISCRETION OF THE ANESTHESIOLOGIST, THEY WILL RECEIVE GENERAL
21 ANESTHESIA OR THEY MAY RECEIVE SEDATION, INTRAVENOUS SEDATION
22 THAT IS SHORT OF GENERAL ANESTHESIA, BUT USUALLY THOSE PATIENTS
23 ARE ASLEEP, AS WELL.
24 THEY ARE PLACED IN STIRRUPS. I REMOVE THE
25 LAMINARIA. THEN, THEY RECEIVE A STERILE WASH. STERILE DRAPES

1 ARE PLACED. THE BLADDER IS DRAINED WITH A CATHETER.
2 AND UNDER ANESTHESIA -- ONCE I HAVE SCRUBBED AND PUT
3 ON A STERILE GOWN AND GLOVES, I WILL DO AN EXAMINATION UNDER
4 ANESTHESIA, AND SOMETIMES, ULTRASOUND AS WELL.
5 AT WHICH TIME I WILL DETERMINE THE DEGREE OF
6 CERVICAL DILATION, THE DEGREE OF CERVICAL EFFACEMENT OR HOW
7 THICK -- HOW LONG THE CERVIX IS, THE PROXIMITY OF THE CERVICAL
8 OPENING TO THE VAGINAL OPENING, WHICH CAN VARY PRIMARILY BASED
9 ON WHETHER WOMEN HAVE GONE THROUGH LABOR AND HAD THEIR PELVIC
10 MUSCLES STRETCHED BEFORE, THE POSITION OF THE FETUS.
11 I CAN ASCERTAIN USUALLY THROUGH A DIGITAL
12 EXAMINATION, BUT WITH ULTRASOUND THAT I HAVE, AS WELL, IN SOME
13 CASES. AND I MAKE A DETERMINATION ABOUT WHAT THE SAFEST -- AT
14 THAT TIME I DETERMINE WHAT THE SAFEST WAY IS TO REMOVE THE
15 FETUS.
16 Q. AND DO YOU PREPARE A PATIENT DIFFERENTLY DEPENDING ON WHAT
17 PROCEDURE YOU ARE CONSIDERING DOING?
18 A. THE PROCEDURE IN ALL CASES IS THE D&E. SOME VARIATIONS OF
19 D&E THAT WE WILL TALK ABOUT, THE INTACT D&E OR THE
20 DISARTICULATION WITH FORCEPS, I DON'T PREPARE PATIENTS ANY
21 DIFFERENTLY, BECAUSE, AGAIN, I DON'T DETERMINE WHAT THE
22 APPROPRIATE TECHNIQUE OR VARIATION OF D&E WILL BE UNTIL THE
23 PATIENT IS UNDER ANESTHESIA AND I EXAMINE THEM.
24 Q. HOW DO YOU PROCEED AT THAT POINT AFTER YOU HAVE DONE THE
25 ASSESSMENT?

1 A. AFTER THE ASSESSMENT, IF I THINK CIRCUMSTANCES ARE SUCH
2 THAT -- AND, AGAIN, MY GOAL IS TO REMOVE THE FETUS WITH AS
3 LITTLE DISARTICULATION AS POSSIBLE WITH FORCEPS, AND IF
4 POSSIBLE, WITH NO DISARTICULATION WITH FORCEPS OR NO
5 INTRODUCTION OF FORCEPS INTO THE UTERINE CAVITY.
6 Q. SLOW DOWN.
7 A. SO, IF AGAIN, CIRCUMSTANCES PERMIT, I WILL PROCEED WITH A
8 MANUAL BREECH EXTRACTION OF THE FETUS. AND I WILL PROCEED WITH
9 A BREECH EXTRACTION. IN MOST CASES THE HEAD WILL BECOME LODGED
10 AT THE CERVIX. AND IN THOSE CASES I WILL TYPICALLY MAKE AN
11 INCISION WITH THE SCISSORS UNDER DIRECT VISUALIZATION, BECAUSE
12 THE BASE OF THE SKULL IS IN THE CERVIX, AND I CAN SEE IT IN
13 ALMOST ALL CASES.
14 I MAKE AN INCISION, INTRODUCE SUCTION, ASPIRATE THE
15 CONTENTS OF THE BRAIN TISSUE. AND AT THAT POINT, THE SIZE OF
16 THE FETAL HEAD IS DECREASED TO THE POINT WHERE IT WILL PASS
17 EASILY THROUGH THE CERVIX.
18 IN CASES WHERE I DON'T FEEL I CAN DO A MANUAL BREECH
19 EXTRACTION, THEN I WILL PROCEED WITH FORCEPS. IN SOME CASES I
20 CAN, WITH THE FIRST PASS OF THE FORCEP, REMOVE ONE OR BOTH LEGS
21 OF THE FETUS FROM THE UTERUS INTO THE VAGINA WITHOUT
22 DISARTICULATION. AND IN THOSE CASES I THEN CAN PROCEED WITH A
23 BREECH EXTRACTION, AS I HAVE DESCRIBED BEFORE.
24 IN MOST CASES WHERE I NEED TO PROCEED WITH FORCEPS,
25 I WILL HAVE TO COMPLETE THE CASE OR REMOVE THE FETUS WITH

1 DISARTICULATION. BUT MY GOAL IS TO DO AS LITTLE
2 DISARTICULATION AS POSSIBLE AND REMOVE THE FETUS AS INTACT AS I
3 CAN.
4 Q. AT WHAT TIME DURING THE PROCEDURE DO YOU DECIDE WHETHER TO
5 PROCEED WITH FORCEPS OR TO DO A MANUAL EXTRACTION?
6 A. THAT'S AFTER I HAVE DONE AN EXAMINATION UNDER ANESTHESIA.
7 THAT'S WHEN I DECIDE THE SAFEST WAY TO PROCEED.
8 Q. DO YOU DO MORE DILATION FOR A PATIENT WHEN YOU ARE ABLE TO
9 DO THE MANUAL EXTRACTION?
10 A. THE PREOPERATIVE DILATION OR DILATION PORTION IS IDENTICAL
11 IN ALL PATIENTS, AND PRIMARILY THAT IS BASED ON THE GESTATIONAL
12 AGE. IN CASES IN WHICH I AM ABLE TO DO AN INTACT -- THE INTACT
13 VARIATION OF D&E, THOSE PATIENTS TEND TO HAVE MORE DILATION
14 THAN PATIENTS IN WHOM I MUST RESORT TO FORCEPS.
15 Q. SO WHAT FACTORS INFLUENCE WHICH OF THE TWO APPROACHES YOU
16 WILL USE?
17 A. AGAIN, PROBABLY THE MOST IMPORTANT, BUT CERTAINLY NOT THE
18 ONLY FACTOR IS THE DEGREE OF CERVICAL DILATION THAT IS
19 ACHIEVED. AND IT'S ACHIEVED IN MOST CASES WITH LAMINARIA. BUT
20 OTHER FACTORS CAN INCLUDE THE EFFACEMENT, OR HOW LONG THE
21 CERVIX IS. AND, AGAIN, A LOT OF THAT RELATES TO WHETHER OR NOT
22 WOMEN HAVE BEEN THROUGH LABOR BEFORE.
23 WOMEN WHO HAVEN'T BEEN THROUGH LABOR BEFORE TEND TO
24 HAVE A CERVIX THAT MAY BE CONSIDERABLY LONGER, WHICH CAN MAKE
25 IT DIFFICULT TO DO A BREECH EXTRACTION. THE DEGREE OF

1 RELAXATION OF THE PELVIC FLOOR CAN PLAY A BIG ROLE.
2 WOMEN WHO HAVE GONE THROUGH LABOR BEFORE TEND TO
3 HAVE THEIR PELVIC FLOOR MUSCLES STRETCHED, AND THE CERVIX MAY
4 BE QUITE A BIT CLOSER TO THE VAGINAL OPENING, SO MY HAND OR A
5 FORCEP DOES NOT NEED TO TRAVEL AS FAR TO GRASP THE FETUS AND
6 HOPEFULLY TO DO A BREECH EXTRACTION.
7 THE POSITION OF THE FETUS PLAYS A ROLE IN IF IT IS
8 IN A BREECH PRESENTATION -- AND NEARLY HALF OF THE FETUSES IN
9 THIS GESTATIONAL AGE MAY BE -- THE LOWER EXTREMITIES MAY BE
10 RIGHT ABOVE THE CERVIX AND MAY BE EASIER TO GRASP.
11 IF THE FETUS IS PRESENTING HEAD FIRST OR
12 TRANSVERSELY, THEN THE LOWER EXTREMITIES ARE NOT AS ACCESSIBLE,
13 EITHER MANUALLY OR WITH FORCEPS. AND SOME IN SOME CASES THERE
14 IS MORE ROOM FOR MANIPULATION WITHIN THE UTERUS THAN IN OTHER
15 CASES.
16 AND THIS CAN KIND OF DEPEND ON THE VOLUME OF
17 AMNIOTIC FLUID AND THE DEGREE OF RELAXATION OF THE UTERUS. IT
18 TENDS TO BE MORE RELAXED IN A WOMAN WHO HAS HAD LABOR BEFORE
19 COMPARED TO A WOMAN FOR WHOM IT MAY BE THE FIRST PREGNANCY.
20 SO THESE ARE -- THERE IS NO FORMULA. THESE ARE ALL
21 THE FACTORS I TAKE INTO ACCOUNT.
22 Q. DO YOU CONVERT THE LIE OR THE POSITION OF THE FETUS TO
23 ACHIEVE MANUAL EXTRACTION?
24 A. YES. YES, I DO.
25 Q. AND HOW DO YOU DO THAT?

1 A. IN SOME CASES, AGAIN, BASED ON THE FACTORS THAT I HAVE TOLD
2 YOU, IN SOME CASES I AM ABLE TO, IF ALL THE FACTORS I DESCRIBED
3 IN MY PRIOR ANSWER ARE FAVORABLE, I CAN ACTUALLY REACH INTO THE
4 UTERUS AND WITH MY HANDS GRASP ONE OR BOTH OF THE LOWER
5 EXTREMITIES AND DO IT MANUALLY.
6 I HAVE MY OTHER HAND ON THE ABDOMEN, AND I CAN
7 EXTERNALLY, BY PRESSURE ON THE ABDOMEN ALSO, TRY TO TURN THE
8 FETUS IN CONCERT WITH THE HAND. OR IN SOME CASES A FORCEP IN
9 THE UTERUS AND ULTRASOUND GUIDANCE IS SOMETIMES HELPFUL IN
10 DOING THIS PODALIC VERSION.
11 Q. AT WHAT GESTATIONAL AGES DO YOU TYPICALLY PERFORM THE
12 INTACT VARIATION OF D&E?
13 A. IN MOST CASES, BUT NOT ALL, IT WILL BE AT OR AFTER 20
14 WEEKS.
15 Q. AND DO YOU SOMETIMES REMOVE AN INTACT FETUS EARLIER THAN 20
16 WEEKS?
17 A. IN SOME CASES I DO.
18 Q. HOW EARLY HAVE YOU BEEN ABLE TO DO THAT?
19 A. I HAVE DONE IT AS EARLY AS 14 OR 15 WEEKS, I BELIEVE.
20 Q. DO YOU HAVE A PREFERENCE AS TO WHETHER YOU'RE ABLE TO
21 REMOVE THE FETUS INTACT?
22 A. MY PREFERENCE IS TO REMOVE A FETUS WITH AS LITTLE
23 INTERVENTION AS POSSIBLE AND WITH AS LITTLE MANIPULATION WITH
24 FORCEPS. EVERY TIME I INSERT A FORCEP INTO THE UTERINE CAVITY
25 I HAVE THE CAPACITY TO CAUSE UTERINE RUPTURE WHICH ULTRASOUND

1 CAN'T COMPLETELY PREVENT. EVERY TIME OF OPEN THE FORCEP WITH
2 THE INTENT OF GRASPING THE FETUS, I CAN'T BE CERTAIN THAT I AM
3 NOT ALSO GRASPING THE WALL OF THE UTERUS. AND, AGAIN,
4 ULTRASOUND CANNOT ALWAYS IDENTIFY THOSE CASES.
5 SO, MY ANSWER IS THAT IT'S ALWAYS WITH AS LITTLE
6 INTERVENTION WITH FORCEPS AS POSSIBLE TO REMOVE THE FETUS, AND
7 WITH AS LITTLE DISARTICULATION, AND PREFERABLY WITH NONE.
8 Q. DR. CHASEN, I NOW WOULD LIKE TO TALK TO YOU A LITTLE BIT
9 ABOUT SOME OF THE RESEARCH THAT YOU HAVE DONE.
10 MS. PARKER: YOUR HONOR, MAY I APPROACH THE WITNESS?
11 THE COURT: YES.
12 BY MS. PARKER:
13 Q. DR. CHASEN, I HAVE SHOWN YOU WHAT HAS BEEN MARKED AS
14 PLAINTIFFS' EXHIBIT 17, WHICH IS AN ARTICLE ENTITLED "IMPACT OF
15 MID-TRIMESTER DILATION AND EVACUATION ON SUBSEQUENT PREGNANCY
16 OUTCOME."
17 I TAKE IT YOU HAVE SEEN THIS BEFORE?
18 A. YES, I HAVE.
19 Q. WHAT IS IT?
20 A. THIS IS A PEER-REVIEWED ARTICLE WITH ORIGINAL RESEARCH THAT
21 WAS PUBLISHED IN THE AMERICAN JOURNAL OF OBSTETRICS AND
22 GYNECOLOGY, OR THE GRAY JOURNAL, IN, I BELIEVE, OCTOBER OF
23 2002.
24 Q. ARE YOU ONE OF THE AUTHORS OF THIS ARTICLE?
25 A. I AM A CO-AUTHOR OF THIS ARTICLE.

1 Q. WHAT WAS YOUR ROLE WITH THE ARTICLE?
2 A. THE PRIMARY AUTHOR, DR. ROBIN KALISH, WAS A MATERNAL FETAL
3 MEDICINE FELLOW IN MY DEPARTMENT AT THE TIME THIS RESEARCH WAS
4 CONDUCTED. AND I WAS -- AND SHE IS NOW MY COLLEAGUE AND A
5 MEMBER OF THE FULL-TIME FACULTY IN MY DEPARTMENT.
6 AT THE TIME SHE WAS A FELLOW AND SPECIFICALLY IN
7 CONDUCTING THIS RESEARCH, I WAS HER SUPERVISOR. AND EVERY
8 STAGE OF THE RESEARCH PROCESS FROM CONCEPTION THROUGH WRITING
9 AND REVISING THE MANUSCRIPT, I WAS CLOSELY INVOLVED.
10 Q. WHEN WAS THE RESEARCH CONDUCTED?
11 A. I BELIEVE WE BEGAN THIS PROJECT IN THE SPRING OF 2001. THE
12 DATA WAS COLLECTED FROM SPRING OF 2001, I BELIEVE, THROUGH JULY
13 OR AUGUST OF 2001, AT WHICH TIME WE ANALYZED IT, AND AN
14 ABSTRACT WAS SUBMITTED FOR PRESENTATION AT THE SOCIETY FOR
15 MATERNAL FETAL MEDICINE ANNUAL MEETING IN 2002.
16 AND IT WAS ACCEPTED. IT WAS A POSTER PRESENTATION
17 IN JANUARY OR FEBRUARY OF 2002 AT THIS MEETING. AND FOLLOWING
18 PRESENTATION AT THE MEETING, WE WROTE A MANUSCRIPT AND
19 SUBMITTED IT TO THE AMERICAN JOURNAL OF OBSTETRICS AND
20 GYNECOLOGY, AND IT WAS ACCEPTED WITH REVISIONS FOR PUBLICATION,
21 WHICH I HAVE BEFORE ME.
22 MS. PARKER: YOUR HONOR, WE WOULD LIKE TO INTRODUCE
23 PLAINTIFFS' EXHIBIT 17 INTO EVIDENCE.
24 THE COURT: ANY OBJECTION?
25 MR. QUINLIVAN: YES, YOUR HONOR. I UNDERSTAND YOUR

1 HONOR'S RULING PREVIOUSLY ABOUT THESE MATTERS, BUT WE ARE GOING
2 TO NOTE OUR OBJECTION FOR THE RECORD. WE OBJECT TO THIS ON THE
3 SAME HEARSAY GROUNDS THAT WE NOTED BEFORE.
4 THE COURT: OKAY.
5 MS. PARKER: AND WE BELIEVE IT COMES IN UNDER THE
6 RESIDUAL EXCEPTION, AS DR. CHASEN IS AN AUTHOR OF THE STUDY,
7 AND HE IS HERE FOR CROSS-EXAMINATION.
8 IT WAS NOT PREPARED FOR PURPOSES OF LITIGATION. AND
9 BECAUSE IT IS A STUDY, IT CONTAINS DATA AND SOME SUMMARIES OF
10 THE DATA. WE THINK IT IS WORTHY OF SUBMITTING INTO THE RECORD.
11 THE COURT: I AM GOING TO ADMIT IT ON THE SAME BASIS
12 I HAVE ADMITTED THE OTHER REPORTS.
13 THE CLERK: SEVENTEEN INTO EVIDENCE.
14 THE COURT: SEVENTEEN IS ADMITTED.
15 (PLAINTIFFS' EXHIBIT 17
16 WAS RECEIVED IN EVIDENCE.)
17 BY MS. PARKER:
18 Q. DR. CHASEN, WHAT WERE THE OBJECTIVES OF THE STUDY THAT ARE
19 WRITTEN ABOUT IN THE ARTICLE, EXHIBIT 17?
20 A. THE OBJECTIVE OF THE STUDY WAS TO LOOK AT PREGNANCY
21 OUTCOMES IN A PREGNANCY FOLLOWING DILATION AND EVACUATION IN
22 THE SECOND-TRIMESTER. AND THE MAIN OUTCOME VARIABLE WAS TO
23 LOOK AT THE RATE OF SPONTANEOUS PRE-TERM BIRTH IN WOMEN WHO HAD
24 UNDERGONE D&E.
25 Q. AND WHY DID YOU WANT TO EVALUATE THE IMPACT OF D&E'S ON

1 SUBSEQUENT PREGNANCY OUTCOMES?
2 A. THERE HAS BEEN MEDICAL LITERATURE AND AS WELL AS MUCH
3 SPECULATION ABOUT THE IMPACT OF ABORTION, ALL ABORTION OR ANY
4 ABORTION, IN TERMS OF BEING A RISK FACTOR FOR SPONTANEOUS
5 PRE-TERM BIRTH IN FUTURE PREGNANCIES.
6 ALMOST ALL THE LITERATURE THAT HAS BEEN PUBLISHED
7 HAS REALLY LOOKED AT THE IMPACT OF ABORTION EARLIER IN
8 PREGNANCY, AND WITH SOME CONFLICTING RESULTS. BUT THERE HAS
9 BEEN VERY LITTLE PUBLISHED DATA REGARDING SECOND-TRIMESTER
10 ABORTION AND FUTURE PREGNANCY OUTCOMES.
11 AND IN OUR HOSPITAL, SINCE D&E STARTED TO BE
12 PERFORMED WITH ANY FREQUENCY, WHICH, I THINK, WAS IN 1995 OR
13 1996, DR. KALISH AND I FELT THAT WE WOULD HAVE ENOUGH DATA
14 ABOUT THESE PATIENTS WHO HAD SUBSEQUENT PREGNANCIES WHERE WE
15 COULD OBTAIN THE RECORDS AND WE COULD REALLY ADDRESS THIS
16 QUESTION SCIENTIFICALLY.
17 Q. HOW WAS THE STUDY PERFORMED?
18 A. THIS WAS A RETROSPECTIVE STUDY. AND THE FIRST STEP OF
19 THE -- WELL, THE FIRST STEP OF THE PROCESS WAS GETTING
20 PERMISSION FROM THE INSTITUTIONAL REVIEW BOARD TO REVIEW
21 PATIENT MEDICAL RECORDS. AND WE DID THAT.
22 ONCE WE HAD PERMISSION FROM THE MEDICAL COLLEGE IRB,
23 WE PERFORMED A RETROSPECTIVE REVIEW. AND, AGAIN, THE FIRST
24 STEP WAS IDENTIFYING WOMEN WHO HAD HAD D&E IN OUR HOSPITAL
25 FROM, I BELIEVE, MAY OF 1996 THROUGH THE MIDDLE OF 2000 -- OF

1 THE YEAR 2000.

2 AND WE TOOK THE MIDDLE OF THE YEAR 2000 SO THAT A

3 WOMAN WHO HAD A D&E AT THAT POINT WOULD HAVE HAD ENOUGH TIME TO

4 GET PREGNANT AND TO COMPLETE A PREGNANCY BY THE TIME WE WERE

5 REVIEWING THE RECORDS IN 2001.

6 Q. HOW MANY MEDICAL RECORDS DID YOU REVIEW?

7 A. WE IDENTIFIED 600 WOMEN WHO HAD HAD D&E FROM 14 TO 24 WEEKS

8 IN OUR HOSPITAL, AND DATA WAS COLLECTED ABOUT THESE WOMEN AND

9 THE PROCEDURES THAT THEY HAD. AND THEN, WE LOOKED IN THE

10 HOSPITAL MEDICAL RECORD DATABASE AT WHAT CARE THESE WOMEN HAD

11 SUBSEQUENT TO THE D&E IN OUR HOSPITAL. AND WE INCLUDED ALL

12 PATIENTS WHO WERE CARED FOR ON THE OBSTETRIC SERVICE IN OUR

13 HOSPITAL FOLLOWING THEIR D&E.

14 Q. HOW MANY SUBSEQUENT PREGNANCIES WERE YOU ABLE TO IDENTIFY?

15 A. WE IDENTIFIED 96 SUBSEQUENT PREGNANCIES.

16 Q. DID YOU LOOK AT THE MEDICAL RECORDS FOR THOSE 96 WOMEN, AS

17 WELL?

18 A. YES, WE DID.

19 Q. WHAT CONCLUSIONS DID THE STUDY DRAW?

20 A. THE PRIMARY CONCLUSION OR ONE PRIMARY CONCLUSION WAS THAT

21 THE RATE OF SPONTANEOUS PRE-TERM BIRTH IN THIS GROUP OF WOMEN

22 WHO GOT PREGNANT FOLLOWING D&E WAS SIX AND A HALF PERCENT. AND

23 THAT THAT WAS CONSISTENT WITH THE OVERALL RATE OF

24 SPONTANEOUS -- CONSISTENT WITH THE OVERALL RATE OF SPONTANEOUS

25 PRE-TERM BIRTH THAT WE SEE IN OUR HOSPITAL AND THAT HAS BEEN

1 DESCRIBED NATIONALLY.
2 ANOTHER OUTCOME THAT WE LOOKED AT WAS THE
3 GESTATIONAL AGE AT WHICH THESE WOMEN UNDERWENT ABORTION AND HOW
4 FAR THE CERVIX WAS DILATED AT THE TIME THEY UNDERWENT SURGICAL
5 ABORTION TO SEE IF THIS HAD ANY IMPACT ON THE RATE OF
6 SPONTANEOUS PRE-TERM BIRTH IN THEIR SUBSEQUENT PREGNANCY.
7 AND WHAT WE FOUND WAS THAT IN WOMEN THAT HAD D&E
8 BETWEEN 14 AND 24 WEEKS, WE ACTUALLY FOUND THE TREND TOWARDS
9 LOWER RATES OF PRE-TERM BIRTH IN WOMEN THAT HAD D&E IN THESE
10 LATER GESTATIONAL PERIODS WITHIN THAT INTERVAL. AND WHEN WE
11 LOOKED FURTHER, WE FOUND A CORRELATION, AN INVERSE CORRELATION,
12 BETWEEN PREOPERATIVE CERVICAL DILATION AND THE RATE OF
13 SPONTANEOUS PRE-TERM BIRTH.
14 IN OTHER WORDS, THAT THE MORE CERVICAL DILATION WAS
15 ACHIEVED PRIOR IT SURGICAL EVACUATION, THE D&E PROCEDURE, THE
16 LOWER RISK, THE RISK OF PRE-TERM BIRTH IN THE SUBSEQUENT
17 PREGNANCY WAS LOWER COMPARED TO WOMEN WHO HAD LESSER DEGREES OF
18 CERVICAL DILATION IN THEIR D&E PROCEDURE.
19 Q. WAS THAT FINDING EXPECTED?
20 A. WELL, IT WAS BASED ON WHAT'S, I THINK, A GOOD BODY OF
21 MEDICAL OPINION, LOOKING AT THE RATES OF COMPLICATIONS IN WOMEN
22 THAT HAVE ABORTION. I THINK IT IS PRETTY CLEAR FROM
23 NATIONWIDE STATISTICS LOOKING AT MORTALITY THAT THE LATER AN
24 ABORTION IS PERFORMED, THE HIGHER THE RATES OF COMPLICATIONS --
25 I AM SORRY -- THE HIGHER RATE OF MORTALITY. AND MOST MATERNAL

1 DEATHS ARE PRECEDED BY VARIOUS COMPLICATIONS. SO I WOULD INFER
2 THAT COMPLICATION RATES ARE HIGHER THE LATER IN PREGNANCY
3 ABORTION IS PERFORMED.
4 WITH THAT IN MIND, YOU KNOW, THE SPECULATION HAS
5 BEEN THAT SOMETHING IN THE ABORTION PROCEDURE IS DONE THAT CAN
6 PERHAPS DAMAGE THE UTERUS, OR SPECIFICALLY THE CERVIX, IN SOME
7 WAY THAT COULD PREDISPOSE TOWARDS PRE-TERM BIRTH IN A
8 SUBSEQUENT PREGNANCY.
9 THE COURT: SLOW DOWN.
10 THE WITNESS: I AM SO SORRY. I HOPE I DON'T GET
11 THIS IN NEW YORK.
12 MS. PARKER: JUST TAKE A DEEP BREATH EVERY ONCE IN
13 AWHILE. WE ARE IN CALIFORNIA NOW.
14 THE COURT: THE COURT REPORTERS IN NEW YORK ARE
15 PROBABLY MORE ACCUSTOMED TO THIS.
16 THE WITNESS: YES, I APOLOGIZE.
17 MS. PARKER: HE IS STILL ON NEW YORK TIME.
18 THE WITNESS: I WILL APOLOGIZE, AGAIN, WHEN I DO IT
19 AGAIN.
20 ANYWAY, GIVEN THAT THE RATE OF COMPLICATIONS MOST
21 LIKELY INCREASE AS GESTATIONAL AGE AT TIME OF ABORTION
22 INCREASES, IF THERE WOULD BE AN EFFECT ON RISK OF
23 COMPLICATIONS, NOTABLY SPONTANEOUS PRE-TERM BIRTH IN THE NEXT
24 PREGNANCY, IT WOULD -- WE INTUITIVELY -- AND, AGAIN, WE WERE
25 HOPING THAT WE DIDN'T SEE HIGH RATES AND, INDEED, WE DIDN'T.

1 BUT TO THE EXTENT THAT ONE MIGHT EXPECT THERE TO BE HIGHER
2 RATES, WE WOULD EXPECT THAT ABORTIONS DONE LATER IN PREGNANCY
3 WOULD BE MORE PRONE TO SPONTANEOUS PRE-TERM BIRTH. AND,
4 INDEED, WE SAW THE OPPOSITE.
5 BY MS. PARKER:
6 Q. DID YOUR STUDY HAVE ANY IMPLICATIONS ABOUT THE IMPACT OF
7 SECOND-TRIMESTER D&E ON CERVICAL INCOMPETENCE?
8 A. CERVICAL INCOMPETENCE, THAT IS A TERRIBLE TERM TO USE
9 ESPECIALLY IN FRONT OF THE PATIENT, BECAUSE THEY TAKE IT
10 PERSONAL. BUT, WE CAN SAY "CERVICAL INSUFFICIENCY."
11 BUT, ANYWAY, THIS TERM IMPLIES A PROPENSITY FOR THE
12 CERVIX TO DILATE PAINLESSLY OR NOT UNDER THE INFLUENCE OF LABOR
13 CONTRACTION IN THE UTERUS. AND THIS IS A RISK FACTOR FOR A
14 MISCARRIAGE IN THE SECOND-TRIMESTER OR PRE-TERM BIRTH, AS WELL.
15 AND TO THE EXTENT THAT D&E COULD OR SURGICAL
16 ABORTION COULD DAMAGE THE CERVIX AND COULD PREDISPOSE TO THIS
17 CONDITION, WE WOULD BE CONCERNED. AND, AGAIN, WE DIDN'T SEE
18 THIS IN THE STUDY. AND THE LOW RATES OF SPONTANEOUS PRE-TERM
19 BIRTH WE SAW IN THE WHOLE COHORT AS A WHOLE WERE EVEN LOWER IN
20 THOSE IN WHOM THE CERVIX WAS DILATED MORE AND AT LATER
21 GESTATIONAL AGES.
22 SO TO THE EXTENT THAT ANYONE COULD BE CONCERNED THAT
23 OSMOTIC DILATION OF THE CERVIX WITH LAMINARIA IS SOMETHING THAT
24 COULD DAMAGE THE CERVIX AND PREDISPOSE TO CERVICAL INCOMPETENCE
25 OR PRE-TERM BIRTH, I THINK THE STUDY SUGGESTS THAT THE OPPOSITE

1 IS TRUE.
2 Q. AND IN YOUR CLINICAL PRACTICE HAVE YOU SEEN AN INCREASED
3 RISK OF CERVICAL INCOMPETENCE IN WOMEN WITH PRIOR
4 SECOND-TRIMESTER D&E PROCEDURES?
5 A. PROBABLY THE THING I SPEND THE MOST TIME DOING IN MY
6 CLINICAL RESPONSIBILITIES IS OVERSEEING AN ULTRASOUND UNIT.
7 AND A PROCEDURE THAT IS PRETTY COMMON THAT MANY -- FOR WHICH
8 MANY WOMEN ARE REFERRED IN THE SECOND OR THE EARLY
9 THIRD-TRIMESTER IS ULTRASOUND EVALUATION OF THE CERVIX.
10 AND ULTRASOUND, VAGINAL ULTRASOUND, IS VERY GOOD IN
11 CHARACTERIZING THE LENGTH OF THE CERVIX AND WHETHER THERE ARE
12 EARLY SIGNS OF CERVICAL DILATION FROM WITHIN THAT CANNOT BE
13 APPRECIATED JUST ON A DIGITAL EXAMINATION.
14 AND WOMEN THAT ARE PERCEIVED TO BE AT HIGHER RISK OF
15 PRE-TERM BIRTH, WHETHER BECAUSE OF A HISTORY, OR WOMEN WITH
16 HISTORY OF ABORTION PROCEDURE, AND INCLUDING D&E, ARE PERCEIVED
17 BY THEIR OBSTETRICIANS TO BE AT HIGHER RISK.
18 TO ME, I SEE MANY WOMEN WITH A HISTORY -- HISTORIES
19 INCLUDING HISTORY OF D&E WHO REFER TO EVALUATE THE CERVIX TO
20 SEE IF THERE IS ANY SIGNS OF CERVICAL INCOMPETENCE.
21 AND WHEN WE DO THESE PROCEDURES ON THESE WOMEN WE
22 VERY, VERY RARELY SEE ANY SIGNS THAT WOULD SUGGEST AN
23 INCOMPETENT CERVIX. WE SEE IT PROBABLY NO MORE COMMONLY THAN
24 WE SEE AS AN INCIDENTAL FINDING IN WOMEN WHO COME FOR
25 ULTRASOUND FOR OTHER REASONS.

1 Q. SO DR. CHASEN, NOW I WOULD LIKE TO TALK TO YOU ABOUT
2 ANOTHER STUDY THAT YOU PERFORMED.
3 MS. PARKER: YOUR HONOR, CAN I APPROACH THE WITNESS?
4 BY MS. PARKER:
5 Q. DR. CHASEN, I HAVE HANDED YOU PLAINTIFFS' EXHIBIT 19, WHICH
6 IS AN ARTICLE CALLED "DILATION AND EVACUATION AT OR EQUAL TO --
7 GREATER THAN OR EQUAL TO 20 WEEKS: COMPARISON OF OPERATIVE
8 TECHNIQUES." DO YOU SEE THAT?
9 A. YES, I DO.
10 Q. AND HAS EXHIBIT 19 BEEN ACCEPTED FOR PUBLICATION?
11 A. IT HAS BEEN ACCEPTED FOR PUBLICATION. IT'S IN PRESS FOR
12 THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. THESE ARE
13 THE UNCORRECTED PROOFS. THE PUBLISHED VERSION IS ALMOST
14 IDENTICAL TO THESE UNCORRECTED PROOFS.
15 Q. RIGHT. AND I NEGLECTED TO NOTE THAT IT IS COPYRIGHTED 2004
16 BY ELSEVIER.
17 WHEN IS IT SCHEDULED FOR PUBLICATION?
18 A. I BELIEVE, ACCORDING TO THE PUBLISHER, THE MAY EDITION OF
19 THIS YEAR.
20 Q. WHAT JOURNAL IS IT GOING TO BE PUBLISHED IN?
21 A. THE GRAY JOURNAL: AMERICAN JOURNAL OF OBSTETRICS AND
22 GYNECOLOGY.
23 Q. WHAT WAS THE OBJECTIVE OF THE STUDY THAT IS DESCRIBED IN
24 THIS ARTICLE?
25 A. THE OBJECTIVE OF THE STUDY WAS TO LOOK AT WOMEN HAVING D&E

1 LATE IN THE SECOND-TRIMESTER, AT 20 WEEKS AND BEYOND, AND
2 LOOKS -- AND SPECIFICALLY DIVIDE THEM INTO TWO COHORTS: WOMEN
3 WHO HAD D&E WITH DISARTICULATION WITH FORCEPS VERSUS WOMEN WHO
4 HAD D&E WITH THE VARIATION WE WILL CALL "INTACT EXTRACTION" OR
5 "INTACT D&E." AND TO COMPARE OUTCOMES, INCLUDING COMPLICATION
6 RATES FROM D&E. AND A SECONDARY OBJECTIVE WAS TO LOOK AT
7 SUBSEQUENT PREGNANCY OUTCOMES IN THESE TWO COHORTS OF WOMEN.
8 Q. WHOSE IDEA WAS IT TO CONDUCT THE STUDY?
9 A. IT WAS MY IDEA TO CONDUCT THE STUDY.
10 Q. WHAT WAS YOUR ROLE ON THE STUDY?
11 A. I WAS THE PRINCIPAL INVESTIGATOR. I CONCEIVED OF THE
12 STUDY. I SOUGHT AND RECEIVED PERMISSION FROM THE INSTITUTIONAL
13 REVIEW BOARD TO CONDUCT THIS RETROSPECTIVE STUDY.
14 I DESIGNED THE DATA SHEET THAT MY CO-INVESTIGATOR --
15 THAT SOME OF MY CO-INVESTIGATORS WOULD USE TO EXTRACT DATA FROM
16 PATIENT MEDICAL RECORDS.
17 I DESIGNED THE DATABASE IN WHICH DATA WOULD BE
18 ENTERED. I DID THE STATISTICAL ANALYSIS MYSELF. I WROTE AND
19 REVISED THE MANUSCRIPT MYSELF WITH APPROPRIATE INPUT FROM MY
20 CO-AUTHORS.
21 Q. WHY DID YOU CONDUCT THE STUDY?
22 A. I CONDUCTED THE STUDY -- AND, AGAIN, THIS IS TRUE FOR ALL
23 THE STUDIES THAT I HAVE CONDUCTED AND PUBLISHED IN MY CAREER.
24 I CONDUCTED THE STUDY, REALLY, BECAUSE TO ANSWER A QUESTION OR
25 QUESTIONS. ANY STUDY THAT IS OUT THERE THAT CAN BE AND SHOULD

1 BE PUBLISHED, REALLY, IS TO ADDRESS A GAP IN MEDICAL KNOWLEDGE
2 THAT IS IN THE LITERATURE.
3 THERE CAN BE TOPICS FOR WHICH THERE AREN'T ANY
4 PUBLISHED STUDIES. THERE CAN BE TOPICS FOR WHICH THERE ARE
5 CONFLICTING DATA.
6 THIS SPECIFIC STUDY THE QUESTION, THE MEDICAL
7 QUESTION WHICH, I THINK, UNFORTUNATELY HAS BOILED OVER INTO A
8 LEGISLATIVE AND JUDICIAL CONTROVERSY, REGARDS THE SAFETY OF
9 DIFFERENT VARIATIONS OF D&E THAT ARE USED.
10 AND THERE ARE MEDICAL QUESTIONS WHICH I'M PRIMARILY
11 INTERESTED IN ABOUT THE SAFETY OF THESE DIFFERENT VARIATIONS OF
12 D&E. OF COURSE, OTHERS ARE INTERESTED IN OTHER FORUMS FOR
13 OTHER REASONS.
14 BUT IT WAS REALLY TO ANSWER QUESTIONS THAT ARE,
15 INDEED, MEDICAL CONTROVERSIES AND LOOKING AT OUR DATA, SHARING
16 OUR DATA IN THE PEER REVIEW LITERATURE, TO FILL IN, I THINK,
17 WHAT IS -- WHAT MOST PEOPLE WOULD AGREE IS A GAP IN THE PEER
18 REVIEW LITERATURE.
19 Q. DID YOU CONDUCT THE STUDY FOR THIS LITIGATION?
20 A. I DID NOT.
21 Q. WERE THERE ANY PREEXISTING PUBLISHED DATA COMPARING THE
22 SAFETY OF THE TWO VARIANTS OF D&E?
23 A. NOT THAT I AM AWARE OF. NOT THAT ANYONE THAT I KNOW OF IS
24 AWARE OF, SO I WOULD ANSWER: NO.
25 Q. WHEN WAS THE STUDY CONDUCTED?

1 A. THE STUDY WAS -- WE SOUGHT AND RECEIVED IRB APPROVAL IN
2 MARCH OF 2003. WE HAD ACCUMULATED DATA FROM WOMEN WHO HAD
3 UNDERGONE D&E FROM DR. KALISH'S STUDY FOR WHICH I WAS A
4 CO-AUTHOR THAT WE ALREADY DISCUSSED.
5 SO WE HAD DATA FROM THE YEARS 1996 THROUGH 2000, OF
6 WOMEN UNDERGOING D&E. WE WENT -- FOR THESE WOMEN WE ONLY WENT
7 TO SEE IF THERE WERE OTHER SUBSEQUENT PREGNANCIES THAT WE HAD
8 NOT RECOGNIZED OR THAT HAD NOT COMPLETED AT THE TIME WE
9 PUBLISHED THE PRIOR STUDY.
10 AND THEN, FROM -- WE RETRIEVED DATA FROM WOMEN
11 UNDERGOING D&E'S FROM, I BELIEVE, MAY 2000, WHERE THE LAST
12 STUDY LEFT OFF, THROUGH THE CURRENT TIME, THROUGH THE SPRING OF
13 2003.
14 SO WE COLLECTED DATA FROM MARCH -- I THINK THE END
15 OF MARCH 2003 THROUGH -- AND I BELIEVE WE WERE READY TO ANALYZE
16 DATA IN JULY. SO WE COLLECTED THROUGH JUNE OF 2003.
17 Q. SO, THE TIME FRAME OF THE DATA WHICH YOU LOOKED AT WAS FROM
18 1996 TO THE SUMMER OF 2003?
19 A. THROUGH JUNE OF 2003, I BELIEVE.
20 Q. WHAT TYPE OF STUDY WAS IT?
21 A. THIS IS A RETROSPECTIVE COHORT STUDY.
22 Q. IN YOUR OPINION IS A RETROSPECTIVE COHORT STUDY AN
23 APPROPRIATE WAY TO CONDUCT A MEDICAL STUDY COMPARING THE SAFETY
24 OF TWO SURGICAL TECHNIQUES?
25 A. IT'S REALLY INVARIABLY -- AGAIN, IT IS ALMOST ALWAYS THE

1 FIRST STUDY THAT COMPARES SAFETY OR OUTCOMES IN DIFFERING
2 SURGICAL TECHNIQUES IS A RETROSPECTIVE STUDY THAT, AGAIN, IT
3 WILL INVARIABLY PROCEED IN ANY RANDOMIZED PROSPECTIVE STUDY.
4 Q. AND YOU INDICATED YOU EXAMINED TWO DIFFERENT VARIANTS OF
5 D&E. SO DID YOU DISTINGUISH BETWEEN THEM FOR PURPOSES OF THIS
6 STUDY?
7 A. YES, WE DID.
8 Q. WHAT DID YOU CALL THE TWO VARIANTS IN THE STUDY?
9 A. IT UNDERWENT AN EVOLUTION IN DIFFERENT VERSIONS OF THE
10 MANUSCRIPT. THE FIRST VERSION MIRRORS MY CLINICAL PRACTICE AND
11 HOW I DESCRIBE THESE THINGS. THAT THERE WAS -- THE TWO
12 VARIATIONS WERE D&E WITH DISARTICULATION AND D&E WITH INTACT
13 EXTRACTION.
14 AS THIS WENT THROUGH PEER REVIEW, IT WAS SUGGESTED
15 THAT WE -- THAT THAT WAS A LITTLE VERBOSE AND THAT WE TALK
16 ABOUT -- WE USE THE TERM THAT ACOG HAD USED "INTACT DILATION
17 AND EXTRACTION," OR "D&X."
18 SO I THINK THE SECOND VERSION TALKED ABOUT D&E,
19 DILATION AND EVACUATION AND DILATION AND EXTRACTION. AND IN
20 THE FINAL VARIATION, WHICH IS THE ONE THAT WILL BE PUBLISHED,
21 WE ADDED THE WORD "INTACT" IN FRONT OF -- BEFORE "DILATION AND
22 EXTRACTION," JUST TO CREATE MORE OF A CONTRAST FOR THE READERS.
23 THERE WAS DILATION AND EVACUATION AND INTACT DILATION AND
24 EXTRACTION.
25 BUT BASED ON THE TITLE OF THE STUDY AND BASED ON THE

1 INTRODUCTION, IT IS VERY CLEAR THAT THESE WERE ALL D&E
2 PROCEDURES AND THEY WERE DEALING WITH TWO VARIATIONS.
3 Q. AND HOW DID YOU DISTINGUISH BETWEEN THE INTACT AND
4 DISARTICULATION PROCEDURES WHEN YOU WERE REVIEWING THE MEDICAL
5 RECORDS?
6 A. WELL, WE REVIEWED THE OPERATIVE REPORTS. AND AT OUR
7 TEACHING INSTITUTION, IN MOST CASES RESIDENTS OR FELLOWS WILL
8 DICTATE THEIR OPERATIVE REPORTS, AND USUALLY THEY WILL REALLY
9 DICTATE EVERYTHING IN USING A LOT OF DETAIL. SO WE WERE ABLE
10 TO DIFFERENTIATE, PRIMARILY, BY LOOKING AT THE DICTATED
11 OPERATIVE REPORTS WHICH TECHNIQUE WAS USED.
12 WERE YOU ASKING HOW WE DEFINED IT?
13 Q. YES. OBVIOUSLY, AT SOME POINT YOU DEFINED THEM IN ONE
14 CATEGORY OR ANOTHER, AND HOW WERE YOU ABLE TO DIFFERENTIATE THE
15 TWO?
16 A. WELL, THE DEFINITION REALLY PRECEDED THE CATEGORIZATION.
17 AND WE HAD ACTUALLY COME UP WITH A DEFINITION BEFORE THE KALISH
18 STUDY, BECAUSE THAT WAS PART OF THE DATA THAT WE COLLECTED AT
19 THAT POINT.
20 AND THE SIMPLEST WAY TO DIFFERENTIATE WAS WHETHER
21 DISARTICULATION WITH FORCEPS WAS USED IN REMOVING THE FETUS.
22 AS WE STATE IN THE "MATERIAL AND METHODS" IT WAS
23 CATEGORIZED AS INTACT EXTRACTION FROM ONE OF TWO SCENARIOS.
24 EASILY, THE MOST COMMON SCENARIO IN PATIENTS CATEGORIZED AS
25 HAVING D&E WITH INTACT EXTRACTION WAS, INDEED, A BREECH

1 EXTRACTION, IN WHICH CASE THE FETUS WAS REMOVED INTACT.
2 IN ALMOST ALL OF THE THESE CASES THE FETUS WAS
3 REMOVED INTACT UP TO THE LEVEL OF THE HEAD. THERE WERE A
4 HANDFUL OF CASES WHERE DISARTICULATION OCCURRED AFTER THE LOWER
5 EXTREMITIES AND THE PELVIS WERE REMOVED, BUT BEFORE THE FETUS
6 WAS REMOVED TO THE LEVEL OF THE HEAD.
7 I THINK MOST OF THESE CASES WERE IN CASES OF FETAL
8 DEMISE WHERE THE FETUS WAS MACERATED TO A CERTAIN DEGREE MORE
9 AND MORE PRONE TO DISARTICULATE.
10 BUT IN THESE CASES, IN DOING THE BREECH EXTRACTION
11 WHEN DISARTICULATION OCCURRED ABOVE THE LEVEL OF THE PELVIS OR
12 SOMEWHERE BETWEEN DELIVERY OF THE ABDOMEN AND DELIVERY OF THE
13 HEAD --
14 Q. SLOW DOWN.
15 A. I AM SORRY -- THE PROCEDURE WAS COMPLETED WITHOUT USING
16 FORCEPS TO DISARTICULATE. SO EVEN THOUGH THE FETUSES DID NOT
17 LOOK AN AS INTACT AS MOST OF THE FETUSES THAT WE CALLED "INTACT
18 D&X" FORCEP -- DISARTICULATION WITH FORCEPS WASN'T USED.
19 THERE WERE A HANDFUL OF CASES WHERE THE CERVIX WAS
20 DILATED TO A CONSIDERABLE DEGREE AND THE CERVIX WAS VERY
21 EFFACED SO THAT WE COULD DIRECTLY VISUALIZE THE FETAL HEAD
22 RIGHT AT THE LEVEL OF THE OPENING OF THE CERVIX.
23 AND IN THESE CASES THE EASIEST THING TO DO WAS,
24 UNDER DIRECT VISUALIZATION, WE WERE ABLE TO -- THE OPERATOR WAS
25 ABLE TO DECOMPRESS THE HEAD BY MAKING AN INCISION WITH SCISSORS

1 UNDER DIRECT VISUALIZATION, INTRODUCING SUCTION TO DECREASE THE
2 SIZE OF THE HEAD, AND INTACT EXTRACTION FOLLOWED THAT WAY
3 HEADFIRST.
4 ALL OTHER CASES WERE CASES THAT REQUIRED
5 DISARTICULATION WITH FORCEPS. AND THEY WERE CATEGORIZED AS
6 D&E.
7 Q. OKAY. HOW MANY PATIENTS WERE INCLUDED IN THE STUDY,
8 ALTOGETHER?
9 A. THERE WERE 383 PATIENTS WHO HAD D&E AT 20 WEEKS OR GREATER.
10 Q. AND -- OH, GO AHEAD.
11 A. THERE WERE 383.
12 Q. AND OF THOSE, HOW MANY WERE CATEGORIZED AS HAVING HAD
13 INTACT D&E'S?
14 A. 120.
15 Q. HOW MANY WERE CATEGORIZED AS HAVING HAD D&E'S WITH
16 DISARTICULATION?
17 A. 263.
18 Q. AND YOU ALSO INDICATED THAT YOU LOOKED AT WHETHER OR NOT
19 SOME OF THE PATIENTS HAD SUBSEQUENT PREGNANCIES?
20 A. SUBSEQUENT PREGNANCIES AT OUR INSTITUTION. AND THERE WERE
21 62 SUCH PATIENTS: 45 IN D&E WITH DISARTICULATION; 17 WITH D&E
22 WITH INTACT EXTRACTION, SOME OF WHOM WERE INCLUDED IN THE PRIOR
23 STUDY.
24 Q. AND HOW DID YOU LOCATE THOSE PATIENTS?
25 A. AGAIN, WE HAD HAD -- I BELIEVE THE MAJORITY OF THESE

1 PATIENTS WERE INCLUDED IN THE OTHER -- IN THE STUDY THAT WAS
2 PUBLISHED PRIOR. AND, AGAIN, IN ALL THE PATIENTS WE LOOKED AT
3 THE HOSPITAL MEDICAL RECORDS TO SEE WHO HAD RECEIVED CARE IN
4 THE OBSTETRICS SERVICE, AND THAT IS HOW WE OBTAINED THAT
5 INFORMATION.
6 Q. IN YOUR OPINION, WAS THE METHODOLOGY AND THE DATA THAT YOU
7 USED SUFFICIENT TO DRAW RELIABLE CONCLUSIONS ABOUT THE
8 RESPECTIVE SAFETY OF THE TWO VARIATIONS OF THE D&E PROCEDURE?
9 A. YES.
10 Q. AND WAS THE NUMBER OF CASES THAT YOU STUDIED SUFFICIENT IN
11 NUMBER TO DRAW YOUR CONCLUSIONS?
12 A. YES, IT WAS.
13 Q. AND WHY IS THAT?
14 A. WELL, BASED ON NATIONWIDE STATISTICS D&E AT THESE
15 GESTATIONAL AGES IS A PRETTY UNCOMMON PROCEDURE. AND I
16 THINK -- AND BASED ON OTHER STUDIES THAT ARISE FROM SINGLE
17 INSTITUTIONS, I THINK I CAN SAY PRETTY CONFIDENTLY A SERIES OF
18 383 PATIENTS UNDERGOING D&E AT THESE GESTATIONAL AGES
19 CONSTITUTES A VERY LARGE STUDY, NUMBER ONE.
20 NUMBER TWO: IN THE ABSENCE OF ANY OTHER PUBLISHED
21 DATA THAT I OR ANYONE ELSE SEEMS TO BE AWARE OF, LOOKING AT
22 THESE VARIATIONS OF D&E, HAVING 120 SUCH CASES, IN AND OF
23 ITSELF IS VERY LARGE, BUT ESPECIALLY IN THE CONTEXT OF A
24 COMPLETE INFORMATION VACUUM. AGAIN, I THINK IT IS A VERY LARGE
25 STUDY. AND IT GAVE ME AND MY CO-AUTHORS THE ABILITY TO DRAW

1 RELIABLE CONCLUSIONS ABOUT ITS SAFETY.
2 Q. YOU ALSO INDICATED YOU REVIEWED INFORMATION AT YOUR
3 INSTITUTION TO DETERMINE COMPLICATIONS OF THE TWO TECHNIQUES;
4 IS THAT RIGHT?
5 A. THAT IS CORRECT.
6 Q. WHAT DID YOU CONSIDER A COMPLICATION FOR PURPOSES OF THE
7 STUDY?
8 A. IN A BROAD SENSE, A COMPLICATION WAS SOMETHING THAT
9 REQUIRED AN INTERVENTION THAT IS NOT NORMALLY DONE OR REQUIRED
10 IN THE COURSE OF THESE PATIENTS UNDERGOING A D&E. AS WE LISTED
11 IN THE "MATERIAL AND METHODS" THESE INCLUDED UNPLANNED HOSPITAL
12 ADMISSIONS. AND, AGAIN, ALMOST ALL OF THESE PATIENTS WERE
13 OUTPATIENTS.
14 SOME PATIENTS, SPECIFICALLY THOSE WHO WERE ADMITTED
15 WITH PRE-TERM PREMATURE RUPTURE OF MEMBRANES, OR IN SOME CASES
16 CERVICAL DILATION WERE ALREADY INPATIENTS. BUT AN UNPLANNED
17 ADMISSION: HEMORRHAGE REQUIRING A BLOOD TRANSFUSION; ADMISSION
18 TO AN INTENSIVE CARE UNIT.
19 AS A TYPICAL PART OF THE D&E PROCEDURE, TYPICALLY
20 NOTHING REQUIRES ANY SUTURING, SO ANY LACERATION REQUIRING
21 SUTURING; ANY PATIENT WHO WENT HOME AS PLANNED, BUT REQUIRED
22 READMISSION FOR COMPLICATIONS RELATING TO D&E. THESE WERE --
23 OR WOMEN WHO WENT TO THE RECOVERY ROOM AFTER THE D&E AND HAD TO
24 GO BACK THE DAY OF THE SURGICAL PROCEDURE FOR SOMETHING
25 ADDITIONAL, THESE WERE ALL THINGS THAT WERE COMPLICATIONS.

1 Q. WHAT DID YOUR STUDY CONCLUDE?
2 A. OUR STUDY CONCLUDED THAT IN THESE WOMEN LATE IN THE
3 SECOND-TRIMESTER UNDERGOING D&E THAT THE OVERALL RATE OF
4 COMPLICATIONS, MOST OF WHICH WERE MINOR, WAS 5 PERCENT, AND
5 THAT THERE WAS NO SIGNIFICANT DIFFERENCE IN THE COMPLICATION
6 RATE BETWEEN THOSE WOMEN UNDERGOING D&E WITH INTACT EXTRACTION
7 COMPARED TO THOSE WOMEN UNDERGOING D&E WITH DISARTICULATION.
8 Q. NOW, YOU INDICATED THE RATE WAS 5 PERCENT OVERALL? WHAT
9 WAS THE COMPLICATION RATE FOR THE D&E'S ANALYZED IN BOTH
10 GROUPS?
11 A. IT WAS 4.9 PERCENT, OR I THINK 13 OUT OF 263 FOR THE D&E
12 WITH DISARTICULATION, COMPARED WITH 4.9 PERCENT COMPARED WITH
13 5.0 PERCENT OR SIX OUT OF 120 IN WOMEN UNDERGOING D&E WITH
14 INTACT EXTRACTION.
15 Q. WHAT DOES THE COMPLICATION RATE OF ROUGHLY 5 PERCENT REVEAL
16 ABOUT BOTH OF THESE VARIATIONS OF D&E?
17 A. I THINK IT REVEALS THAT THESE -- ESPECIALLY GIVEN THAT
18 ALMOST ALL OF THE -- THAT ALL BUT THREE OF THESE COMPLICATIONS
19 WOULD BE CONSIDERED MINOR, THIS IS A -- THAT THESE ARE SAFE.
20 BOTH VARIATIONS OF D&E SHOULD BE CONSIDERED SAFE.
21 Q. HOW MANY COMPLICATIONS WERE REPORTED IN THE STUDY?
22 A. TOTAL OF 19.
23 Q. WHAT KIND OF COMPLICATIONS DID YOU OBSERVE?
24 A. I THINK MORE THAN HALF OF THE COMPLICATIONS WERE GENITAL
25 TRACT LACERATIONS. I THINK MOST OF THOSE WERE CERVICAL --

1 SUPERFICIAL CERVICAL LACERATIONS, REALLY, AT THE SITE OF THE
2 TENACULUM OR THE CLAMP THAT HOLDS THE CERVIX IN PLACE. THERE
3 WERE SOME LACERATIONS INVOLVING THE LABIA, I THINK.
4 THERE WERE OTHER COMPLICATIONS. THEY INCLUDED A FEW
5 PATIENTS THAT NEEDED CURETTAGE AFTER THEY WENT TO THE RECOVERY
6 ROOM. A COUPLE PATIENTS WHO GOT READMITTED FOR HAVING BLEEDING
7 AND REQUIRED CURETTAGE. AND THERE WERE THREE SEVERE
8 COMPLICATIONS.
9 Q. SO THERE WAS THREE SEVERE COMPLICATIONS OUT OF 383
10 PATIENTS?
11 A. THAT'S RIGHT.
12 Q. AND WHAT WERE THOSE?
13 A. THESE THREE COMPLICATIONS, ONE WOMAN HAD UTERINE
14 PERFORATION, AND SHE UNFORTUNATELY REQUIRED A HYSTERECTOMY.
15 ONE WOMAN HAD AN AMNIOTIC FLUID EMBOLISM, AND SHE
16 WAS ADMITTED TO THE INTENSIVE CARE UNIT, AND SHE REQUIRED
17 TRANSFUSION OF BLOOD AND BLOOD PRODUCTS.
18 AND ANOTHER WOMAN HAD A DISSEMINATED BODY WIDE
19 INFECTION AND SEPSIS, WHICH WAS A LIFE-THREATENING CONDITION,
20 AND SHE REQUIRED ADMISSION TO THE INTENSIVE CARE UNIT.
21 AND DURING THAT ADMISSION, SHE WAS ALSO DIAGNOSED
22 WITH PULMONARY EMBOLISM, WHICH IS A BLOOD CLOT THAT LODGES IN
23 THE BLOOD VESSELS AND IN THE LUNG, WHICH IS ALSO A
24 LIFE-THREATENING COMPLICATION.
25 Q. AND WHAT VARIANT OF D&E DID THE THREE WOMEN WHO EXPERIENCED

1 THE SEVERE COMPLICATIONS HAVE?
2 A. ALL THREE OF THESE WOMEN HAD D&E WITH DISARTICULATION.
3 Q. DID YOU FIND THAT THE DIFFERENCE IN TERMS OF SEVERE
4 COMPLICATIONS BETWEEN THE TWO VARIANTS AT A LEVEL OF
5 STATISTICAL SIGNIFICANCE?
6 A. NO. IT WAS A 1.1 PERCENT RATE OF SEVERE COMPLICATIONS IN
7 THE WOMEN WHO HAD D&E WITH DISARTICULATION COMPARED TO
8 0 PERCENT, NONE, IN THE WOMEN WHO HAD D&E WITH INTACT
9 EXTRACTION. BUT THAT DID NOT APPROACH THE LEVEL OF STATISTICAL
10 SIGNIFICANCE.
11 Q. WERE THERE DIFFERENCES IN THE DEMOGRAPHICS OF THE TWO
12 GROUPS, PATIENTS THAT WERE IN THE STUDY?
13 A. THERE WERE SOME IMPORTANT DIFFERENCES IN THE DEMOGRAPHICS.
14 STARTING WITH THE INDICATION FOR HAVING THE PROCEDURE, A
15 SIGNIFICANTLY HIGHER PROPORTION OF WOMEN WHO HAD D&E WITH
16 INTACT EXTRACTION HAD IT BECAUSE THEY HAD ADVANCED CERVICAL
17 DILATION OR THEY HAD PRE-TERM PREMATURE RUPTURE OF MEMBRANE
18 SYNDROME, OR PPROM, BOTH OF WHICH ARE ASSOCIATED WITH HIGH
19 RISK -- HIGH RATES OF UTERINE INFECTIONS.
20 THE WOMEN THAT UNDERWENT D&E WITH INTACT EXTRACTION
21 WERE AT SIGNIFICANTLY ADVANCED DEGREES OF GESTATION, THAT THE
22 MEDIAN GESTATIONAL AGE IN THIS GROUP WAS 23 WEEKS COMPARED TO A
23 MEDIAN GESTATIONAL AGE OF ONLY 21 WEEKS IN THE WOMEN THAT HAD
24 D&E WITH DISARTICULATION.
25 Q. IS THAT DIFFERENCE IN GESTATIONAL AGE SIGNIFICANT?

1 A. IT WAS HIGHLY STATISTICALLY SIGNIFICANT. THE PROBABILITY
2 THAT THIS DIFFERENCE OCCURRED PURELY AS A MATTER OF CHANCE AND
3 DIDN'T REPRESENT A TRUE DIFFERENCE WAS LESS THAN ONE IN A
4 THOUSAND.
5 Q. WHY IS IT SIGNIFICANT?
6 A. IT IS SIGNIFICANT BECAUSE, AGAIN, THE LITERATURE THAT IS
7 OUT THERE IS CONSISTENT WITH THE NOTION THAT COMPLICATIONS OF
8 D&E OR ANY TYPE OF ABORTION, INCLUDING MEDICAL ABORTION,
9 INCREASE WITH ADVANCING GESTATIONAL AGE.
10 SO, IN THAT THE WOMEN THAT HAD D&E WITH INTACT
11 EXTRACTION WERE AT SIGNIFICANTLY MORE ADVANCED GESTATIONAL AGES
12 COMPARED TO THOSE THAT HAD D&E WITH DISARTICULATION, THAT THESE
13 WOMEN WOULD BE EXPECTED TO BE AT HIGH RISK OF COMPLICATION.
14 Q. SO YOU WOULD EXPECT MORE COMPLICATIONS AT A LATER
15 GESTATIONAL AGE?
16 A. ABSOLUTELY.
17 Q. BUT YOU DIDN'T FIND THAT?
18 A. WE DID NOT FIND THAT.
19 Q. DID THE STUDY KEEP TRACK OF THE AMOUNT OF BLOOD LOSS FOR
20 BOTH INTACT D&E AND THE D&E WITH DISARTICULATION GROUPS?
21 A. IT DID.
22 Q. AND WHAT WERE THE RESULTS REGARDING THE AMOUNT OF BLOOD
23 LOSS?
24 A. THE RESULTS, THE MEDIAN BLOOD LOSS OF 100 MILLILITERS WAS
25 THE SAME IN BOTH GROUPS. THE GROUPS THAT HAD THE HIGHEST

1 RATES, THAT THE CASES WHERE THERE WERE THE HIGHEST DEGREES OF
2 BLOOD LOSS WERE IN THE DISARTICULATION GROUP. BUT AS A WHOLE,
3 LOOKING AT THE DISTRIBUTIONS, THEY WERE NOT STATISTICALLY
4 SIGNIFICANT BETWEEN THE TWO GROUPS.
5 Q. DID YOU KEEP TRACK OF THE PROCEDURE TIME FOR BOTH INTACT
6 D&E AND THE D&E WITH DISARTICULATION GROUPS?
7 A. WE DID.
8 Q. AND WHAT WERE THE RESULTS REGARDING THE PROCEDURE TIME
9 COMPARING THE TWO GROUPS?
10 A. SIMILAR TO THE BLOOD LOSS. THE MEDIAN TIME OF 22 MINUTES
11 FOR USING BOTH VARIANTS WAS IDENTICAL. THE LONGEST CASES IN
12 THE SERIES -- IN THIS SERIES WERE IN THE DISARTICULATION GROUP.
13 BUT, AGAIN, IT WASN'T A STATISTICAL -- STATISTICALLY
14 SIGNIFICANT DIFFERENCE IN OPERATING TIME BETWEEN THE TWO
15 COHORTS.
16 Q. YOU ALSO INDICATED THAT THE STUDY LOOKED AT OBSTETRIC
17 OUTCOMES. DID THE STUDY FIND A DIFFERENCE IN THE OBSTETRIC
18 OUTCOMES OF SUBSEQUENT PREGNANCIES BETWEEN THE TWO GROUPS?
19 A. WE DID NOT.
20 Q. AND WHAT DID THE STUDY FIND?
21 A. THE STUDY FOUND IN THE 62 -- THERE WERE 62 PATIENTS WHO HAD
22 SUBSEQUENT PREGNANCIES IN OUR HOSPITAL, 45 -- AND THE
23 PROPORTIONS OF THE TWO VARIANTS WERE ROUGHLY THE SAME AS IN THE
24 OVERALL STUDY.
25 FORTY-FIVE OF THESE WOMEN HAD -- WITH SUBSEQUENT

1 PREGNANCIES HAD D&E WITH DISARTICULATION, COMPARED TO 17 WHO
2 HAD SUBSEQUENT PREGNANCY WHO HAD D&E WITH INTACT EXTRACTION.
3 THE VARIABLE WE LOOKED AT WAS THE RATE OF
4 SPONTANEOUS PRE-TERM BIRTH. TWO WOMEN IN EACH OF THE GROUPS
5 HAD SUBSEQUENT SPONTANEOUS PRE-TERM BIRTH. TWO OUT OF 45 WAS
6 BETWEEN FOUR AND FIVE PERCENT. TWO OUT OF 17 WAS BETWEEN 11
7 AND 12 PERCENT. THAT DIFFERENCE DID NOT APPROACH STATISTICAL
8 SIGNIFICANCE.
9 Q. WHAT IS THE IMPORT OF THOSE RESULTS REGARDING OBSTETRIC
10 OUTCOMES?
11 A. WELL, THE OTHER THING THAT WE NOTE IN THE "RESULT" SECTION
12 OF THE STUDY THAT IS IMPORTANT TO CONSIDER IS THAT THE TWO
13 WOMEN OUT OF THE 17 THAT HAD D&E WITH INTACT EXTRACTION WHO HAD
14 A SPONTANEOUS PRE-TERM BIRTH, BOTH UNDERWENT ABORTION IN THE
15 PRIOR PREGNANCY BECAUSE THEY HAD EVIDENCE OF -- THAT THEY WOULD
16 INEVITABLY MISCARRY OR DELIVER VERY PREMATURELY.
17 ONE OF THESE WOMEN HAD ADVANCE DEGREES OF CERVICAL
18 DILATION AT AROUND 23 WEEKS, AND THE OTHER ONE HAD RUPTURED HER
19 MEMBRANES AT 23 WEEKS, AS WELL. SO THESE TWO WOMEN, ONE
20 DELIVERED AT 32 WEEKS IN THE NEXT PREGNANCY, AND ONE DELIVERED
21 AT 35 WEEKS IN THE NEXT PREGNANCY.
22 THESE TWO WOMEN, IF THEY HADN'T BEEN TOUCHED, IF
23 THEY DIDN'T HAVE A D&E, OR IF THEY DELIVERED SPONTANEOUSLY OR
24 MEDICAL INDUCTION OR DIDN'T HAVE AN INTERVENTION WOULD BE
25 CONSIDERED AT VERY, VERY HIGH RISK FOR SPONTANEOUS PRE-TERM

1 BIRTH IN THE NEXT PREGNANCY.
2 AND, INDEED, THESE WOMEN HAD MUCH, MUCH, YOU KNOW,
3 MUCH MORE SUCCESSFUL OBSTETRIC OUTCOMES IN THE PRIOR PREGNANCY
4 AFTER UNDERGOING D&E WITH INTACT EXTRACTION.
5 SO TO SUM IT ALL UP, BASED ON THE DATA WITH
6 SUBSEQUENT OBSTETRIC OUTCOMES, WE DO NOT SEE ANY EVIDENCE THAT
7 INTACT EXTRACTION INCREASES THE RISK OF SPONTANEOUS PRE-TERM
8 BIRTH WHEN THAT RISK DOES NOT ALREADY EXIST.
9 Q. YOU INDICATED YOU LOOKED AT 62 WOMEN WHO HAD HAD SUBSEQUENT
10 PREGNANCIES?
11 A. YES.
12 Q. IS THAT NUMBER A SUFFICIENT NUMBER ON WHICH TO BASE THE
13 CONCLUSIONS THAT YOU'VE DRAWN?
14 A. I THINK IT'S A SUFFICIENT NUMBER TO SAY THAT IF THERE IS
15 ANY IMPACT UPON THE D&E OVERALL, OR THE SPECIFIC VARIATION OF
16 D&E, THAT THE IMPACT OR THE RELATIVE IMPACT IN TERMS OF RISK OF
17 SPONTANEOUS PRE-TERM BIRTH IS LIKELY TO BE SMALL.
18 Q. WHAT WAS THE OVERALL CONCLUSION OF YOUR STUDY AS TO THE
19 RELATIVE SAFETY OF THE TWO VARIATIONS OF D&E?
20 A. THE OVERALL CONCLUSION -- AND THIS BEING THE FIRST STUDY
21 THAT HAS LOOKED AT THIS TOPIC, I THINK WE WERE APPROPRIATELY
22 CONSERVATIVE IN OUR CONCLUSIONS. THE OVERALL CONCLUSION IS
23 THAT THESE ARE BOTH SAFE PROCEDURES, AND THAT THE COMPLICATION
24 RATES IN THE SUBSEQUENT PREGNANCY OUTCOMES, WITH THE CAVEATS
25 THAT I HAVE DESCRIBED ALREADY, APPEAR TO BE COMPARABLE. AND

1 THAT SORT OF THE TAKE-HOME MESSAGE IS THAT THE APPROPRIATE WAY
2 TO PERFORM A D&E AT THESE GESTATIONAL AGES SHOULD BE BASED ON
3 THE INTRAOPERATIVE JUDGMENTS OF THE PHYSICIAN.
4 NOW, IN THE CONCLUSION, YOU KNOW, WE ALSO SPECULATE
5 THAT IN THE 120 WOMEN WHO HAD D&E WITH INTACT EXTRACTION THAT
6 THE -- THAT IT IS VERY LIKELY -- THAT WE THINK IT IS LIKELY
7 THAT THE ABILITY FOR US TO USE OUR JUDGMENT, TO IMPLEMENT OUR
8 JUDGMENT AND TO USE THIS TECHNIQUE, OR VARIATION OF D&E, LIKELY
9 AVOIDED SOME OF THE COMPLICATIONS, AND ESPECIALLY SEVERE
10 COMPLICATIONS THAT WERE SEEN IN THE OTHER COHORT PATIENTS.
11 Q. DO YOU HAVE AN OPINION AS TO WHAT THE STUDY SHOWS ABOUT THE
12 RELATIVE SAFETY OF THE TWO VARIANTS?
13 A. YES.
14 Q. WHAT IS THAT OPINION?
15 A. AGAIN, THE OPINION EXPRESSED IN THE PAPER -- AND IS A VALID
16 OPINION -- IS THAT THEY ARE BOTH SAFE PROCEDURES. BUT I THINK
17 IN LOOKING AT THE DATA, I CONCLUDE THAT D&E INTACT EXTRACTION
18 COULD HAVE SAFETY ADVANTAGES.
19 Q. WHY IS THAT?
20 A. AGAIN, THE TWO COHORT PATIENTS WERE NOT THE SAME. AND TO
21 ME, THE MOST SALIENT DIFFERENCES WITH WERE THE GESTATIONAL
22 AGES, THE WOMEN HAVING D&E WITH INTACT EXTRACTION WERE AT MORE
23 ADVANCED GESTATIONAL AGES. AND THE HIGHER PROPORTION OF THEM
24 WERE UNDERGOING D&E BECAUSE THEY HAD RUPTURED MEMBRANES OR
25 SIGNIFICANT DEGREES OF CERVICAL DILATION, BOTH OF WHICH ARE

1 ASSOCIATED WITH COMPLICATIONS.
2 BECAUSE THE INTACT EXTRACTION COHORT WOULD BE
3 EXPECTED, VERY REASONABLY, TO HAVE HIGHER RATES OF
4 COMPLICATIONS, AND WE, IN FACT, DID NOT SEE THAT, AND WE SAW
5 FEWER, ALTHOUGH NOT STATISTICALLY SIGNIFICANT DIFFERENCE, BUT
6 WE DIDN'T SEE ANY SEVERE COMPLICATIONS, THAT THIS SUGGESTS THAT
7 THE ABILITY TO USE THE INTACT EXTRACTION VARIATION OF D&E IS
8 SAFER AND DOES -- AND WHEN IT IS FEASIBLE DOES PREVENT
9 COMPLICATIONS.
10 Q. DO ANY OTHER RESULTS FROM YOUR STUDY SUPPORT YOUR OPINION
11 THAT INTACT D&E MAY, IN FACT, BE SAFER?
12 A. YES.
13 Q. WHAT ARE THOSE RESULTS?
14 A. AS WE DESCRIBED, SIMILAR TO THE OVERALL RATE OF
15 COMPLICATIONS, THE INTRAOPERATIVE BLOOD LOSS AND THE OPERATING
16 TIMES, BECAUSE WITH THE ADVANCED GESTATIONAL AGES THAT WE SAW
17 IN THE INTACT EXTRACTION COHORT, WE WOULD EXPECT -- AND, YOU
18 KNOW, THE MEDIANS WERE 21 AND 23 WEEKS IN THE TWO GROUPS.
19 THE SIZE OF THE FETUS AT 23 WEEKS, BASED ON WEIGHT,
20 IS APPROXIMATELY 50 PERCENT MORE THAN THE SIZE OF A 21 WEEK
21 FETUS. THE SIZE OF THE -- THE RELATIVE PLACENTAL SIZES ALSO
22 WOULD PROBABLY CORRESPOND TO THAT DIFFERENCE. THAT I WOULD
23 EXPECT THAT REMOVING THE FETUS AND PLACENTA AT THOSE
24 GESTATIONAL AGES WOULD TAKE LONGER.
25 SO, AGAIN, I THINK THAT THE DATA ARE CONSISTENT

1 WITH -- IF WE DIDN'T SEE ANY DIFFERENCE IN OPERATING -- ANY
2 SIGNIFICANT DIFFERENCE IN OPERATING TIMES IN THE TWO COHORTS OF
3 PATIENTS, THAT THAT SUGGESTS THAT USE OF INTACT EXTRACTION CAN
4 SHORTEN OPERATIVE TIMES.
5 AND, AGAIN, SHORTER OPERATIVE TIMES PROBABLY
6 REFLECTS SHORTER BLOOD LOSS AND LESS ANESTHESIA EXPOSURE AND
7 WOULD LOWER THE COMPLICATION RISK AND INCREASE THE SAFETY.
8 AND, AGAIN, LOOKING AT BLOOD LOSS, AGAIN THE SAME
9 FACTORS THAT WE TALKED ABOUT. WITH INCREASING GESTATIONAL AGE,
10 THE UTERUS IS BIGGER. THE AMOUNT OF BLOOD THAT THE HEART PUMPS
11 TO THE UTERUS IS MORE. OPERATIVE TIMES MAY BE MORE.
12 SO, AGAIN, THESE ARE INCREASED RISKS OF HEMORRHAGE.
13 AND TO THE EXTENT THAT WE DIDN'T SEE ANY SIGNIFICANT DIFFERENCE
14 IN THE RATES OF BLOOD LOSS, AND WE SAW NONSIGNIFICANT
15 DIFFERENCES IN THE RATE OF TRANSFUSION, AGAIN, THIS SUGGESTS
16 THAT THE RATE OF BLOOD LOSS -- THAT THAT USE OF THE INTACT
17 VARIATION OF D&E PREVENTS OR MINIMIZES BLOOD LOSS.
18 MS. PARKER: YOUR HONOR, I AM READY TO MOVE TO THE
19 NEXT TOPIC, BUT I NOTICE IT IS ABOUT 10:00.
20 THE COURT: YES. I THINK IT IS TIME FOR OUR FIRST
21 BREAK OF THE MORNING. WE WILL BREAK FOR 15 MINUTES.
22 (RECESS TAKEN AT 10:00 A.M.)
23 (PROCEEDINGS RESUMED AT 10:18 A.M.)
24 THE COURT: ALL RIGHT. PLEASE CONTINUE.
25 ///

1 BY MS. PARKER:
2 Q. DR. CHASEN, WE HAVE BEEN TALKING ABOUT TWO STUDIES THAT YOU
3 PERFORMED. I WOULD NOW LIKE TO MOVE TO TALKING ABOUT YOUR
4 OPINIONS BASED MORE ON YOUR CLINICAL EXPERIENCE.
5 DO YOU HAVE AN OPINION REGARDING THE SAFETY OF
6 INTACT D&E VARIANT AS COMPARED TO THE DISARTICULATION VARIANT
7 OF D&E?
8 A. YES, I DO.
9 Q. WHAT IS THAT OPINION?
10 A. MY OPINION IS THAT IN CASES IN WHICH THE INTACT EXTRACTION
11 VARIANT CAN BE PERFORMED THAT THIS IS A SAFER PROCEDURE THAN
12 D&E WITH DISARTICULATION.
13 Q. AND WHY CAN INTACT D&E VARIANT BE THE SAFEST WAY TO PERFORM
14 A D&E?
15 A. AS I SAID BEFORE, MY OBJECTIVE IN PERFORMING ANY D&E IS TO
16 REMOVE THE FETUS AND THE PLACENTA WITH A MINIMAL AMOUNT OF
17 INTERVENTION. EVERY TIME I INTRODUCE A FORCEP INTO THE UTERUS
18 I RUN A RISK OF PERFORATION. AND EVERY TIME I OPEN THE FORCEP
19 AND GRASP WHAT I HOPE IS FETAL OR PLACENTAL TISSUE I COULD BE
20 GRASPING THE UTERINE WALL, AND I COULD RISK PERFORATION.
21 MY OBJECTIVE IS TO REMOVE THE FETUS AND PLACENTA
22 WITH AS LITTLE OF THIS TYPE OF MANIPULATION AS POSSIBLE, AND
23 THE INTACT VARIATION OF D&E ALLOWS ME TO DO THAT.
24 Q. HAVE YOU EVER PERFORATED A UTERUS DURING A D&E PROCEDURE?
25 A. YES, I HAVE.

1 Q. HAVE YOU EVER PERFORATED A UTERUS OR HAD A CERVICAL
2 LACERATION DURING AN INTACT VARIATION OF THE D&E PROCEDURE?
3 A. I HAVE NEVER HAD AN UTERINE PERFORATION WITH THE INTACT
4 VARIATION OF D&E. THE FEW CERVICAL LACERATIONS I HAVE HAD HAVE
5 BEEN AT THE SITE OF THE TENACULUM. IT HASN'T INVOLVED TRAUMA
6 TO THE CERVIX AND REMOVAL OF THE FETUS.
7 Q. IN ADDITION TO THE RISKS OF LACERATION OR PERFORATION, ARE
8 THERE OTHER ADVANTAGES TO THE INTACT VARIATION OF D&E?
9 A. YES, I THINK SO. IN DISARTICULATING THE FETUS AND THE
10 DISMEMBERMENT USING THE FORCEPS, THERE CAN BE SHARP EDGES OR
11 BONEY FRAGMENTS EXPOSED THAT ARE NOT EXPOSED IN INTACT
12 EXTRACTION. AND IN REMOVING THESE FROM THE UTERUS, THAT COULD
13 RISK TRAUMA TO THE UTERINE WALL OR TO THE CERVIX.
14 AND IN THE INTACT VARIATION OF D&E THE BONEY
15 FRAGMENTS ARE NOT EXPOSED AT ALL TO THE MATERNAL TISSUES. IN
16 THAT THE PROCEDURE, BASED ON MY EXPERIENCE, CAN BE ACCOMPLISHED
17 MORE QUICKLY WHEN CONSIDERING GESTATIONAL AGE, THIS WOULD
18 REDUCE THE RISK OF INFECTION AND REDUCE THE RISK OF BLOOD LOSS,
19 AS WELL.
20 FROM WEARING MY HAT, YOU KNOW, AS A MATERNAL FETAL
21 MEDICINE SPECIALIST AND AS A MATERNAL FETAL MEDICINE SPECIALIST
22 A LOT OF WHAT I DEAL WITH ARE FETAL ABNORMALITIES, WHICH MAY
23 INVOLVE GENETIC CONDITIONS, AND THESE ARE A LOT OF MY CASES.
24 AND A LOT OF MY PATIENTS ARE TERMINATING BECAUSE OF A FETAL
25 ABNORMALITY. AND IN SOME OF THESE CASES IT MAY BE DUE TO A

1 GENETIC CAUSE. AND THERE MAY BE A SIGNIFICANT RISK OF
2 RECURRENCE.
3 THERE ARE SOME D&E'S I PERFORM WHEN WE HAVE A
4 DIAGNOSIS, IF I DO AN AMNIOCENTESIS AND THE CHROMOSOMES ARE
5 ABNORMAL WITH DOWN'S SYNDROME BEING MOST COMMON, I HAVE A
6 DIAGNOSIS.
7 BUT THERE ARE OTHER CASES WHERE USUALLY BASED ON
8 ULTRASOUND WE CAN SEE CLEARLY THAT THERE IS SOMETHING VERY
9 ABNORMAL ABOUT THE FETUS, AND VERY OFTEN WE CAN SPECULATE UPON
10 THE SEVERITY AND REALLY KNOW THAT IT IS REALLY A SEVERE
11 ABNORMALITY, BUT WE DON'T HAVE A DIAGNOSIS. AND MANY DIFFERENT
12 SPECIFIC SYNDROMES MAY HAVE CAUSED WHAT WE ARE SEEING ON
13 ULTRASOUND, BUT WE DON'T KNOW WHAT.
14 IN THESE CASES THE ABILITY TO DO AN AUTOPSY FOR A
15 TRAINED PATHOLOGIST, LIKE I HAVE AT MY HOSPITAL, TO LOOK AT THE
16 FETAL SPECIMEN AND EXAMINE IT CAN YIELD IMPORTANT INFORMATION
17 THAT COULD LEAD TO A SPECIFIC DIAGNOSIS, AND THAT CAN LEAD TO
18 BEING ABLE TO DO EARLY PRENATAL DIAGNOSIS IN A FUTURE PREGNANCY
19 IF A GENETIC TEST IS IDENTIFIED. OR JUST IN TERMS OF
20 COUNSELING A PATIENT ABOUT WHAT THE RECURRENCE RISK IS.
21 AND MANY PATIENTS, YOU KNOW, WHAT IS MOST IMPORTANT
22 TO THEM IS KNOWING WHY. THESE PATIENTS TEND TO BE DEVASTATED.
23 THEY ARE DEVASTATED, ALL OF THEM. AND LOT OF IT, WHAT CAN
24 CONTRIBUTE IN NO SMALL MEASURE IS JUST NOT KNOWING WHAT IT IS.
25 Q. SO ONE OF THE ADVANTAGES TO AN INTACT D&E IS TO HAVE AN

1 INTACT FETUS IN ORDER TO DO A PATHOLOGY?
2 A. IN A CASE WHERE WE CAN REMOVE THE FETUS WITHOUT HAVING ANY
3 DISARTICULATION, THEN THAT INCREASES THE POSSIBILITY -- OR
4 DECREASES THE POSSIBILITY THAT ANY MEANINGFUL STRUCTURE THAT
5 MAY BE ABNORMAL MAY BE DAMAGED BEYOND RECOGNITION IN DOING
6 DISARTICULATION.
7 Q. WOULDN'T THAT BE AN ADVANTAGE TO AN INDUCTION, AS WELL, THE
8 ABILITY TO GET AN INTACT FETUS?
9 A. IT COULD BE. BUT THERE ARE A FEW OTHER ISSUES TO CONSIDER.
10 IN AN INDUCTION, VERY COMMONLY THE FETUS WILL NOT BE DELIVERED
11 ALIVE. IN THE COURSE OF AN INDUCTION, IT IS NOT UNCOMMON FOR
12 THE FETUS TO EXPIRE DURING THE PROCEDURE. INDUCTION -- AND THE
13 TIME BETWEEN THE DEATH OF THE FETUS AND THE TIME OF THE
14 DELIVERY CAN BE MANY HOURS OR IT MAY BE MORE THAN 24 HOURS. SO
15 BY THE TIME THE FETUS DELIVERS, AND INTACT, MANY OF THE
16 STRUCTURES THAT MAY BE MOST RELEVANT IN ACHIEVING A DIAGNOSIS
17 MAY HAVE UNDERGONE A PROCESS CALLED "MACERATION" WHERE A TYPE
18 OF DEGRADATION WHERE IMPORTANT INFORMATION MAY NOT BE ABLE TO
19 BE OBTAINED.
20 THE OTHER PART ABOUT THE INDUCTION IS THAT WE CAN
21 NEVER GUARANTEE THAT THE FETUS WILL BE ABLE TO BE DELIVERED BY
22 INDUCTION. AND I THINK IN MOST SERIES SUGGEST FIVE TO
23 10 PERCENT OF NOT BEING ABLE TO SUCCESSFULLY DELIVERY THE FETUS
24 WITH INDUCTION BECAUSE OF OUR ABILITY, UNDER MANY CONDITIONS,
25 TO NOT BE ABLE TO DUPLICATE THE PROCESSES OF LABOR

1 PHARMACOLOGICALLY.
2 SO, A MINORITY, BUT A REAL THING. IT HAPPENS IN A
3 MINORITY OF OCCASIONS. BUT ANY WOMAN HAVING A MEDICAL
4 INDUCTION MAY NOT DELIVER THROUGH MEDICAL INDUCTION, AND SHE
5 MAY NEED TO SUBSEQUENTLY HAVE A D&E.
6 SO, AGAIN, I CAN'T GUARANTEE ANY WOMAN UNDER EITHER
7 SCENARIO THAT SHE'LL DELIVER AN INTACT FETUS.
8 Q. IN YOUR OPINION, DOES INTACT D&E OFFER SAFETY ADVANTAGES
9 FOR WOMEN CARRYING FETUSES WITH SPECIFIC TYPES OF FETAL
10 ANOMALIES?
11 A. YES. PROBABLY THE MOST COMMON SCENARIO HERE IS A CONDITION
12 CALLED "HYDROCEPHALUS" IN WHICH THERE IS TYPICALLY OBSTRUCTION
13 IN THE FLOW OF CEREBRAL SPINAL FLUID, OR BRAIN AND SPINAL
14 FLUID, AND THAT CAUSES AN ACCUMULATION OF FLUID IN THE BRAIN.
15 AND, TYPICALLY, THAT -- OR VERY OFTEN THAT WILL
16 RESULT IN THE SIZE THE FETAL HEAD BEING DISPROPORTIONATELY
17 LARGER, OFTENTIMES VERY MUCH LARGER, THAN THE GESTATIONAL AGE
18 THAT THE FETUS IS.
19 AND IN THESE CASES IN DOING A DISARTICULATION, AND
20 IN THE PROCESS OF DISARTICULATION THE FETAL SKULL REALLY NEEDS
21 TO BE GRASPED AND CRUSHED WITH FORCEPS. AND IF THE HEAD IS
22 SIGNIFICANTLY LARGER THAN THE GESTATIONAL AGE WOULD DICTATE,
23 THEN THE -- I MAY NEED TO OPEN THE FORCEPS TO A VERY WIDE
24 DEGREE. AND THE WIDER I OPEN THE FORCEPS, THE MORE LIKELY I AM
25 TO TRAUMATIZE OR PERFORATE THE UTERUS.

1 IN DOING D&E USING INTACT EXTRACTION, THE FETUS IS
2 DELIVERED AS A BREECH, AND THE HEAD COMES DOWN TO THE SAME
3 LEVEL OF THE CERVIX AS IN ANY OTHER D&E WITH INTACT EXTRACTION.
4 AND IT LODGES SIMILARLY IN THE CERVIX. AND UNDER DIRECT
5 VISUALIZATION, I CAN MAKE AN INCISION WITH SCISSORS AND
6 DECOMPRESS THE HEAD THE SAME WAY WITH THE SUCTION.
7 SO THERE ISN'T THE RISK OF -- THERE ISN'T A RISK OF
8 NEEDING TO OPEN FORCEPS TO A WIDE ENOUGH DEGREE TO CRUSH THE
9 FETAL SKULL IN THOSE CASES.
10 THERE ARE OTHER CASES WHERE CERTAIN ANOMALIES, OTHER
11 PORTIONS OF THE FETAL ANATOMY CAN BE DISTORTED AND BE ENLARGED.
12 THERE IS A CONDITION KNOWN AS "HYDROPS," WHICH IS NOT A
13 SPECIFIC DIAGNOSIS, BUT IT IS A CONDITION VERY AKIN TO HEART
14 FAILURE, WHERE FLUID CAN ACCUMULATE TO SOMETIMES AN ENORMOUS
15 DEGREE IN CERTAIN CAVITIES. AND IT CAN ACCUMULATE IN THE
16 ABDOMINAL CAVITY. AND THE ABDOMINAL CAVITY CAN SOMETIMES BE
17 VERY, VERY LARGE.
18 AND, AGAIN, THE SAME PROBLEM WILL HAPPEN IN TRYING
19 TO CRUSH THIS PART OF THE FETUS WITH FORCEPS COULD EXPOSE A
20 WOMAN TO A GREATER DEGREE OF RISK THAN IN MOVING THIS PART OF
21 THE FETUS THROUGH THE BREECH EXTRACTION TO A MUCH LOWER PART OF
22 THE UTERUS.
23 Q. I HAVE ONE FOLLOW-UP QUESTION ON HYDROCEPHALUS. COULD YOU
24 USE A PROCEDURE CALLED CEPHALOCENTESIS TO REDUCE THE SIZE OF
25 THE HEAD?

1 A. CEPHALOCENTESIS CAN BE USED. AND I PUBLISHED ON THIS, AND
2 I HAVE DONE IT IN A HANDFUL OF CASES IN WOMEN CLOSER TO TERM TO
3 AVOID HAVING TO DO A C-SECTION.
4 Q. SO WHY DON'T YOU FIRST DESCRIBE WHAT CEPHALOCENTESIS IS AND
5 THEN --
6 A. CEPHALOCENTESIS IS A PROCEDURE IN WHICH A NEEDLE IS PLACED
7 THROUGH THE FETAL SKULL, AND THE FLUID THAT HAS ACCUMULATED IN
8 A FETUS WITH HYDROCEPHALUS CAN BE REMOVED. SOMETIMES LITERS OF
9 FLUID CAN BE REMOVED. AND THE SIZE OF THE HEAD CAN BE NORMAL
10 OR CLOSER TO NORMAL.
11 IN THE CASE OF HYDROCEPHALUS IN A WOMAN UNDERGOING A
12 D&E, CEPHALOCENTESIS IS SOMETHING THAT CAN BE DONE. HOWEVER,
13 THE CONDITION -- AFTER IT IS DONE, THE FLUID CAN REACCUMULATE
14 RAPIDLY.
15 I HAVE HAD ONE CASE I CAN RECALL IN A WOMAN IN LABOR
16 AT TERM WHERE I REMOVED SEVERAL LITERS OF FLUID. THE HEAD WAS
17 REDUCED TO A NORMAL SIZE. AND THEN, BY THE TIME SHE WAS READY
18 TO DELIVER SEVERAL HOURS LATER, THE FLUID HAD REACCUMULATED AND
19 THE SIZE OF THE HEAD WAS AS BIG AS IT HAD BEEN BEFORE.
20 SO DOING A CEPHALOCENTESIS PRIOR TO LAMINARIA
21 INSERTION OR PRIOR TO BEING IN THE OPERATING ROOM WOULD RUN THE
22 RISK OF NEEDING TO REPEAT THIS PROCEDURE.
23 AND IF I WAITED UNTIL THE TIME OF DELIVERY OF THE
24 CEPHALOCENTESIS, THE PROBLEM IS THAT CEPHALOCENTESIS IS A
25 DESTRUCTIVE PROCEDURE. MOST FETUSES THAT HAVE THIS PROCEDURE

1 DONE DURING THE PROCESS OF LABOR OR IN THE PROCESS OF A D&E, IT
2 IS A DESTRUCTIVE PROCEDURE, AND IT RESULTS IN A HIGH RATE OF
3 FETAL DEATH.
4 SO, IF I DID A CEPHALOCENTESIS -- IF I REDUCE THE
5 SIZE OF THE FETAL HEAD BY CEPHALOCENTESIS WHILE I AM DOING A
6 D&E, RATHER THAN DECREASE THE FETAL HEAD, AS I HAVE DESCRIBED
7 BEFORE, I THINK THAT WOULD VIOLATE THE ACT.
8 Q. IN YOUR OPINION, DOES THE INTACT VARIATION OF D&E OFFER
9 SAFETY ADVANTAGES FOR WOMEN WITH PARTICULAR MATERNAL HEALTH
10 CONDITIONS?
11 A. SOME OF THE CASES I DO BECAUSE OF DETERIORATING MATERNAL
12 HEALTH. AND, AGAIN, THE WAY I DO A D&E WITH THE DILATION AND
13 HOW I CHOOSE A PROCEDURE DOESN'T DIFFER BETWEEN THEM. THE WAY
14 I DILATE THE CERVIX AND THE APPROPRIATE PROCEDURE I AM CHOOSING
15 IN THE OPERATING ROOM DOESN'T DIFFER AT ALL.
16 BUT WHAT IS DIFFERENT IN THESE WOMEN WHO ARE IN A
17 TENUOUS MEDICAL STATE IS THAT THESE ARE THE WOMEN LEAST ABLE TO
18 TOLERATE ANY COMPLICATION, BE IT HEMORRHAGE OR UTERINE
19 PERFORATION OR SOMETHING ELSE.
20 SO TO THE EXTENT THAT I BELIEVE THAT THE ABILITY TO
21 USE INTACT EXTRACTION MINIMIZES THE RISK OF COMPLICATIONS IN
22 ALL WOMEN, IN THESE WOMEN WHO ARE LEAST ABLE TO TOLERATE A
23 COMPLICATION WOULD BE MOST THREATENED BY IT. THE ABILITY TO
24 USE INTACT EXTRACTION, BASED ON MY JUDGMENT IS PARTICULARLY --
25 IS A PARTICULAR SAFETY ADVANTAGE IN THESE WOMEN.

1 Q. LET'S TALK SPECIFICALLY ABOUT PATIENTS WHO HAVE A
2 PARTICULAR RISK FOR BLOOD LOSS OR HEMORRHAGE. DOES THE INTACT
3 VARIATION OFFER SAFETY ADVANTAGES FOR THEM?
4 A. AS WE DISCUSSED, I THINK IT IS MY OPINION -- I THINK THAT
5 THE DATA IN THE STUDIES IS CONSISTENT WITH THIS -- THAT IN ALL
6 WOMEN THE ABILITY TO USE INTACT EXTRACTION CAN DECREASE
7 OPERATIVE TIME AND MINIMIZE BLOOD LOSS.
8 WOMEN THAT MAY BE ANEMIC, SUCH AS WOMEN WITH
9 ADVANCED -- WOMEN ON CHEMOTHERAPY OR WOMEN WITH OTHER ADVANCED
10 STAGES OF MEDICAL ILLNESS, THESE WOMEN ARE, AGAIN, MOST LIKELY
11 TO BE INJURED BY HEMORRHAGE. AND MANY OF THESE WOMEN ARE
12 TECHNICALLY PRONE TO HEMORRHAGE, BECAUSE NOT ONLY IS THEIR
13 BLOOD COUNT LOW, BUT THEIR CONCENTRATION OF CLOTTING FACTORS
14 MAY BE LOW, AS WELL.
15 SO THESE WOMEN ARE PARTICULARLY PRONE TO HEMORRHAGE
16 AND PARTICULARLY PRONE TO SUFFER FROM HEMORRHAGE. AND, AGAIN,
17 IN THAT I BELIEVE THAT THE ABILITY TO USE INTACT EXTRACTION
18 WHEN DOING A D&E, WHEN IN MY JUDGMENT THAT I CAN DO THAT, THAT
19 WOULD AVOID -- MINIMIZE THE RISK OF THESE COMPLICATIONS THAT
20 COULD BE PARTICULARLY HARMFUL TO SUCH A PATIENT.
21 Q. DOES THE INTACT VARIATION OFFER SAFETY ADVANTAGES FOR
22 PATIENTS WHO NEED AN ABORTION URGENTLY TO PROTECT THEIR HEALTH?
23 A. YES, I THINK IT DOES.
24 Q. WHAT TYPE OF CONDITIONS WOULD LEAD A WOMAN TO NEED TO HAVE
25 AN ABORTION MORE QUICKLY THAN OTHERWISE?

1 A. WOMEN WITH -- THE PHYSIOLOGY OF PREGNANCY OR THE
2 PHYSIOLOGIC CHANGES OF PREGNANCY ARE MOST LIKELY TO EFFECT
3 WOMEN WHO HAVE HEART DISEASE. AND OFTENTIME THESE WOMEN
4 TOLERATE THE CHANGES WELL UNTIL THE SECOND-TRIMESTER WHEN THE
5 CHANGES BECOME MOST PRONOUNCED. AND WE CAN SEE MARKED
6 DETERIORATION SO THAT WE KNOW IF THE PREGNANCY CONTINUES, THAT
7 THEY WOULD BE AT RISK OF DEATH OR OTHER SEVERE COMPLICATIONS.
8 SO WE KNOW THAT IN A WOMAN LIKE THIS, OR PERHAPS IN
9 A WOMAN WHO -- THE RARE WOMAN WHO HAS SEVERE PREECLAMPSIA
10 DEVELOP IN THE SECOND-TRIMESTER, AND WE KNOW THAT IF THAT WOMAN
11 IS NOT DELIVERED OF THE FETUS IN A RELATIVELY SHORT AMOUNT OF
12 TIME, THAT THIS WOMAN COULD DIE OR SUSTAIN OTHER DREADED
13 COMPLICATIONS.
14 IT IS NOT THAT THE PREGNANCY NEEDS TO END IN A
15 MATTER OF MINUTES OR EVEN IN A MATTER OF A FEW HOURS, BUT IT IS
16 URGENT ENOUGH THAT IT REALLY NEEDS TO BE DONE WITHIN THE NEXT
17 DAY OR TWO.
18 AND I THINK IN THESE WOMEN I THINK D&E -- AND
19 SPECIFICALLY USING INTACT EXTRACTION -- IS A PREFERRED CHOICE,
20 IF POSSIBLE.
21 Q. WOULD WOMEN WITH SEVERE CARDIAC CONDITIONS, WOULD INDUCTION
22 BE AN OPTION FOR THEM?
23 A. INDUCTION MIGHT BE AN OPTION. THE PROBLEM WITH INDUCTION
24 IS THAT FOR A SUSTAINED AMOUNT OF TIME THE INDUCTION METHOD, IN
25 THAT IT CAUSES, BY NATURE, LABOR. AND EVERY TIME THE UTERUS

1 CONTRACTS THAT CAUSES PHYSIOLOGIC CHANGES IN THE BODY. THE
2 UTERUS CONTRACTS AND GETS SMALLER. A LOT OF BLOOD THAT'S IN
3 THE UTERINE CIRCULATION GETS INJECTED INTO THE GENERAL
4 CIRCULATION. AND IN WOMEN WITH DETERIORATING CARDIAC HEALTH,
5 THIS EXPOSES THEM TO A PROLONGED PERIOD OF JEOPARDY.
6 CONTRAST THAT TO A D&E PROCEDURE. THE CERVIX IS NOT
7 DILATED THROUGH A PROCESS OF LABOR. IT IS DILATED WITH OSMOTIC
8 DILATORS THAT TYPICALLY DOESN'T CAUSE CONTRACTIONS. DOESN'T
9 CHANGE BODY WIDE CHANGES IN PHYSIOLOGY. AND I WOULDN'T EXPECT
10 THAT PROCEDURE OF DILATION TO EFFECT THEIR CARDIAC STATUS.
11 WHEN THE EVACUATION OCCURS, ALL THE PHYSIOLOGIC
12 CHANGES, WHEN THE UTERUS -- WHEN AFTER THE FETUS AND PLACENTA
13 ARE REMOVED, THEN THE UTERUS CONTRACTS DOWN, AND THE
14 PHYSIOLOGIC CHANGES HAPPEN, IT HAPPENS IN A VERY CONTROLLED
15 SETTING. THE PATIENT IS UNDER ANESTHESIA WITH AN
16 ANESTHESIOLOGIST WHO IS VERY SKILLED IN CRITICAL CARE RIGHT
17 THERE. IT IS EXPECTED. IT IS ANTICIPATED.
18 WHEREAS, THE DELIVERY, THE LABOR AND THE DELIVERY IN
19 MEDICAL INDUCTION, WE DON'T KNOW HOW LONG IT IS GOING TO TAKE,
20 IF IT IS GOING TO BE SUCCESSFUL, WHETHER IT IS GOING TO TAKE 12
21 HOURS, 24 HOURS OR LONGER. AND IT EXPOSES THE PATIENTS TO A
22 PROLONGED DURATION OF THE THESE CHANGES THAT THEY MAY NOT
23 TOLERATE.
24 Q. WOULD A HYSTEROTOMY BE AN OPTION FOR WOMEN WITH SEVERE
25 CARDIAC CONDITIONS?

1 A. I THINK THE ONLY TIME WHEN HYSTEROTOMY IS INDICATED IS IN A
2 WOMAN WHO IS IN CARDIAC ARREST, NEEDS CARDIOPULMONARY
3 RESUSCITATION OR CPR, AND YOU NEED TO EMPTY THE UTERUS IN A
4 MATTER OF MINUTES TO SAVE THE MATERNAL LIFE.
5 ONLY IN THAT CIRCUMSTANCE, I THINK, IS HYSTEROTOMY
6 INDICATED. HYSTEROTOMY, WHICH IS LIKE DOING A C-SECTION, IS
7 THE MOST INVASIVE WAY -- IT IS THE MOST INVASIVE THING YOU CAN
8 DO. IT WOULD BE ASSOCIATED WITH THE HIGHEST RATE OF
9 COMPLICATIONS, INCLUDING INFECTION, HEMORRHAGE.
10 AND, AGAIN, IF A WOMAN IS HAVING DETERIORATING
11 MEDICAL CONDITION AND SHE NEEDS TO DELIVER, THAT WOULD BE THE
12 LAST THING THAT I WOULD WANT TO HAVE TO RESORT TO.
13 AND EITHER INDUCTION OR D&E WOULD BE PREFERABLE.
14 AND, AGAIN, FOR THE REASONS I HAVE STATED I THINK D&E IS
15 PREFERABLE TO INDUCTION IN THESE WOMEN.
16 Q. ARE THERE OTHER CONDITIONS WHERE A WOMAN MIGHT NEED TO HAVE
17 AN ABORTION MORE RAPIDLY TO PROTECT HER HEALTH?
18 YOU'VE TALKED ABOUT CARDIAC CONDITIONS.
19 A. SURE, THERE ARE. IF A WOMAN HAS AN INFECTION, AND, AGAIN,
20 SOME WOMEN THEY MAY HAVE AN INFECTION. THEY MAY HAVE HAD AN
21 AMNIOCENTESIS A COUPLE WEEKS AGO, AND THAT COULD INTRODUCE
22 BACTERIA INTO THE UTERUS AND CAUSE AN INFECTION. THEY MAY BE
23 IN PRE-TERM LABOR, WHICH CAN HAPPEN IN THE SECOND-TRIMESTER, OR
24 THEY MAY HAVE RUPTURED THE MEMBRANES, BOTH OF WHICH CAN BE
25 PRECEDED BY INFECTION OR BOTH OF WHICH CAN LEAD TO AN INFECTION

1 IN THE UTERUS. THESE WOMEN ARE AT RISK OF EXPERIENCING SEPSIS,
2 WHICH IS A LIFE-THREATENING CONDITION WITH A BODY WIDE
3 INFECTION IF THE PREGNANCY IS CONTINUED.
4 THESE WOMEN MAY NEED TO BE DELIVERED URGENTLY. AND
5 I THINK THAT D&E IS THE SAFEST WAY TO TREAT THESE WOMEN.
6 Q. WOULD YOU EVER RECOMMEND AN INDUCTION PROCEDURE FOR WOMEN
7 WHO NEED AN ABORTION IMMEDIATELY DUE TO AN EMERGENT HEALTH
8 CONDITION?
9 A. THE PROBLEM WITH AN INDUCTION IS THAT, AGAIN, IN ADDITION
10 TO THE PROBLEMS I HAVE STATED ABOUT THE CHANGES IN PHYSIOLOGY
11 IN WOMEN THAT MAY NOT BE ABLE TO TOLERATE THESE CHANGES IS THAT
12 AN INDUCTION CAN TAKE HOURS OR IT CAN TAKE DAYS WHERE IT MAY
13 NOT BE SUCCESSFUL AT ALL.
14 A D&E, I CAN REPLACE LAMINARIA AT EIGHT HOURS OR 12
15 HOURS, SO I CAN ACHIEVE THE SAME DEGREE OF DILATION THAT I
16 WOULD ACHIEVE AT 48 HOURS IN THE NORMAL CASE IN A MUCH
17 COMPRESSED TIME INTERVAL. AND I -- IT'S A MUCH MORE RELIABLE
18 TIME FRAME IN WHICH I CAN END THE PREGNANCY THAT NEEDS TO BE
19 NEEDED FOR A MEDICAL REASON.
20 Q. AND FOR THOSE PATIENTS, WOULD THE ENTIRE D&E PROCESS OCCUR
21 IN THE HOSPITAL?
22 A. YES, IT WOULD.
23 Q. AND WOULD YOU EVER DO A HYSTEROTOMY FOR WOMEN WITH ANY OF
24 THOSE CONDITIONS?
25 A. AGAIN, GIVEN THAT IT IS THE MOST INVASIVE THING THAT WOULD

1 LEAD TO THE HIGHEST RATE OF SHORT-TERM COMPLICATIONS, AND ALSO
2 IT WOULD BE MOST LIKELY TO EFFECT THEIR FUTURE PREGNANCIES, NO.
3 I WOULD NOT, EXCEPT, AS I SAY IN A WOMAN THAT NEEDS TO BE
4 DELIVERED THAT MINUTE TO DO CPR OR TO RESUSCITATE HER.
5 Q. WHAT PROCEDURE WOULD YOU PERFORM IF A WOMAN CAME TO YOU AT
6 20 WEEKS LMP WHO HAD HAD TWO PREVIOUS VAGINAL DELIVERIES, A
7 BLEEDING PLACENTA PREVIA AND CLOTTING DISORDER?
8 A. IN ANY WOMAN WITH A PLACENTA PREVIA -- THAT IS A CONDITION
9 IN WHICH THE PLACENTA COVERS THE CERVIX. IN ANY WOMAN WITH
10 PLACENTA PREVIA, LABOR IS CONTRAINDICATED. THAT IS A TERM
11 THAT'S MEDICAL INDUCTION IF AN ABORTION IS DONE IN THE
12 SECOND-TRIMESTER.
13 SO MY CHOICE IS IN SUCH A WOMAN WOULD BE
14 HYSTEROTOMY. AND I PRETTY MUCH EXPRESSED HOW I FEEL WITH THAT,
15 IN GENERAL, OR D&E. AND IN MY EXPERIENCE I HAVE TAKEN CARE OF
16 WOMEN WITH PLACENTA PREVIA, IN THE CIRCUMSTANCES YOU ARE
17 DESCRIBING. AND IN A HOSPITAL SETTING, I WOULD INSERT
18 LAMINARIA. IN MY EXPERIENCE IN THE CASES I HAVE DONE IT HAS
19 NOT LED TO HEMORRHAGE, AND WE HAVE HAD ENOUGH TIME TO ACHIEVE
20 DILATION OF THE CERVIX SO THAT A D&E COULD BE PERFORMED, AND
21 THESE WOMEN DON'T NEED A HYSTEROTOMY.
22 Q. WHAT ABOUT A WOMAN WHO CAME TO YOU WITH THREE PREVIOUS
23 CESAREAN DELIVERIES, EVIDENCE OF PLACENTA ACCRETA AND IS
24 PRESENTING AT 22 WEEKS LMP, WHAT PROCEDURE WOULD YOU RECOMMEND
25 UNDER THAT CIRCUMSTANCE?

1 MR. QUINLIVAN: YOUR HONOR, I OBJECT TO THIS
2 QUESTION, AND I MOVE TO STRIKE THE PREVIOUS QUESTION. NEITHER
3 OF THESE SITUATIONS WERE ADDRESSED EITHER IN DR. CHASEN'S
4 EXPERT REPORT OR DURING HIS DEPOSITION.
5 THE COURT: ALL RIGHT. THOSE ARE THE PARAMETERS.
6 MS. PARKER: WHAT?
7 THE COURT: THOSE ARE THE PARAMETERS, UNLESS IT IS
8 FOR IMPEACHMENT OR REBUTTAL OR SOMETHING OF THAT WITH NATURE.
9 MS. PARKER: HE IS A REBUTTAL WITNESS, YOUR HONOR,
10 AND DR. COOK EXPRESSLY WAS GIVEN THESE TWO SCENARIOS AS
11 HYPOTHETICALS. AND HE GAVE AN OPINION AS TO WHAT PROCEDURE HE
12 WOULD PERFORM FOR THESE TWO SCENARIOS. AND WE ARE PRESENTING
13 DR. CHASEN AS A REBUTTAL EXPERT ON THAT.
14 THE COURT: OKAY. I AM GOING TO PERMIT IT. HE
15 WASN'T DESIGNATED, OBVIOUSLY, EXCEPT AS A WITNESS IN YOUR
16 CASE-IN-CHIEF. I DO THINK IT IS APPROPRIATE TO USE HIM NOW IN
17 REBUTTAL TO DR. COOK.
18 BY MS. PARKER:
19 Q. DO YOU NEED ME TO REPEAT THE QUESTION OR YOU HAVE IT FIRMLY
20 IN YOUR HEAD?
21 A. I HAVE IT FIRMLY IN MY HEAD. AND BEFORE I ANSWER THAT
22 QUESTION, I THINK, YOU KNOW, I HAVEN'T MENTIONED IT YET, BUT
23 WOMEN WITH -- WHO HAVE HAD A PRIOR C-SECTION OR ANY OTHER
24 PROCEDURE LEAVING A SCAR IN THE UTERUS ARE PARTICULARLY AT RISK
25 FOR UTERINE RUPTURE IF THEY UNDERGO LABOR UNDER ANY

1 CIRCUMSTANCE, AT TERM OR IN THE CONTEXT OF A MEDICAL ABORTION.
2 SO, I CONSIDER THAT A RELATIVE CONTRAINDICATION TO
3 MEDICAL INDUCTION IN ANY PATIENT WITH A PRIOR C-SECTION, FOR
4 INSTANCE.
5 NOW, IN THE PATIENT YOU JUST DESCRIBED WHO HAS HAD,
6 I THINK, THREE PRIOR C-SECTIONS?
7 Q. YES.
8 A. THREE PRIOR C-SECTIONS AND PLACENTA ACCRETA THAT WAS
9 SUSPECTED BASED ON ULTRASOUND, I THINK. PLACENTA ACCRETA IS A
10 CONDITION THAT WE CAN STRONGLY SUSPECT BASED ON ULTRASOUND
11 FINDINGS IN WHICH THE PLACENTA IS ABNORMALLY ADHERENT TO THE
12 WALL OF THE UTERUS BECAUSE IT IS SORT OF GROWING INTO THE SCAR
13 OF THE UTERUS.
14 IN A WOMAN LIKE THIS, PLACENTA ACCRETA IS ASSOCIATED
15 WITH -- IN MANY CASES THESE WOMEN ULTIMATELY HAVE A
16 HYSTERECTOMY OR ULTIMATELY REQUIRE A HYSTERECTOMY. HOWEVER, IN
17 SOME CASES THE PLACENTA, INDEED, IS ABNORMALLY ADHERENT TO THE
18 WALL OF THE UTERUS. THE PLACENTA CAN BE LEFT IN SIGHT. IT CAN
19 BE LEFT THERE IN A WOMAN WHO MAY NOT BE BLEEDING AFTER REMOVAL
20 OF THE FETUS. AND, YOU KNOW, IT'S -- WE HAVE HAD SEVERAL CASES
21 IN MY HOSPITAL, AND THERE ARE SEVERAL CASES PUBLISHED IN
22 MEDICAL LITERATURE THAT OVER A LONG PERIOD OF TIME THE PLACENTA
23 MAY EITHER BE ABSORBED BY THE BODY OR IT MAY DETACH AND DELIVER
24 DAYS OR WEEKS LATER.
25 IN A PATIENT LIKE THIS, I THINK SHE IS A CANDIDATE

1 FOR A D&E. HOWEVER, IN THE COURSE OF THE D&E I WOULD NOT WANT
2 TO DISRUPT THE PLACENTA, BECAUSE, AGAIN, IF I PULL ON THE
3 PLACENTA AND THE PLACENTA IS ABNORMALLY ADHERENT TO THE WALL OF
4 THE UTERUS, THAT COULD PERFORATE THE UTERUS.
5 SO I WOULD WANT TO BE ABLE TO DO A D&E WHERE I WOULD
6 WANT TO BE ABLE TO REMOVE THE FETUS WITHOUT DISRUPTING THE
7 PLACENTA. THAT IS SOMETHING I CAN DO WITH A LOT OF CONFIDENCE
8 USING THE INTACT EXTRACTION VARIATION OF D&E.
9 WHEN I USE FORCEPS TO DISARTICULATE THE FETUS, IN
10 ANY GIVEN PASS, I CAN ALSO BE DISRUPTING THE PLACENTA. AND,
11 AGAIN, THAT WOULD, IN THIS PATIENT IN PARTICULAR, WOULD RUN A
12 PARTICULAR RISK OF UTERINE RUPTURE.
13 Q. NOW, YOU'VE INDICATED THAT IN THE MAJORITY OF CIRCUMSTANCES
14 YOUR PREFERENCE IS TO DO A D&E, AND, IF POSSIBLE, AN INTACT
15 D&E. BUT DO YOU DISCUSS WITH YOUR PATIENTS THE OPTION OF
16 INDUCTION?
17 A. I DISCUSS WITH ALL OF MY PATIENTS OPTIONS, UNLESS THEY HAVE
18 A LIFE-THREATENING CONDITION, AND, REALLY, IN MY OPINION THEY
19 MUST END THE PREGNANCY, I DISCUSS THE OPTIONS OF CONTINUING THE
20 PREGNANCY, AND WHAT THAT WOULD ENTAIL, AS WELL AS THE OPTION OF
21 MEDICAL INDUCTION, YES.
22 Q. AND IN YOUR EXPERIENCE IS INDUCTION A SAFE METHOD OF
23 ABORTION?
24 A. FOR MOST WOMEN INDUCTION IS A SAFE METHOD OF ABORTION.
25 Q. IN YOUR EXPERIENCE, WHICH METHOD OF ABORTION IS SAFER,

1 INDUCTION OR D&E?
2 A. IN MY EXPERIENCE, D&E IS A SAFER METHOD OF ABORTION.
3 Q. WHY IS THAT?
4 A. THE COMPLICATION RATES ASSOCIATED WITH D&E ARE LOWER THAN
5 THE COMPLICATION RATES ASSOCIATED WITH INDUCTION. AND I
6 BELIEVE NATIONWIDE DATA SUPPORTS LOWER RATES OF MORTALITY,
7 WHICH, TO ME, SUGGESTS ALSO LOWER RATES OF COMPLICATIONS.
8 I THINK THERE IS LESS OF A RISK OF BLEEDING AND LESS
9 OF A RISK OF INFECTION. WOMEN UNDERGOING INDUCTION NEED TO BE
10 HOSPITALIZED COMPARED TO WOMEN HAVING D&E WHERE, IN MOST CASES,
11 IT IS DONE AS AN OUTPATIENT PROCEDURE, ALTHOUGH THIS GETS INTO
12 PATIENT PREFERENCE, AS WELL.
13 AND A SIGNIFICANT PROPORTION OF PATIENTS UNDERGOING
14 INDUCTION WILL NOT EXPEL THE PLACENTA, AND THEN THEY NEED AN
15 EVASIVE SURGICAL PROCEDURE TO REMOVE THAT.
16 AND IN SOME CASES THEY WILL NOT EXPEL THE FETUS IN
17 PART, OR AT ALL, AND THEN THEY MAY NEED TO HAVE A D&E, WHICH
18 UNDER THESE CIRCUMSTANCES WOULD BE RISKIER THAN DOING A D&E
19 THAT DOESN'T PRECEDE A MEDICAL INDUCTION.
20 Q. BASED ON YOUR EXPERIENCE WHICH IS THE MORE COMMON PROCEDURE
21 THROUGHOUT THE SECOND-TRIMESTER, INDUCTION OR D&E?
22 A. D&E.
23 Q. AND WHY DO MOST WOMEN CHOOSE D&E OVER INDUCTION?
24 A. I THINK WHEN IT IS AVAILABLE AND WOMEN ARE PRESENTED WITH
25 THE TWO OPTIONS, I THINK MOST WOMEN -- NOT ALL -- BUT MOST

1 WOMEN EXPRESS A PREFERENCE FOR D&E COMPARED TO INDUCTION.
2 Q. AND DO YOU HAVE AN OPINION AS TO WHY THAT IS?
3 A. YES. AGAIN, INDUCTION IS A PROCEDURE THAT IS DONE IN THE
4 HOSPITAL. WITH ALL MY PATIENTS THEY FEEL LIKE THEY HAVE BEEN
5 STRUCK BY LIGHTENING. AND, YOU KNOW, THEY HAVE HAD SOMETHING
6 DEVASTATING AND UNEXPECTED HAPPEN.
7 AND WHEN THEY ARE INFORMED THAT INDUCTION CAN TAKE
8 12 HOURS OR IT CAN TAKE 48 HOURS OR IT CANNOT BE SUCCESSFUL AT
9 ALL, THAT'S SOMETHING THAT IS DISTRESSING TO VERY MANY OF THEM
10 WHO ARE ALREADY DISTRESSED.
11 WHEN THEY HAVE TO BE HOSPITALIZED INSTEAD OF BEING
12 AT HOME WHERE THEY ARE MORE LIKELY TO HAVE A SUPPORT SYSTEM
13 INTACT, I THINK THAT IS MEANINGFUL TO A LOT OF WOMEN.
14 WOMEN WHO --
15 MR. QUINLIVAN: YOUR HONOR, I HAVE TO OBJECT. IT
16 SEEMS TO ME THAT HE IS SPECULATING AS TO WHAT WOMEN MAY FEEL.
17 HE -- IF A WOMAN HAS TOLD HIM DIRECTLY, THAT IS ONE THING, BUT
18 I OBJECT --
19 THE COURT: THE OBJECTION IS SUSTAINED. WE HAVE
20 ALLOWED THIS KIND OF TESTIMONY FROM OTHER WITNESSES WHO ARE
21 ABLE TO ESTABLISH THE FOUNDATION THAT THEY OBTAINED THIS
22 KNOWLEDGE THROUGH IN THEIR OWN PATIENT PRACTICE.
23 YOU HAVEN'T ESTABLISHED SUCH A FOUNDATION WITH HIM.
24 MS. PARKER: THAT IS FINE. I CAN DO THAT, YOUR
25 HONOR. AND I THINK WE ARE ALMOST WRAPPING THIS LINE OF

1 QUESTIONING UP, ANYWAY.
2 BY MS. PARKER:
3 Q. ALL RIGHT. DR. CHASEN, YOU INDICATED THAT WHEN PATIENTS
4 COME TO YOU YOU DISCUSS WITH THEM THE VARIOUS OPTIONS; IS THAT
5 RIGHT?
6 A. YES, IT IS.
7 Q. AND DO YOUR PATIENTS -- DO YOU HAVE A DISCUSSION WITH YOUR
8 PATIENTS ABOUT WHAT OPTIONS ARE AVAILABLE?
9 A. YES, I DO.
10 Q. AND THEN, DO YOU TALK TO THEM ABOUT WHICH OPTIONS THEY WANT
11 TO PURSUE?
12 A. YES, I DO. I DESCRIBE WHAT EITHER OPTION WILL ENTAIL,
13 EITHER OF THE THREE OPTIONS, INCLUDING CONTINUING THE PREGNANCY
14 WOULD ENTAIL.
15 Q. IN THE COURSE OF THAT DO YOUR PATIENTS DESCRIBE TO YOU
16 THEIR PREFERENCES FOR PARTICULAR PROCEDURES?
17 A. THEY CERTAINLY DO.
18 Q. AND WHY THEY WANT A PARTICULAR PROCEDURE OVER ANOTHER ONE?
19 A. YES, THEY DO.
20 Q. AND IN THE COURSE OF THAT, DO THEY DISCUSS WITH YOU WHY
21 THEY PREFER THE D&E PROCEDURE OVER THE INDUCTION PROCEDURE?
22 A. OFTEN, IN GREAT DETAIL AND WITH GREAT EMPHASIS.
23 THE COURT: ALL RIGHT.
24 BY MS. PARKER:
25 Q. I DON'T KNOW IF YOU FINISHED YOUR TESTIMONY ABOUT WHY YOUR

1 PATIENTS PREFERRED D&E'S OVER INDUCTION.
2 A. I THINK --
3 THE COURT: I WANT TO MAKE SURE YOUR TESTIMONY IS
4 BASED UPON YOUR PATIENTS AND NOT SPECULATION AS TO OTHER
5 PATIENTS.
6 THE WITNESS: NO. NO, IT IS NOT SPECULATIVE. THIS
7 IS WHAT WOMEN TELL ME. THIS IS WHAT MY PATIENTS HAVE TOLD ME.
8 THAT IS HOW I KNOW HOW THEY FEEL.
9 I TALKED ABOUT THE MORE PREDICTABLE NATURE OF WHEN A
10 D&E WILL START AND WHEN IT WILL BE COMPLETED. I TALKED ABOUT
11 WOMEN'S PREFERENCE FOR NOT BEING HOSPITALIZED. MANY OF MY
12 PATIENTS -- MOST OF MY PATIENTS ARE PROFESSIONAL WOMEN. AND
13 THEY -- IN MANY CASES, THEIR COLLEAGUES MAY NOT EVEN KNOW THEY
14 ARE PREGNANT, OR THEY MAY NOT HAVE DISCLOSED THAT.
15 AND THEY CAN GO TO WORK AFTER THEY HAVE HAD
16 LAMINARIA PLACED, AND THEN THEY TAKE, YOU KNOW, ONLY ONE OR TWO
17 DAYS OFF. RATHER THAN HAVING TO BE HOSPITALIZED AND TO LOSE
18 MORE TIME.
19 SO, FOR VARIETY OF REASONS I THINK THEY -- MY
20 PATIENTS, IN GENERAL, EXPRESS A STRONG PREFERENCE FOR AN
21 OUTPATIENT PROCEDURE RATHER THAN AN INPATIENT PROCEDURE.
22 ANOTHER BIG ISSUE IS GOING THROUGH LABOR. THAT
23 WOMEN -- I AM NOT A WOMAN, BUT I AM AN OBSTETRICIAN. AND I
24 THINK I -- WOMEN REGARD, NOT INAPPROPRIATELY, LABOR AS A VERY
25 PAINFUL PROCEDURE.

1 WOMEN UNDERGOING INDUCTION DO GET APPROPRIATE
2 ANALGESIC THAT USUALLY CONSISTS OF EPIDURAL ANESTHESIA, BUT
3 THEY ARE AWAKE THROUGHOUT THE PROCEDURE. EPIDURAL DOESN'T
4 REMOVE ALL PAINFUL SENSATIONS.
5 AND MOST WOMEN EXPRESS A PREFERENCE FOR NOT WANTING
6 TO BE AWAKE AND AWARE OF WHAT IS GOING ON DURING DELIVERY.
7 SO I THINK THESE ARE ALL REASONS WHY THE PATIENTS
8 THAT I SEE WHO KNOW THAT D&E PERFORMED IN A SAFE SETTING BY AN
9 EXPERIENCED PRACTITIONER LIKE ME OR MY COLLEAGUES WHO DO THIS
10 ARE FAR PREFERABLE THAN MEDICAL INDUCTION.
11 BY MS. PARKER:
12 Q. DO YOU HAVE AN OPINION AS TO WHETHER INDUCING LABOR BETWEEN
13 20 AND 23 WEEKS IS A MORE PHYSIOLOGICAL PROCESS THAN A D&E
14 PROCEDURE?
15 A. YES, I DO HAVE AN OPINION.
16 MR. QUINLIVAN: YOUR HONOR, I WANT TO NOTE MY
17 OBJECTION FOR THE RECORD. THIS, AGAIN, IS AN ISSUE THAT WAS
18 NOT RAISED IN DR. CHASEN'S EXPERT REPORT NOR ADDRESSED IN HIS
19 DEPOSITION.
20 THE COURT: ALL RIGHT.
21 MS. PARKER: IT IS REBUTTAL.
22 THE COURT: TO DR. COOK?
23 MS. PARKER: YES, YOUR HONOR.
24 THE COURT: IT IS UNFORTUNATE, OBVIOUSLY, THAT THE
25 PLAINTIFF WAS UNABLE TO CALL THE WITNESS AFTER BECAUSE

1 OBVIOUSLY YOU WOULDN'T HAVE HAD THIS OPPORTUNITY BUT FOR THE
2 SCHEDULING DIFFICULTY TO HAVE A REBUTTAL WITNESS. BUT HE IS
3 HERE, AND DR. COOK DID TESTIFY AS TO THESE SPECIFIC THINGS, SO
4 YOU ARE PERMITTED TO GO BEYOND THE DEPOSITION AND EXPERT
5 REPORT, BUT ONLY TO THE EXTENT THAT HE IS REGARDING SPECIFIC
6 TESTIMONY GIVEN BY ONE OF THE DEFENSE WITNESSES.
7 MS. PARKER: THIS IS SPECIFIC TESTIMONY, AS YOUR
8 HONOR RECALLS, THAT WAS GIVEN BY DR. COOK.
9 THE COURT: ALL RIGHT.
10 THE WITNESS: CAN YOU REPEAT THE QUESTION?
11 BY MS. PARKER:
12 Q. YES. WHAT IS YOUR OPINION AS TO WHETHER INDUCING LABOR
13 BETWEEN 20 AND 24 WEEKS IS A MORE PHYSIOLOGICAL PROCESS THAN
14 THE D&E PROCEDURE?
15 A. I DON'T AGREE WITH THAT.
16 Q. AND WHY NOT?
17 A. FIRST OF ALL, OUR ABILITY TO MIMIC A NATURAL PHYSIOLOGIC
18 PROCESS IN INDUCING LABOR, OR OUR INABILITY TO DO THAT IS ONE
19 OF THE BIG, BIG PUBLIC HEALTH ISSUES THAT IS CONFRONTING
20 OBSTETRICS, IN GENERAL, TODAY. REGARDING OUR ABILITY TO DO IT
21 IN WOMEN AT TERM, WE ARE NOT THAT GOOD AT IT, AND THAT IS ONE
22 OF THE REASONS THAT HAS CONTRIBUTED TO RISING CESAREAN SECTION
23 RATES, AN INCREASED USE OF INDUCTION OF LABOR AND OUR INABILITY
24 TO MIMIC A NATURAL PHYSIOLOGIC PROCESS THAT IS IN LABOR.
25 AND WOMEN WHO ARE REMOTE FROM TERM, WHO ARE, MOST

1 LIKELY, VERY REMOTE FROM THE ONSET OF THE NATURAL PHYSIOLOGIC
2 LABOR PROCESS, INDUCTION OF LABOR IS EVEN MORE CHALLENGING.
3 AND THE -- AND WE -- OUR TECHNIQUES MAY HAVE
4 IMPROVED. MISOPROSTOL IS, I THINK, AN IMPROVEMENT OVER OLD
5 PHARMACOLOGIC FORMS OF INDUCING LABOR, BUT WE ARE NOT ABLE TO
6 MIMIC THE NATURAL PHYSIOLOGIC CHANGES OF LABOR, THE NATURAL
7 INTENSITY OF UTERINE CONTRACTIONS OR ANYTHING SIMILAR TO IT.
8 SO I DO NOT THINK THAT THIS IS A PHYSIOLOGIC PROCESS
9 AT ALL THAT WE INDUCE WITH MEDICAL INDUCTION.
10 Q. WOULD A WOMEN EXPERIENCE THE SAME LEVEL OF PHYSIOLOGICAL
11 STRESS BY UNDERGOING 24 HOURS OF DILATION FOLLOWING LAMINARIA
12 INSERTION THAN SHE WOULD BY UNDERGOING 24 HOURS OF LABOR?
13 A. SHE WOULD EXPERIENCE LESS PHYSIOLOGIC CHANGES OR STRESS,
14 CERTAINLY, WITH THE LAMINARIA INSERTION. LAMINARIA EXERT
15 OSMOTIC EFFECT ON THE CERVIX IN THAT LOCAL AREA OF HER BODY.
16 IN GENERAL, IT DOES NOT INDUCE LABOR. OR IF IT
17 DOES, IN VERY RARE CASES. IT TYPICALLY DOESN'T CAUSE
18 CONTRACTIONS IN THE UTERUS. AND IT DOES NOT CAUSE SYSTEMIC OR
19 BODY WIDE PHYSIOLOGIC CHANGES AS HAPPEN WHEN LABOR OCCURS
20 NATURALLY OR WHEN WE MAKE AN ATTEMPT TO MAKE IT OCCUR
21 UNNATURALLY.
22 Q. A FEW MORE QUESTIONS ABOUT THE COMPLICATIONS OF INDUCTION.
23 YOU INDICATED THAT, I THINK, RETAINED PLACENTA WAS A
24 COMPLICATION OF INDUCTION?
25 A. YES.

1 Q. AND HOW OFTEN DOES THAT OCCUR?
2 A. I THINK BASED ON OUR EXPERIENCE AT MY HOSPITAL, AS WELL AS
3 PUBLISHED STUDIES, I THINK IT OCCURS TEN TO TWENTY PERCENT OF
4 THE TIME.
5 Q. HAVE YOU EVER SEEN AN INDUCTION FAIL?
6 A. YES.
7 Q. AND WHY COULD IT FAIL?
8 A. AGAIN, BECAUSE OF OUR INABILITY, USING THE MOST CURRENT
9 METHODS OF PHARMACOLOGIC INTERVENTION TO INITIATE OR TO TRY TO
10 MIMIC A NATURAL PHYSIOLOGIC PROCESS. SOME WOMEN DON'T RESPOND
11 TO WHATEVER FORMULATION OF PROSTAGLANDIN OR PITOCIN THAT WE TRY
12 TO USE.
13 IN SOME OF THEM WE JUST CAN'T INDUCE LABOR. NOT
14 MOST OF THE TIME, BUT IT CAN HAPPEN SOME OF THE TIME.
15 Q. HOW WOULD YOU GO ABOUT EVACUATING THE UTERUS IF THE
16 INDUCTION FAILED?
17 A. IF THE INDUCTION FAILED, THEN THE BEST OPTION WOULD BE D&E.
18 Q. AND HAVE YOU SEEN INDUCTIONS WHERE THE FETUS IS PARTIALLY
19 DELIVERED UP TO THE CALVARIUM AND THEN BECOMES TRAPPED?
20 A. YES, I HAVE.
21 Q. AND WHAT DO YOU DO UNDER THOSE CIRCUMSTANCES?
22 A. UNDER THOSE CIRCUMSTANCES I THINK THE LEAST INVASIVE AND
23 IF -- IF THE MOTHER DOESN'T HAVE -- IF SHE IS NOT BLEEDING A
24 LOT, OR SHE DOESN'T HAVE ANY URGENT NEED FOR IMMEDIATE
25 DELIVERY, AN OPTION IS TO DO NOTHING.

1 NOW, AGAIN, IN AN AWAKE PATIENT WHO CAN PERCEIVE
2 THIS FETUS IN HER VAGINA AND PORTIONS OF EXTERNAL TO HER, THAT
3 IS OFTEN NOT AN ACCEPTABLE ALTERNATIVE, DOING NOTHING AND
4 WAITING. SOME WOMEN, THE PLACENTA MAY HAVE DETACHED. SHE MAY
5 BE BLEEDING HEAVILY, SO URGENT INTERVENTION IS NECESSARY.
6 THE OPTIONS HERE COULD INCLUDE SOMETHING CALLED
7 DUHRSSEN'S INCISIONS, WHICH ARE WHEN THE CERVIX IS INCISED SO
8 THAT A TRAPPED FETAL HEAD COULD DELIVERY. THAT IS A VERY
9 INVASIVE PROCEDURE THAT COULD CAUSE HEMORRHAGE OR OTHER
10 COMPLICATIONS.
11 AND THAT IS SOMETHING THAT, I THINK, COULD DAMAGE
12 THE CERVIX AND LEAD TO CERVICAL INCOMPETENCE, NOT THAT I LIKE
13 THAT TERM, IN THE FUTURE.
14 ANOTHER VERY INVASIVE THING, OBVIOUSLY, WOULD BE
15 HYSTEROTOMY. I THINK THE LEAST WORSE ALTERNATIVE IN THAT
16 CIRCUMSTANCE IS TO DO WHAT I WOULD DO IN THE COURSE OF AN
17 INTACT EXTRACTION WHILE I AM DOING A D&E, TO MAKE AN INCISION
18 AT THE BASE OF THE SKULL AND TO SUCTION OUT THE BRAIN TISSUE SO
19 THAT THE HEAD COULD PASS THROUGH THE CERVIX EASILY.
20 Q. DO YOU ROUTINELY USE EITHER KCL OR DIGOXIN TO CAUSE FETAL
21 DEMISE BEFORE STARTING TO EVACUATE THE UTERUS IN A D&E
22 PROCEDURE?
23 A. I DO NOT.
24 Q. WHY NOT?
25 A. IN THE D&E PROCEDURE, IT DOESN'T FACILITATE THE PROCEDURE.

1 IT DOES NOT MAKE IT EASIER. A PROCEDURE LIKE THIS, THE PATIENT
2 IS AWAKE. IT IS, IN MOST WOMEN, NOT ASSOCIATED WITH A GREAT
3 DEAL OF PAIN, BUT IN SOME WOMEN IT MAY BE.
4 THE CASES THAT ARE EASY MAY ONLY TAKE A FEW MINUTES,
5 BUT MANY CASES AREN'T EASY, AND IT COULD TAKE A LONG TIME TO DO
6 THAT.
7 IN MY HOSPITAL, WE DON'T USE DIGOXIN. WE USE
8 POTASSIUM CHLORIDE. AND WE INJECT THAT EITHER DIRECTLY INTO
9 THE UMBILICAL CORD OR INTO THE HEART OF THE FETUS.
10 AND, AGAIN, IN SOME CASES FOR TECHNICAL REASONS THIS
11 CAN BE EXTREMELY DIFFICULT OR IMPOSSIBLE TO DO. SOME WOMEN ARE
12 VERY OBESE. SOME WOMEN HAVE AN ABNORMAL UTERUS THAT MAY HAVE
13 VERY LARGE FIBROIDS BETWEEN -- THAT MAKE IT DIFFICULT TO
14 NAVIGATE.
15 SOME WOMEN MAY HAVE BE CARRYING A FETUS WITH AN
16 ABNORMALITY ASSOCIATED WITH NO AMNIOTIC FLUID OR SHE MAY HAVE
17 RUPTURED HER MEMBRANES AND HAVE NO AMNIOTIC FLUID. AND THE
18 LACK OF AMNIOTIC FLUID CAN SEVERELY COMPROMISE OUR ABILITY TO
19 SEE ANYTHING WITH ULTRASOUND, BECAUSE THE ABILITY TO VISUALIZE
20 THINGS ON ULTRASOUND DEPENDS ON A LIQUID/SOLID CONTRAST SO THAT
21 THE SOUND WAVES CAN PENETRATE.
22 SO WITHOUT THAT CONTRAST WITH NO AMNIOTIC FLUID WE
23 OFTENTIMES ARE VERY LIMITED IN OUR ABILITY TO AN
24 ULTRASOUND-GUIDED PROCEDURE.
25 ANOTHER REASON IS IF THERE IS A FETAL ABNORMALITY

1 FOR WHICH EVALUATION BY A PATHOLOGIST CAN PRODUCE USEFUL
2 INFORMATION, INDUCING FETAL DEATH IN ADVANCE OF D&E COULD,
3 AGAIN, CAUSE THE PROCESS OF MACERATION OR DEGRADATION OF FETAL
4 TISSUE TO BEGIN. AND, AGAIN, THAT COULD CAUSE A LOSS OF
5 INFORMATION THAT COULD BE USEFUL OTHERWISE.
6 Q. HAVE YOU EVER CUT THE UMBILICAL CORD TO CAUSE FETAL DEMISE
7 BEFORE EVACUATING THE UTERUS IN A D&E PROCEDURE?
8 A. NOT WITH THAT INTENTION, NO.
9 Q. DO YOU GENERALLY CUT THE CORD?
10 A. NOT WITH THAT INTENTION. I DON'T SPECIFICALLY DO IT AS A
11 SPECIFIC STEP IN THE PROCEDURE TO BE DONE PRIOR TO ANYTHING
12 ELSE.
13 Q. AND WHY NOT?
14 A. IT DOESN'T FACILITATE THE PROCEDURE. THE CORD MAY BE NOT
15 EASILY ACCESSIBLE IN SOME CASES. IF I AM DOING A MANIPULATION
16 IN THE UTERUS, EITHER WITH MY HANDS OR WITH FORCEPS, WITH THE
17 ONLY INTENT BEING TO GRASP THE CORD AND CUT IT, I AM NOT DOING
18 ANYTHING THAT IS GOING TO FACILITATE THE PROCEDURE THAT I AM
19 THERE TO DO.
20 IT COULD PROLONG THE OPERATIVE TIME, AND IT COULD
21 INCREASE THE RISK OF COMPLICATIONS. SO I DON'T DO THAT.
22 Q. DR. CHASEN, YOU ARE FAMILIAR WITH THE PARTIAL-BIRTH
23 ABORTION BAN ACT, ARE YOU NOT?
24 A. YES, I AM.
25 THE COURT: EXCUSE ME. BEFORE YOU CHANGE SUBJECTS,

1 I WANT TO MAKE SURE I UNDERSTOOD. YOU SAID AT YOUR INSTITUTION
2 YOU DON'T GENERALLY USE DIGOXIN, BUT YOU DO ON OCCASION USE
3 POTASSIUM CHLORIDE?
4 THE WITNESS: YES.
5 THE COURT: OKAY. ALL RIGHT.
6 BY MS. PARKER:
7 Q. SO YOU ARE FAMILIAR WITH THE PARTIAL-BIRTH ABORTION BAN ACT
8 OF 2003?
9 A. INDEED I AM.
10 Q. YOU ARE A PLAINTIFF IN THE NEW YORK CASE; IS THAT RIGHT?
11 A. YES, IT IS.
12 Q. AND YOU ARE CURRENTLY COVERED BY THE INJUNCTION IN THAT
13 CASE?
14 A. YES, I AM.
15 Q. I HAVE PUT UP ON THE EASEL THE OPERATIVE PORTION OF THAT
16 ACT. IS IT YOUR OPINION THAT THE WAY YOU PERFORM A D&E
17 ABORTION WOULD VIOLATE THE ACT?
18 A. IT MAY.
19 Q. WHY IS THAT?
20 A. WHEN I DO A D&E WITH INTACT EXTRACTION, THEN I THINK THAT
21 COULD VIOLATE THE ACT BASED ON MY INTERPRETATION OF THE
22 SEQUENCE OF THE STEPS LISTED THERE.
23 WHEN I AM DOING A D&E AND I HAVE MADE THE DECISION
24 TO PROCEED WITH DISARTICULATION WITH FORCEPS, THE ACT DOESN'T
25 SAY A THING ABOUT A FETUS BEING DELIVERED INTACT. IT ONLY

1 DESCRIBES ONE PORTION OF THE FETUS BEING DELIVERED BEFORE AN
2 OVERT ACT THAT I KNOW WILL KILL THE PARTIALLY DELIVERED LIVING
3 FETUS.
4 IT IS NOT MY PRACTICE TO DOCUMENT AFTER EVERY STEP
5 IN A D&E WHETHER THE FETUS IS ALIVE OR NOT, BECAUSE, AGAIN,
6 THAT DOESN'T FACILITATE ANY STEP OF THE CASE, AND IT COULD
7 PROLONG IT IF I STOP AND CONSIDER THAT IN EVERY CASE.
8 AND I CAN AND I AM SURE I HAVE IN CERTAIN CASES
9 REMOVED OR DELIVERED A PORTION OF THE FETUS ABOVE THE UMBILICUS
10 OUTSIDE THE MOTHER. AND I HAVE NO DOUBT IN SOME OF THESE CASES
11 THE FETUS IS STILL ALIVE. AND EVERY TIME THAT I AM INTRODUCING
12 THE FORCEPS, MY PURPOSE IS TO REMOVE THE FETUS. IT'S AN OVERT
13 ACT.
14 AND I KNOW THAT ANY TIME I INTRODUCE THE FORCEPS, I
15 COULD DO SOMETHING. AND, AGAIN, IT IS MY INTENTION TO REMOVE
16 THE FETUS. AND EVERY TIME I PERFORM SUCH AN OVERT ACT I KNOW
17 IT COULD KILL THIS FETUS, PORTIONS OF WHICH I HAVE REMOVED
18 ALREADY.
19 SO I DON'T HAVE ANY DOUBT, PERSONALLY, THAT THIS ACT
20 COULD COVER ANY D&E THAT I DO ON A LIVING FETUS.
21 Q. IS IT YOUR OPINION YOU WOULD VIOLATE THE ACT BY THE WAY YOU
22 PERFORM AN INDUCTION ABORTION?
23 A. THERE ARE SCENARIOS I CAN FORESEE IN AN INDUCTION ABORTION
24 THAT COULD ALSO VIOLATE THE ACT.
25 MR. QUINLIVAN: OBJECTION, YOUR HONOR. I DON'T

1 THINK THERE HAS BEEN ANY TESTIMONY THAT THE WITNESS DOES
2 INDUCTION ABORTIONS.
3 THE COURT: I DON'T RECALL HE HAS. YOU NEED TO
4 ESTABLISH THAT.
5 MS. PARKER: I THOUGHT I HAD ASKED HIM THAT AT THE
6 BEGINNING OF THE -- WAY AT THE BEGINNING OF THE EXAMINATION,
7 BUT I WILL ASK HIM THAT QUESTION.
8 BY MS. PARKER:
9 Q. DO YOU PERFORM INDUCTION ABORTIONS?
10 A. MUCH LESS COMMONLY THAN I DO D&E, BUT, YES, THAT IS
11 SOMETHING THAT I HAVE DONE AND CAN DO.
12 Q. AND IS IT YOUR OPINION THAT YOU WOULD VIOLATE THE ACT BY
13 THE WAY THAT YOU WOULD PERFORM AN INDUCTION ABORTION?
14 A. AGAIN, I CAN FORESEE A SCENARIO THAT COULD OCCUR IN WHICH
15 THE INDUCTION ABORTION COULD VIOLATE THE ACT.
16 Q. AND WHAT IS THAT SCENARIO?
17 A. AGAIN, I COULD HAVE A PATIENT IN THE PROCESS OF BEING
18 INDUCED COULD PARTIALLY EXPEL A FETUS. FOR INSTANCE, THE
19 BREECH-PRESENTING FETUS COULD BE EXPELLED, PARTIALLY, WHEREBY
20 THE DEGREE OF CERVICAL DILATION COULD ACCOMMODATE THE FETUS UP
21 TO, BUT NOT INCLUDING THE HEAD. THE HEAD COULD BECOME
22 ENTRAPPED IN THE CERVIX. A WOMAN COULD BE BLEEDING HEAVILY,
23 AND I MAY NEED TO DO SOMETHING QUICKLY AND EMERGENTLY TO
24 COMPLETE THE PROCEDURE IN THIS PATIENT THAT MAY BE
25 HEMORRHAGING.

1 AND WHAT I COULD DO TO THIS FETUS WHO MAY BE ALIVE
2 COULD VIOLATE THE ACT. THAT IS TRUE IN A NORMAL FETUS. IT MAY
3 BE ESPECIALLY TRUE IN A FETUS WITH HYDROCEPHALUS, FOR INSTANCE.
4 Q. DO YOU MANAGE SPONTANEOUS MISCARRIAGES AS PART OF YOUR
5 PRACTICE?
6 A. I DO.
7 Q. IS IT YOUR OPINION YOU WOULD VIOLATE THE ACT IN THE WAY YOU
8 MONITOR SPONTANEOUS MISCARRIAGES?
9 A. I COULD.
10 Q. HOW COULD THAT HAPPEN?
11 A. AGAIN, SPONTANEOUS MISCARRIAGE -- AGAIN, SOME OF THE WOMEN
12 THAT I DO A D&E ARE IN THE STAGE OF HAVING A SPONTANEOUS
13 MISCARRIAGE. THEY MAY BE DILATING THE CERVIX. THEY MAY HAVE
14 RUPTURED THEIR MEMBRANES. AND SO A MINORITY OF PATIENTS ON
15 WHOM I DO A D&E ARE IN THE PROCESS OF HAVING A SPONTANEOUS
16 ABORTION.
17 PATIENTS HAVING A SPONTANEOUS ABORTION COULD PRESENT
18 TO ME WITH THE SCENARIO THAT I JUST DESCRIBED WITH AN
19 INDUCTION. A PATIENT IN AN ADVANCED STAGE OF LABOR IN WHICH
20 THE BREECH-PRESENTING FETUS IS EXPELLED, BUT THE HEAD IS
21 TRAPPED WITHIN THE CERVIX.
22 AND, AGAIN, SHE MAY BE BLEEDING HEAVILY AT THAT
23 POINT. THE DELIVERY MAY BE YET NEED TO BE ACCOMPLISHED
24 QUICKLY.
25 AND UNDER THOSE SCENARIOS I CAN DO A HYSTEROTOMY,

1 WHICH I THINK IS A TERRIBLY INVASIVE AND COMPLETELY UNINDICATED
2 PROCEDURE IN THIS CIRCUMSTANCE TO FREE THE ENTRAPPED HEAD.
3 I COULD DO DUHRSSEN'S INCISIONS. AND I FEEL THAT
4 THAT IS A VERY INAPPROPRIATE THING TO DO.
5 AND, AGAIN, IN THIS CASE THE MOST APPROPRIATE THING
6 TO DO WOULD BE TO MAKE AN INCISION AT THE BASE OF THE SKULL,
7 DECREASE THE SIZE OF THE HEAD, AS I'VE DESCRIBED, AND IN THIS
8 FETUS THAT MAY BE ALIVE, THAT WOULD VIOLATE THE ACT, IN MY
9 OPINION.
10 Q. IF THE INJUNCTION WERE LIFTED, WHAT IMPACT WOULD THE ACT
11 HAVE ON YOUR PRACTICE?
12 A. IT WOULD HAVE AN IMPACT, AND NOT A GOOD ONE. I WOULD HAVE
13 TO -- IN DOING A D&E, I WOULD HAVE TO CONSIDER EVERY STEP THAT
14 I AM DOING, NOT -- WHEN I AM TAKING CARE OF A PATIENT, I THINK
15 I WANT -- AND I ESPECIALLY THINK THE PATIENT AND HER FAMILY
16 WANT ME TO HAVE MY FULL AND UNDIVIDED ATTENTION DEVOTED TO HER,
17 TAKING CARE OF HER.
18 IF I AM WORRIED THAT ANYTHING I AM DOING IN THE
19 PROCESS OF DOING A D&E COULD VIOLATE THE ACT, THEN I MAY DO
20 THINGS DIFFERENTLY. I MAY NOT BE ABLE TO PROCEED AS
21 DELIBERATELY. I MAY PROLONG THE CASE, BECAUSE I AM CONCERNED
22 ABOUT BEING PROSECUTED FOR TAKING CARE OF MY PATIENT USING MY
23 BEST MEDICAL JUDGMENT. AND MY PATIENT COULD BE HARMED.
24 Q. AND WHAT IMPACT WOULD THE ACT HAVE ON YOUR PATIENTS?
25 A. MY PATIENTS, THEY MAY NOT SEEK OUT A SURGICAL ABORTION.

1 AGAIN, MANY WITH THE PASSAGE OF --
2 MR. QUINLIVAN: OBJECTION, SPECULATION, YOUR HONOR.
3 THE COURT: SUSTAINED.
4 BY MS. PARKER:
5 Q. DO YOU HAVE AN OPINION AS TO WHAT IMPACT THE ACT WOULD HAVE
6 ON YOUR PATIENTS THAT IS BASED ON YOUR OWN EXPERIENCE AND
7 COUNSELING YOUR PATIENTS?
8 A. YES, I DO.
9 Q. WHAT IS THAT?
10 A. I HAVE MANY PATIENTS OVER THE LAST YEAR OR TWO WHO ARE
11 AWARE OF ATTEMPTS TO LIMIT MY USE OF MY MEDICAL JUDGMENT, OR
12 ANY OBSTETRICIAN'S MEDICAL JUDGMENT, IN BANNING CERTAIN TYPES
13 OF PROCEDURES TO ABORTION. AND MORE THAN A FEW PATIENTS HAVE
14 ASKED ME IF I AM GOING TO BE DOING A PARTIAL-BIRTH ABORTION, OR
15 THEY MAY USE THE TERM "INTACT D&E." IF I CAN DO IT, AND
16 SPECIFICALLY AFTER THIS BILL WAS ENACTED, THEY HAVE EXPRESSED
17 CONCERNED ABOUT WHETHER I CAN STILL TAKE CARE OF THEM OR ABOUT
18 WHETHER THEY WOULD BE FORCED TO ENDURE AN INDUCTION THAT THE
19 THOUGHT OF WHICH THEY DREADED.
20 SO IF I WERE NOT COVERED BY A RESTRAINING ORDER OR
21 IF THIS ACT WERE IN EFFECT, MY PATIENTS MIGHT BE UNDER THE
22 FALSE IMPRESSION THAT THEY WOULD HAVE TO HAVE AN INDUCTION.
23 THEY MAY FEEL THAT THEY HAD TO HAVE AN ADDITIONAL PROCEDURE,
24 POTASSIUM CHLORIDE INJECTION.
25 MR. QUINLIVAN: OBJECTION, YOUR HONOR. HE IS NOW

1 SPECULATING AS TO WHAT HIS OPINIONS MAY BE.
2 THE COURT: SUSTAINED AS TO THE SECOND PART OF THE
3 ANSWER. IT IS STRICKEN.
4 MS. PARKER: I HAVE NO FURTHER QUESTIONS, YOUR
5 HONOR.
6 THE COURT: CROSS-EXAMINATION?
7 MR. QUINLIVAN: YOUR HONOR, BEFORE WE BEGIN, I DO
8 WANT TO RENEW MY OBJECTION ON THE MATTERS IN WHICH DR. CHASEN
9 WAS RESPONDING TO THE TESTIMONY OF DR. COOK. I DO SO BECAUSE
10 MY CO-COUNSEL HAS REMINDED ME DR. CHASEN DID NOT SUBMIT A
11 REBUTTAL EXPERT REPORT IN THIS CASE.
12 THE ONLY REBUTTAL EXPERT REPORTS WERE SUBMITTED BY
13 DR. CREININ AND DR. DOE. OUR UNDERSTANDING WAS THAT DR. CHASEN
14 WAS ATTENDING TRIAL TODAY DUE TO SCHEDULING CONCERNS, NOT
15 BECAUSE HE WAS A REBUTTAL WITNESS.
16 AND GIVEN THAT HE DID NOT SUBMIT A REBUTTAL EXPERT
17 REPORT, I THINK THAT THAT ENTIRE LINE OF QUESTIONING NEEDS TO
18 BE STRICKEN.
19 THE COURT: WERE THE TWO AREAS THAT DR. COOK
20 TESTIFIED ABOUT FOR WHICH THIS DOCTOR HAS GIVEN EXPERT
21 TESTIMONY. WERE THOSE HYPOTHETICALS, FOR INSTANCE, INVOLVING
22 THE TWO MEDICAL CONDITIONS, WERE THOSE PART OF THE EXPERT
23 REPORT OF DR. COOK?
24 MS. GARTNER: THEY WERE NOT, YOUR HONOR. AND THEY
25 WERE NOT DISCUSSED IN HIS DEPOSITION. IN FACT, DURING

1 DR. COOK'S TESTIMONY IN THAT I SPECIFICALLY OBJECTED TO THE
2 INTRODUCTION OF THE LETTER FROM DR. DARDIAN (PHONETIC), AND
3 MS. CLARK POSED THOSE QUESTIONS AS HYPOTHETICALS TO DR. COOK,
4 WHICH WE UNDERSTAND IS PROPER WITH RESPECT TO AN EXPERT TO ASK
5 HYPOTHETICAL QUESTIONS, WHICH IS WHAT MS. PARKER WAS DOING WITH
6 DR. CHASEN.
7 THE COURT: YOUR OBJECTION IS STILL OVERRULED. I AM
8 NOT GOING TO CHANGE MY RULING.
9 MR. QUINLIVAN: VERY WELL, YOUR HONOR. I WANTED TO
10 NOTE IT FOR THE RECORD.
11 CROSS-EXAMINATION
12 BY MR. QUINLIVAN:
13 Q. DOCTOR, GOOD MORNING.
14 A. IT IS AFTERNOON ON MY CLOCK.
15 Q. ACTUALLY, IT IS THE AFTERNOON WHERE I AM FROM, TOO, SO --
16 MY NAME IS MARK QUINLIVAN. I AM ONE OF THE CO-COUNSEL FOR THE
17 GOVERNMENT. WE JUST MET THIS MORNING FOR THE FIRST TIME; ISN'T
18 THAT RIGHT?
19 A. THAT IS CORRECT.
20 Q. DOCTOR, I WANT TO BEGIN -- YOU TESTIFIED IN RESPONSE TO
21 SEVERAL QUESTIONS ABOUT THE LABOR INDUCTION METHOD OF ABORTION.
22 AND YOU SAID THAT YOU USE THAT METHOD -- I THINK THE WORDS YOU
23 USED WERE, QUOTE, "MUCH LESS COMMONLY."
24 HOW MUCH LESS COMMONLY DO YOU USE THE LABOR
25 INDUCTION METHOD?

1 A. MUCH LESS COMMONLY. I AM SORRY?
2 Q. LET ME ASK YOU: WHEN WAS THE LAST TIME YOU DID A LABOR
3 INDUCTION ABORTION?
4 A. I BELIEVE IN CALENDAR YEAR 2002. IT WAS THE LAST YEAR THAT
5 I SPECIFICALLY PERFORMED IT IN MY CAPACITY AS SOMEONE WHO
6 SUPERVISES RESIDENTS. I HAVE BEEN A SUPERVISING PHYSICIAN AND
7 RESPONSIBLE ATTENDING PHYSICIAN FOR PATIENTS UNDERGOING MEDICAL
8 INDUCTION MUCH MORE RECENTLY.
9 Q. YOU DON'T CONSIDER YOURSELF TO HAVE SPECIAL EXPERTISE IN
10 THE LABOR INDUCTION METHOD OF ABORTION, DO YOU?
11 A. I BELIEVE I HAVE EXPERTISE IN THIS METHOD OF ABORTION.
12 MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE
13 WITNESS?
14 THE COURT: YES, YOU MAY.
15 MR. QUINLIVAN: DOES YOUR HONOR HAVE A COPY?
16 THE COURT: I DON'T HAVE A COPY.
17 BY MR. QUINLIVAN:
18 Q. DOCTOR, YOUR DEPOSITION WAS TAKEN IN THE NEW YORK CASE;
19 ISN'T THAT RIGHT?
20 A. THAT'S RIGHT.
21 Q. AND THAT DEPOSITION WAS TAKEN -- A COURT REPORTER TOOK IT
22 DOWN?
23 A. YES.
24 Q. AND YOU HAD THE OPPORTUNITY TO REVIEW IT AFTERWARDS?
25 A. YES, I DID.

1 Q. IF YOU COULD TURN TO PAGES 157 AND 158. SPECIFICALLY,
2 LINES 157:21 THROUGH 158:2. AND JUST READ THAT -- I AM SORRY,
3 157:21 THROUGH 158:13, AND JUST READ THAT TO YOURSELF SILENTLY.
4 A. THROUGH LINE WHAT?
5 Q. I AM SORRY, 158:13.
6 A. YES.
7 Q. AND YOU WERE ASKED:
8 "QUESTION: DO YOU DO ANY TERMINATIONS BY THE
9 LABOR INDUCTION METHOD?
10 "ANSWERS: VERY RARELY.
11 "QUESTION: I GOT THAT FROM YOUR AFFIDAVIT.
12 WHEN'S THE LAST TIME THAT YOU DID ONE OF THOSE?
13 "ANSWER: IN 2001 OR 2002.
14 "QUESTION: AND WHY DON'T YOU USE THAT METHOD
15 VERY OFTEN?
16 "ANSWER: WELL, I DON'T HAVE ANY SPECIAL
17 EXPERTISE IN THAT METHOD COMPARED WITH THE OTHER
18 OBSTETRICIAN GYNECOLOGISTS. MY MAIN POSITION AS A
19 MATERNAL FETAL SPECIALIST IS AS A MATERNAL FETAL
20 MEDICINE SPECIALIST. AND PREGNANCY TERMINATION IS A
21 SMALL PORTION OF WHAT I DO. AND TO THE EXTENT THAT
22 I DO IT, I CONFINE IT TO CASES THAT -- TO SITUATIONS
23 OR PROCEDURES FOR WHICH I HAVE EXPERTISE THAT ISN'T
24 WIDELY AVAILABLE."
25 WAS THAT YOUR TESTIMONY DURING THE DEPOSITION?

1 A. YES, IT WAS, NOT INCONSISTENT WITH WHAT I STATED HERE.
2 MR. QUINLIVAN: YOUR HONOR, MOVE TO STRIKE THAT LAST
3 STATEMENT.
4 THE COURT: YOUR REQUEST IS GRANTED.
5 DOCTOR, IF YOU WOULD SIMPLY AT THIS TIME --
6 THE WITNESS: OKAY.
7 THE COURT: -- ANSWER HIS QUESTIONS AS DIRECTLY AS
8 YOU CAN.
9 THE WITNESS: I WILL, YOUR HONOR.
10 BY MR. QUINLIVAN:
11 Q. DOCTOR, I WOULD LIKE TO TURN YOUR ATTENTION TO -- I THINK
12 THE FIRST STUDY THAT YOU DISCUSSED WITH MS. PARKER THIS
13 MORNING, WHICH, I BELIEVE, IS PLAINTIFFS' EXHIBIT 17.
14 A. YES.
15 Q. AND IF I AM NOT MISTAKEN, THAT IS THE STUDY THAT YOU
16 CO-AUTHORED DEALING WITH THE "IMPACT OF MID-TRIMESTER DILATION
17 AND EVACUATION ON SUBSEQUENTLY -- ON SUBSEQUENT PREGNANCY
18 OUTCOMES"; IS THAT RIGHT?
19 A. THAT'S RIGHT.
20 Q. AND YOU LOOKED AT THE MEDICAL RECORDS OF, I BELIEVE, 600
21 WOMEN?
22 A. YES.
23 Q. AND YOU WERE ABLE TO FOLLOW THE PREGNANCY OUTCOMES OF 81 OF
24 THE WOMEN; ISN'T THAT RIGHT?
25 A. THAT IS CORRECT.

1 Q. AND THE REASON YOU WERE ONLY ABLE TO FOLLOW-UP WITH
2 PREGNANCY OUTCOMES OF 81 OF THOSE WOMEN IS BECAUSE SOME OF THE
3 OTHER WOMEN MAY HAVE GONE TO THEIR REFERRING OBSTETRICIANS;
4 ISN'T THAT RIGHT?
5 A. OTHER WOMEN UNDOUBTEDLY DID GO TO THEIR REFERRING
6 OBSTETRICIANS.
7 Q. AND IN DOING THAT STUDY, YOU DIDN'T FOLLOW UP WITH WOMEN
8 WHO WENT TO, SAY, BACK TO THEIR REFERRING OBSTETRICIANS OR TO
9 OTHER OBSTETRICIANS?
10 A. WE DID NOT.
11 Q. AND YOU WOULD AGREE, DOCTOR, WOULD YOU NOT, THAT THE
12 QUALITY OF YOUR CONCLUSION IN THAT STUDY MAY DEPEND ON THE
13 NUMBER OF PATIENTS THAT YOU ARE ABLE TO FOLLOW-UP AT YOUR
14 INSTITUTION?
15 A. IT MAY.
16 Q. AND YOU WOULD AGREE, ALSO, DOCTOR, THAT THE PATIENTS WHO
17 UNDERWENT A D&E PROCEDURE AT YOUR HOSPITAL AND DELIVERED
18 ELSEWHERE MAY HAVE HAD A HIGHER OR LOWER RATE OF SPONTANEOUS
19 BIRTH?
20 A. AS WE ACKNOWLEDGE IN THE PAPER.
21 Q. AND YOUR ANSWER IS: YES?
22 A. YES.
23 Q. OKAY. NOW, LET'S TURN TO YOUR MORE RECENT STUDY, WHICH I
24 BELIEVE IS PLAINTIFFS' EXHIBIT 19.
25 IS IT FAIR TO SAY THAT THE OBJECTIVE OF YOUR STUDY

1 WAS TO COMPARE THE RELATIVE SAFETY OF TWO TECHNIQUES FOR
2 SURGICAL ABORTION LATE IN THE SECOND-TRIMESTER?
3 A. YES.
4 Q. AND, IN FACT, THAT IS WHAT YOU SAID ON THE FIRST PAGE OF
5 YOUR STUDY IN THE OBJECTIVE SECTION; ISN'T THAT RIGHT?
6 A. THAT'S CORRECT.
7 Q. AND THE TWO TECHNIQUES THAT WERE BEING COMPARED AS DEFINED
8 IN THE STUDY WERE DILATION AND EVACUATION AND INTACT DILATION
9 AND EXTRACTION?
10 A. THOSE WERE THE TWO VARIATIONS OF DILATION AND EVACUATION
11 THAT WE WERE COMPARING.
12 Q. LET ME TALK -- LET'S TALK A LITTLE BIT ABOUT THE
13 DESCRIPTION OR THE -- OR HOW YOU DESCRIBED THE INTACT DILATION
14 AND EXTRACTION OR INTACT D&X.
15 A. YES.
16 Q. IN REVIEWING THE MEDICAL RECORDS, YOU DETERMINED THAT IF
17 THE FETUS WAS DELIVERED INTACT IN THE BREECH PRESENTATION TO
18 THE LEVEL OF THE UMBILICUS OR HIGHER, THE PROCEDURE WAS
19 CONSIDERED AN INTACT DILATION AND EXTRACTION; IS THAT RIGHT?
20 A. THAT IS CORRECT.
21 Q. AND JUST TO BE CLEAR, IN LAYMEN'S TERMS THE UMBILICUS IS
22 WHERE THE UMBILICAL CORD ATTACHES TO THE FETUS, RIGHT?
23 A. THE BEST LAYMEN'S TERM IS THE BELLY BUTTON, YES.
24 Q. I WAS JUST ABOUT TO ASK FOR THOSE OF US, AFTER THE BELLY
25 BUTTON IS CUT OR AFTER THE UMBILICAL CORD IS CUT, THAT IS YOUR

1 NAVEL OR BELLY BUTTON, RIGHT?
2 A. YES.
3 Q. AND IF THE FETUS WAS DELIVERED INTACT IN THE BREECH
4 PRESENTATION TO THE LEVEL OF THE UMBILICUS OR HIGHER, YOU
5 CONSIDERED THAT TO BE AN INTACT DILATION AND EXTRACTION,
6 WHETHER OR NOT THE ENTIRE FETUS WAS REMOVED INTACT OR
7 DECOMPRESSION OF THE HEAD WAS REQUIRED, RIGHT?
8 A. THAT IS CORRECT.
9 Q. AND YOU SELECTED BREECH PRESENTATION TO THE LEVEL OF THE
10 UMBILICUS OR HIGHER, BECAUSE THE UMBILICUS IS AN EASILY
11 IDENTIFIED LANDMARK THAT YOU COULD IDENTIFY, RIGHT?
12 A. THAT IS CORRECT.
13 Q. NOW, THERE WAS ANOTHER SITUATION WHICH MIGHT FALL IN THE
14 INTACT D&X CATEGORY, AND THAT WAS WHERE THE FETUS WAS IN THE
15 VERTEX OR HEADFIRST PRESENTATION, RIGHT?
16 A. CORRECT.
17 Q. AND IF THE FETUS WAS PRESENTING HEADFIRST, AND THE FETUS'
18 HEAD WAS DECOMPRESSED WITH SUCTION, FOLLOWED BY AN INTACT
19 DELIVERY OF THE FETUS, THAT, FOR PURPOSES OF YOUR STUDY,
20 CONSTITUTED AN INTACT D&X?
21 A. THAT IS CORRECT.
22 Q. NOW, DOCTOR, YOUR STUDY DOES NOT INCLUDE ALL PATIENTS WHO
23 HAD SURGICAL ABORTIONS AT CORNELL DURING THE PERIOD UNDER YOUR
24 REVIEW; ISN'T THAT RIGHT?
25 A. THAT IS CORRECT.

1 Q. YOU ONLY INCLUDED PROCEDURES OR SITUATIONS IN WHICH THE
2 PHYSICIAN WAS ABLE TO DO BOTH THE D&E AND INTACT D&X PROCEDURE,
3 RIGHT?
4 A. YES.
5 Q. AND THERE IS ONE PHYSICIAN AT CORNELL -- AND I'M JUST GOING
6 TO CALL HIM "DR. X" WHO ONLY PERFORMS THE DILATION AND
7 EVACUATION METHOD THAT INVOLVES DISMEMBERMENT OR
8 DISARTICULATION, RIGHT?
9 A. YES.
10 Q. AND YOU DIDN'T INCLUDE HIM IN THIS STUDY BECAUSE HE DOESN'T
11 EVER PERFORM INTACT -- THE INTACT D&X PROCEDURE, RIGHT?
12 A. THAT'S MY UNDERSTANDING BASED ON CONVERSATIONS WITH HIM.
13 Q. AND YOUR UNDERSTANDING IS THAT DR. X'S SURGICAL APPROACH
14 DIFFERS FROM YOURS BECAUSE HE ONLY PERFORMS DILATION AND
15 EVACUATION INVOLVING DISMEMBERMENT AND DISARTICULATION?
16 A. THAT IS CORRECT.
17 Q. DOCTOR, I WANT TO ASK YOU A FEW QUESTIONS JUST SO I
18 UNDERSTAND THE TIME LINE OF YOUR STUDY ENTIRELY. AM I CORRECT
19 YOU INITIALLY THOUGHT ABOUT DOING THE STUDY THAT IS PLAINTIFFS'
20 EXHIBIT 19 SOMETIME IN THE EARLY SPRING OF 2003?
21 A. THAT'S WHEN WE DECIDED TO DO THE STUDY, YES.
22 Q. IT WAS YOUR IDEA TO DO THE STUDY, RIGHT, DOCTOR?
23 A. I WAS.
24 Q. AND THE REASON YOU WANTED TO DO THE STUDY IS BECAUSE THERE
25 WEREN'T ANY EXISTING STUDIES IN THE MEDICAL LITERATURE

1 COMPARING THESE TWO DIFFERENT TECHNIQUES, RIGHT?
2 A. THAT IS CORRECT.
3 Q. AND YOU SUBMITTED A REQUEST FOR AN EXPEDITED REVIEW OF
4 INVESTIGATION OF HUMAN SUBJECTS TO THE INSTITUTIONAL REVIEW
5 BOARD IN MARCH OF 2003, RIGHT?
6 A. THAT IS CORRECT.
7 Q. AND YOU HAD TO SEEK APPROVAL FROM THE INSTITUTIONAL REVIEW
8 BOARD TO REVIEW THE MEDICAL RECORDS -- THE MEDICAL RECORDS AT
9 ISSUE, RIGHT?
10 A. RIGHT. THE EXPEDITED REQUEST IS ONLY -- IS PRUDENT IF ALL
11 YOU ARE GOING TO DO IS A RETROSPECTIVE REVIEW.
12 Q. YOU HAD TO LOOK AT BOTH MEDICAL RECORDS OF WOMEN WHO HAD
13 UNDERGONE -- AGAIN, USING THE TERMS OF YOUR STUDY -- EITHER THE
14 D&E OR THE INTACT D&X PROCEDURE, RIGHT?
15 A. THAT'S RIGHT.
16 Q. AND IF YOU HAD BEEN DENIED ACCESS OR IF YOUR PROPOSAL HAD
17 BEEN DENIED BY THE IRB, YOU WOULDN'T HAVE BEEN ABLE TO CONDUCT
18 YOUR STUDY AT ALL BECAUSE YOU WOULDN'T HAVE BEEN ABLE TO SEE
19 THE MEDICAL RECORDS, RIGHT?
20 A. RIGHT. WE COULD HAVE LOOKED AT THE DATA THAT HAD BEEN
21 ACCUMULATED BASE ON THE PRIOR STUDY, BUT THAT WOULDN'T HAVE AS
22 MANY PATIENTS AS WE ULTIMATELY ACHIEVED.
23 Q. THE IRB APPROVED YOUR REQUEST, RIGHT?
24 A. THEY DID.
25 Q. THE MEDICAL RECORDS YOU REVIEWED ARE IN THE CUSTODY AND

1 CONTROL OF THE NEW YORK WEILL CORNELL MEDICAL CENTER WHICH
2 ITSELF IS PART OF NEW YORK PRESBYTERIAN HOSPITAL?
3 A. YES.
4 Q. AND NEW YORK PRESBYTERIAN HOSPITAL IS THE SAME INSTITUTION
5 THAT HAS CUSTODY AND CONTROL OF THE RECORDS WHICH THE
6 GOVERNMENT IS SEEKING IN THE NEW YORK LITIGATION; IS THAT
7 RIGHT?
8 MS. PARKER: I AM GOING OBJECT TO THIS LINE OF
9 QUESTIONING, YOUR HONOR, BECAUSE IT IS IRRELEVANT TO OUR CASE,
10 WHAT OCCURRED IN THE NEW YORK CASE.
11 THE COURT: CAN YOU TELL ME HOW IT IS RELEVANT?
12 MR. QUINLIVAN: I AM JUST ESTABLISHING A RECORD,
13 YOUR HONOR. I'LL MOVE ON.
14 MS. PARKER: HE IS ESTABLISHING A RECORD FOR --
15 THE COURT: FOR ANOTHER CASE --
16 MS. PARKER: YES.
17 THE COURT: THAT IS ENTIRELY INAPPROPRIATE,
18 COUNSEL.
19 MR. QUINLIVAN: NOT FOR ANOTHER CASE, YOUR HONOR. I
20 AM JUST -- I WILL MOVE ON.
21 THE COURT: I DON'T UNDERSTAND THE RELEVANCE TO THIS
22 CASE, HOWEVER.
23 MR. QUINLIVAN: WELL, I WILL MOVE ON, YOUR HONOR.
24 THAT QUESTION, I CAN GIVE IT AN EXPLANATION, BUT IT IS NOT
25 WORTH TAKING THE --

1 MS. PARKER: WELL, I WILL MOVE TO STRIKE THE PRIOR
2 SEVERAL QUESTIONS AND ANSWERS. AS YOUR HONOR PROBABLY KNOWS,
3 THERE IS AN ARGUMENT IN THE SECOND CIRCUIT ON TUESDAY AND I --
4 THE COURT: UNLESS IT HAS RELEVANCE TO THIS CASE,
5 WHO IS IN POSSESSION OF THE RECORDS THAT YOU ARE RELYING UPON,
6 I AM GOING TO STRIKE IT UNLESS YOU WISH TO MAKE AN OFFER OF
7 PROOF.
8 MR. QUINLIVAN: ON MY LAST QUESTION, WHICH IS THE
9 CUSTODY AND CONTROL, YOUR HONOR, I HAVE NO -- IF YOU WANT TO
10 STRIKE, THAT IS FINE. THE QUESTIONS PRIOR ON THE INSTITUTIONAL
11 REVIEW BOARD, I WILL GIVE AN OFFER OF PROOF. BUT CUSTODY AND
12 CONTROL, THAT IS FINE. I WILL MOVE ON.
13 THE COURT: ALL RIGHT. THE ANSWER IS STRICKEN WITH
14 RESPECT TO THE CUSTODY AND CONTROL. I THINK THE OTHERS ONE ARE
15 PROBABLY ALL RIGHT.
16 BY MR. QUINLIVAN:
17 Q. GOING BACK TO THE TIME LINE OF THE STUDY, AFTER THE
18 INSTITUTIONAL REVIEW BOARD GRANTED YOUR OR APPROVED YOUR
19 REQUEST, YOU LOOKED AT THE MEDICAL RECORDS DURING THE SPRING
20 AND SUMMER OF 2003?
21 A. THROUGH JUNE 30TH.
22 Q. AND DATA COLLECTION WAS COMPLETED, THEN, JULY OR AUGUST OF
23 2003?
24 A. YES.
25 Q. AND YOU WERE THE -- YOU ACTUALLY WROTE THE MANUSCRIPT; IS

1 THAT RIGHT?
2 A. YES, IT IS.
3 Q. AND YOU COMPLETED THE MANUSCRIPT SOMETIME IN AUGUST OR
4 SEPTEMBER OF 2003?
5 A. YES.
6 Q. AND AFTER YOU COMPLETED THE MANUSCRIPT YOU FIRST SUBMITTED
7 IT TO THE JOURNAL KNOWN AS OBSTETRICS AND GYNECOLOGY, RIGHT?
8 A. THAT'S CORRECT.
9 Q. AND IS THAT THE JOURNAL OF THE AMERICAN COLLEGE OF
10 OBSTETRICIANS AND GYNECOLOGISTS?
11 A. IT IS THE OFFICIAL JOURNAL. THE ACOG DOESN'T HAVE ANY
12 EDITORIAL CONTROL.
13 Q. UNDERSTOOD. AND YOU HEARD BACK FROM THE JOURNAL OF
14 OBSTETRICS AND GYNECOLOGY IN OCTOBER OF 2003?
15 A. YES.
16 Q. AND YOUR STUDY WAS NOT ACCEPTED FOR PUBLICATION, RIGHT?
17 A. THAT IS CORRECT.
18 Q. AND THEN, YOU THEN SUBMITTED THE MANUSCRIPT TO THE AMERICAN
19 JOURNAL OF OBSTETRICS AND GYNECOLOGY ALSO IN OCTOBER OF 2003?
20 A. THAT IS CORRECT.
21 Q. AND YOU RECEIVED AN E-MAIL FROM THE AMERICAN JOURNAL OF
22 OBSTETRICS AND GYNECOLOGISTS TENTATIVELY ACCEPTING IT ON
23 DECEMBER 12TH, 2003?
24 A. THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, YES.
25 Q. AND THAT E-MAIL INCLUDED PEER REVIEW COMMENTS, DIDN'T IT?

1 A. YES, IT DID.
2 Q. AND YOU WROTE A LETTER TO THE EDITORS OF THE AMERICAN
3 JOURNAL OF OBSTETRICS AND GYNECOLOGY RESPONDING TO THAT E-MAIL
4 AND RESPONDING TO THE PEER REVIEW COMMENTS ON DECEMBER 12TH OF
5 2003; IS THAT RIGHT?
6 A. THAT IS CORRECT.
7 Q. I AM SORRY. YOUR LETTER WAS DECEMBER 19TH. THE E-MAIL WAS
8 DECEMBER 12TH. YOUR LETTER WAS DECEMBER 19TH; IS THAT RIGHT?
9 A. SOUNDS RIGHT.
10 Q. OKAY. AND YOUR ARTICLE IS CURRENTLY IN PAGE PROOFS, I
11 BELIEVE YOU TESTIFIED?
12 A. IT'S BEYOND THAT. IT IS IN PRESS.
13 Q. NOW, DOCTOR, YOU DID MENTION THAT YOU ARE ONE OF THE NAMED
14 PLAINTIFFS IN THE NEW YORK LITIGATION CHALLENGING
15 CONSTITUTIONALITY OF THE PARTIAL-BIRTH ABORTION BAN ACT OF
16 2003; CORRECT?
17 A. YES.
18 Q. AND YOU'RE REPRESENTED BY ATTORNEYS FROM THE ACLU IN THAT
19 CASE, RIGHT?
20 A. THAT IS CORRECT.
21 Q. AND, IN FACT, DOCTOR, YOU HAVE BEEN IN CONTACT WITH
22 ATTORNEYS FROM THE ACLU GOING BACK TO 1998 DEALING WITH
23 POTENTIAL CHALLENGES TO ANY FEDERAL LAW ON PARTIAL-BIRTH
24 ABORTION; ISN'T THAT RIGHT?
25 A. YES.

1 Q. IN FACT, IT IS TRUE, IS IT NOT, DOCTOR, THAT IN SEPTEMBER
2 OF 1998, YOU EXECUTED A DECLARATION IN A LAWSUIT THAT WAS NEVER
3 BROUGHT THAT WOULD HAVE CHALLENGED A THEN-PENDING BILL IN
4 CONGRESS BANNING PARTIAL-BIRTH ABORTION?
5 A. THAT IS CORRECT.
6 Q. AND YOU SIGNED THAT DECLARATION ON -- I DON'T WANT TO
7 MISSTATE MY DATE AGAIN. YOU SIGNED THAT DECLARATION ON
8 SEPTEMBER 17TH, 1998?
9 A. THAT IS CORRECT.
10 Q. SEPTEMBER 17TH, 1998. SINCE 1998, YOU'VE -- AND PRIOR TO
11 BEGINNING THE STUDY, YOU'VE BEEN IN FURTHER CONTACT WITH
12 ATTORNEYS FROM THE ACLU; ISN'T THAT RIGHT?
13 A. THAT IS CORRECT.
14 Q. SEPTEMBER OF 2002, YOU E-MAILED A COPY OF YOUR CURRICULUM
15 VITAE TO ONE OF THE ATTORNEYS FROM THE ACLU; ISN'T THAT RIGHT?
16 A. THAT IS CORRECT.
17 Q. AND THE DECLARATION THAT YOU SIGNED IN THE NEW YORK
18 LITIGATION WAS DATED NOVEMBER 4TH, 2003, CORRECT?
19 A. THAT SOUNDS CORRECT.
20 Q. NOW, DOCTOR, WHEN YOU FIRST SUBMITTED YOUR ARTICLE TO THE
21 JOURNAL OBSTETRICS AND GYNECOLOGY, WHICH DID NOT ACCEPT IT, DID
22 YOU INFORM THEM THAT YOU HAD BEEN IN CONTACT WITH ATTORNEYS
23 FROM THE ACLU FOR ANY POSSIBLE LAWSUIT INVOLVING THE PROCEDURE
24 AT ISSUE?
25 A. NO, I DIDN'T.

1 Q. AND WHEN YOU SUBMITTED YOUR ARTICLE IN OCTOBER OF 2003, TO
2 THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, DID YOU
3 INFORM THEM THAT YOU WERE GOING TO BE A PLAINTIFF IN A LAWSUIT
4 CHALLENGING THE CONSTITUTIONALITY OF THE ACT IN QUESTION?
5 A. I DID NOT.
6 Q. NOW, TURNING BACK TO THE E-MAIL YOU RECEIVED FROM THE
7 EDITORS OF THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, I
8 BELIEVE YOU TESTIFIED THAT E-MAIL CONTAINS SOME PEER REVIEW
9 COMMENTS?
10 A. YES.
11 Q. AND AM I CORRECT THAT ONE OF THE REVIEWERS STATED THAT THE
12 AUTHORS SHOULD ALSO MENTION THAT, ONCE AGAIN, CONGRESS HAS
13 PASSED A LAW BANNING THE D&X EXTRACTION PROCEDURE; THAT LEGAL
14 CHALLENGES TO ITS CONSTITUTIONALITY ARE UNDERWAY? WAS THAT ONE
15 OF THE PEER REVIEW COMMENTS?
16 A. THAT WAS.
17 Q. AND YOU RESPONDED TO THE EDITORS -- YOU RESPONDED IN YOUR
18 LETTER TO THE EDITORS OF THE AMERICAN JOURNAL OF OBSTETRICS AND
19 GYNECOLOGY. I THINK YOU SAID IT WAS DECEMBER 19TH OF 2003. YOU
20 RESPONDED SPECIFICALLY TO THAT PEER REVIEW COMMENT, DIDN'T YOU?
21 A. I DID.
22 Q. AND AM I CORRECT THAT YOUR RESPONSE STATED, QUOTE:
23 "THE REVIEWER WANTS US TO ACKNOWLEDGE THE
24 CURRENT POLITICAL CONTROVERSY, INCLUDING RECENT
25 LEGISLATION. WE HAVE RESTRICTED THE CONTENT OF THIS

1 PAPER TO OUR EXPERIENCE WITH THESE PROCEDURES.
2 THOUGH THIS PAPER MAY BE RELEVANT TO THE POLITICAL
3 CONTROVERSY, WE DO NOT THINK IT IS APPROPRIATE TO
4 INCLUDE IN OUR PAPER."
5 THOSE WERE YOUR WORDS; ISN'T THAT RIGHT, DOCTOR?
6 A. MY RESPONSE CONTAINED THOSE WORDS, YES.
7 Q. IN THAT LETTER OF DECEMBER 19TH, 2003, DID YOU AT THAT
8 POINT INFORM THE EDITORS OF THE AMERICAN JOURNAL OF OBSTETRICS
9 AND GYNECOLOGY THAT YOU ALREADY WERE A PLAINTIFF IN THE NEW
10 YORK LITIGATION CHALLENGING THE CONSTITUTIONALITY OF THE ACT IN
11 QUESTION?
12 A. I DID NOT.
13 Q. AND, DOCTOR, I AM CURIOUS. DO YOU THINK THAT YOU WERE
14 BEING ENTIRELY CANDID WITH THE EDITORS OF THAT JOURNAL IN NOT
15 DISCLOSING THE FACT THAT YOU ARE A PLAINTIFF IN THE NEW YORK
16 LITIGATION THAT INVOLVED ONE OF THE PROCEDURES THAT WAS AT
17 ISSUE IN YOUR PAPER?
18 A. I KNOW THAT I WAS IN COMPLIANCE WITH THEIR POLICY OF
19 DISCLOSURE AT ALL TIMES.
20 Q. SO YOU WERE TELLING THE TRUTH, BUT JUST NOT THE WHOLE
21 TRUTH; IS THAT YOUR FAIR ASSESSMENT, DOCTOR?
22 A. THE JOURNAL, BEFORE THEY WOULD CONSIDER A MANUSCRIPT, ASKS
23 YOU TO CONSIDER CIRCUMSTANCES THAT THEY WOULD CONSIDER A
24 CONFLICT. AND THE CIRCUMSTANCES THAT THEY DETAILED RELATED TO
25 COMMERCIAL CONFLICTS OF INTEREST. IT DIDN'T TALK ABOUT

1 LITIGATION OR ANYTHING LIKE THAT. AND I WAS IN COMPLIANCE.
2 AND MY SENIOR AUTHOR, MY CHAIRMAN, AGREED. AND WE WERE IN FULL
3 COMPLIANCE WITH THE REQUIREMENTS OF THE JOURNAL REGARDING
4 DISCLOSURE OF CONFLICTS OF INTEREST.
5 Q. DOCTOR, AM I CORRECT THAT THE VERSION THAT WILL BE
6 PUBLISHED DOES NOT MENTION THE FACT THAT YOU ARE A PLAINTIFF IN
7 THE NEW YORK LITIGATION?
8 A. IT DOES NOT.
9 Q. SO THE CASUAL READER, OR ANY READER, WOULD HAVE NO IDEA
10 THAT YOU WERE A PLAINTIFF IN THAT LAWSUIT?
11 A. THEY MAY NOT.
12 Q. DOCTOR, I WANT TO TURN YOUR ATTENTION NOW TO SOME OF THE
13 BENEFITS THAT YOU PERCEIVE THE INTACT D&X PROCEDURE TO HAVE.
14 AND I BELIEVE YOU TESTIFIED THAT THOSE INCLUDE FEWER PASSES OF
15 THE FORCEPS INTO THE UTERUS, FEWER BONEY FRAGMENTS THAT MAY BE
16 LEFT IN THE UTERUS, THE POSSIBILITY OF A SHORTER PROCEDURE
17 TIME, AND LESS BLOOD LOSS.
18 IS THAT A FAIR ASSESSMENT?
19 A. IT INCLUDES THOSE.
20 Q. NOW, LET'S TURN YOUR ATTENTION BACK TO PLAINTIFFS' EXHIBIT
21 19. DO YOU HAVE A COPY OF THAT WITH YOU NOW?
22 A. I DON'T.
23 MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE
24 WITNESS?
25 THE COURT: YES.

1 BY MR. QUINLIVAN:
2 Q. DOCTOR, I BELIEVE IN YOUR ARTICLE YOU ACTUALLY EXPRESSED
3 THE FACT THAT YOU BELIEVE THE INTACT D&X PROCEDURE OFFERED
4 SAFETY ADVANTAGES. AND THE EXAMPLE YOU USED WAS THE LESS OR
5 FEWER PASSES INTO THE UTERUS; IS THAT RIGHT?
6 A. YOU SAY IN MY TESTIMONY OR THE ARTICLE?
7 Q. IN THE ARTICLE ITSELF.
8 A. I BELIEVE I DID EXPRESS THAT.
9 Q. BUT IN TERMS OF YOUR CONCLUSION, IT IS FAIR TO SAY THAT --
10 AND I THINK YOU TESTIFIED -- THAT THERE WERE NO STATISTICALLY
11 SIGNIFICANT DIFFERENCES IN COMPLICATIONS BETWEEN THE TWO
12 PROCEDURES; IS THAT RIGHT?
13 A. THAT IS CORRECT.
14 Q. OUT OF THE 383 PATIENTS, OVERALL, ONLY 19 HAD
15 COMPLICATIONS, AND THE COMPLICATION RATES BETWEEN THE TWO WERE
16 NOT STATISTICALLY SIGNIFICANT; IS THAT RIGHT?
17 A. THERE WAS NO STATISTICALLY SIGNIFICANT DIFFERENCE.
18 Q. AND IN TERMS OF THE OPERATIVE TIME BETWEEN THE TWO, THE
19 MEDIAN OPERATIVE TIME WAS IDENTICAL BETWEEN THE TWO GROUPS; IS
20 THAT RIGHT?
21 A. THAT IS CORRECT.
22 Q. AND THE MEDIAN ESTIMATED BLOOD LOSS BETWEEN THE TWO GROUPS
23 ALSO WAS IDENTICAL; IS THAT RIGHT?
24 A. THAT IS CORRECT.
25 Q. THOSE FIGURES APPEAR IN TABLE 3 OF YOUR STUDY?

1 A. YES.
2 Q. AND THE WAY YOU CALCULATED THAT WAS USING SOMETHING CALLED
3 A MANN-WHITNEY TEST?
4 A. THE MANN-WHITNEY U TEST.
5 Q. MANN-WHITNEY U TEST. AND A MANN-WHITNEY U TEST IS A TEST
6 TO COMPARE TWO GROUPS WITH CONTINUOUS VARIABLES THAT ARE NOT
7 NORMALLY DISTRIBUTED; IS THAT A FAIR STATEMENT?
8 A. YES, IT IS. I AM IMPRESSED.
9 Q. THANKS. AND OPERATIVE TIME AND BLOOD LOSS ARE CONTINUOUS
10 VARIABLES?
11 A. THEY ARE.
12 Q. AND ONE OF THE VARIABLES THAT THE MANN-WHITNEY U TEST ALSO
13 CONTROLS FOR IS THE RANGE IN PROCEDURE TIMES; IS THAT RIGHT?
14 A. NO, IT DOES NOT.
15 Q. IT DOES NOT.
16 DOCTOR, IS IT CORRECT THAT ONE OF THE PEER REVIEWERS
17 ASKED THAT THE THREE COMPLICATIONS, OR SHOULD I SAY, THE THREE
18 SERIOUS COMPLICATIONS COULD HAVE BEEN AVOIDED IF THE INTACT D&X
19 PROCEDURE HAD BEEN USED?
20 A. YES.
21 Q. AND YOU RESPONDED TO THAT REVIEWER'S QUESTION BY SAYING
22 "NO," CORRECT?
23 A. SPECIFICALLY, IN A LETTER, AS WELL AS IN THE PAPER WE
24 ACKNOWLEDGE THAT.
25 Q. DIRECTING YOUR ATTENTION TO PAGE 4, WHICH IS THE LAST PAGE

1 OF YOUR STUDY.
2 A. YES.
3 Q. IN THE RIGHT-HAND COLUMN, THE SECOND TO LAST PARAGRAPH.
4 THE LAST SENTENCE OF THE SECOND TO LAST PARAGRAPH YOU STATED:
5 "BECAUSE OUR APPROACH IS TO PERFORM INTACT D&X
6 WHEN POSSIBLE ON THE BASIS OF CERVICAL DILATION AND
7 FETAL POSITION, IT IS UNLIKELY THAT INTACT D&X COULD
8 HAVE BEEN PERFORMED IN THESE PATIENTS UNDERGOING
9 DILATION AND EVACUATION WHO EXPERIENCED SEVERE
10 COMPLICATIONS."
11 THOSE WERE YOUR RECORDS, RIGHT, DOCTOR?
12 A. YES.
13 Q. AND I THINK -- IS IT A FAIR STATEMENT TO SAY THAT YOU
14 PERFORM AN INTACT D&X WHENEVER YOU'RE ABLE TO, SO THE FACT THAT
15 A D&E PROCEDURE WAS PERFORMED IN THOSE PATIENTS SUGGESTS THAT
16 YOU COULDN'T PERFORM AN INTACT D&X IN THOSE THREE CASES?
17 A. AS I WILL READILY ACKNOWLEDGE.
18 Q. NOW, DOCTOR, YOU ALSO TESTIFIED ON DIRECT EXAMINATION THAT
19 YOU BELIEVE YOUR STUDY SUPPORTS THE COMPARATIVE SAFETY OF THE
20 INTACT D&X PROCEDURE BECAUSE OF THE HIGHER GESTATIONAL AGE IN
21 THE INTACT D&X GROUP AS COMPARED TO THE D&E GROUP?
22 A. YES.
23 Q. BUT YOU DON'T MAKE ANY SUCH CLAIM IN YOUR ARTICLE, DO YOU?
24 A. IN THE DISCUSSION WE MAKE REFERENCE TO THAT.
25 Q. BUT YOU DON'T CLAIM IN THAT DISCUSSION THAT THE INTACT D&X

1 PROCEDURE IS SAFER BECAUSE OF THE HIGHER COMPARATIVE
2 GESTATIONAL AGE. THAT IS NOT ONE OF THE CONCLUSIONS OF YOUR
3 PAPER, IS IT?
4 A. NO. OUR CONCLUSIONS WERE CONSERVATIVE.
5 Q. IN FACT, BECAUSE THIS IS A RETROSPECTIVE STUDY, THE DATA
6 WILL NOT SUPPORT A STATEMENT THAT ONE TECHNIQUE IS SAFER OR
7 SUPERIOR TO THE OTHER, CORRECT?
8 A. THAT'S CORRECT.
9 Q. AND YOU SAID AS MUCH IN YOUR ARTICLE; ISN'T THAT RIGHT,
10 DOCTOR?
11 A. YES.
12 Q. AND TURNING BACK, AGAIN, YOUR ATTENTION TO PAGE 4 IN THE
13 LEFT-HAND COLUMN, IN THE MIDDLE OF THE PAGE, THE LAST SENTENCE
14 OF THE PARAGRAPH BEGINNING "OUR APPROACH," IT STATES:
15 "THOUGH WE BELIEVE OUR LOW COMPLICATION RATE
16 VALIDATES OUR APPROACH, WE KNOWLEDGE THAT THE
17 RETROSPECTIVE NATURE OF THIS STUDY PRECLUDES US FROM
18 CONCLUDING WITH CERTAINTY THAT INTACT D&X PREVENTED
19 ADVERSE OUTCOMES."
20 THOSE WERE YOUR WORDS, RIGHT, DOCTOR?
21 A. THOSE ARE THE WORDS.
22 Q. NOW, DOCTOR, AM I CORRECT THAT YOU COULD HAVE STRATIFIED
23 THE GESTATIONAL AGES? YOU COULD HAVE COMPARED INTACT D&X
24 PROCEDURES AS COMPARED TO D&E PROCEDURES AT DIFFERENT
25 GESTATIONAL AGES? SAY AT 21 WEEKS, 22 WEEKS AND 23 WEEKS?

1 A. YES. THAT COULD BE DONE.
2 Q. AND THE REASON YOU DIDN'T DO THAT IS BECAUSE THE
3 COMPLICATION RATES WERE SO LOW IN BOTH GROUPS YOU WOULD HAVE
4 NEEDED A STUDY OF THOUSANDS TO DETERMINE IF THERE WAS ANY
5 SIGNIFICANT DIFFERENCE; IS THAT FAIR?
6 A. THANKFULLY SO, YES.
7 Q. DOCTOR, AM I CORRECT THAT WE LOOK AT THOSE INDIVIDUAL WEEKS
8 THE ONLY PROCEDURE THAT WAS PERFORMED AT 27 WEEKS GESTATIONAL
9 AGE WAS A D&E WITH DISMEMBERMENT OR DISARTICULATION?
10 A. THAT'S CORRECT.
11 Q. AND AT 26 WEEKS, THE ONLY PROCEDURE THAT WAS PERFORMED WAS
12 A D&E WITH DISARTICULATION OR DISMEMBERMENT?
13 A. CORRECT.
14 Q. AND 25 WEEKS THERE ARE TWO D&E'S AND TWO INTACT D&X'S,
15 CORRECT?
16 A. CORRECT.
17 Q. AND 24 WEEKS, YOU HAVE 22 D&E'S AND 17 INTACT D&X'S, RIGHT?
18 A. CORRECT.
19 Q. AND IT ISN'T UNTIL YOU GET TO 23 WEEKS THAT YOU HAVE MORE
20 INTACT D&X'S THAN D&E'S; 40 COMPARED TO 34, RIGHT?
21 A. THAT'S CORRECT.
22 Q. GOING BACK TO -- I THINK WE TALKED A LITTLE BIT ABOUT THE
23 NUMBERS. CAN YOU TELL US WHAT THE -- WHEN YOU ARE DOING A
24 STUDY OF THIS NATURE, WHAT DOES THE WORD "POWER" MEAN?
25 A. "POWER" IN THIS CONTEXT MEANS THE -- TO SAY IT'S THE

1 ABILITY TO DISCERN SOME STATED DIFFERENCE IN SOME STATED
2 OUTCOME.
3 Q. AND YOU ACKNOWLEDGE, DOCTOR, THAT BECAUSE THE COMPLICATIONS
4 BETWEEN THE INTACT D&X AND THE D&E GROUPS WERE VIRTUALLY
5 IDENTICAL, YOUR STUDY DIDN'T HAVE SUFFICIENT POWER TO DETECT
6 DIFFERENCES OF THAT MAGNITUDE?
7 A. YES, AGAIN, FOR WHICH WE ARE THANKFUL.
8 Q. YOU STATED AS MUCH IN YOUR DECEMBER 19TH LETTER TO THE
9 EDITORS OF THE JOURNAL; ISN'T THAT RIGHT?
10 A. THAT'S CORRECT.
11 Q. AND YOU ALSO ACKNOWLEDGED THAT OF THE 383 PATIENTS WHOSE
12 MEDICAL RECORDS YOU REVIEWED IN TERMS OF DETERMINING THE
13 SUBSEQUENT PREGNANCY OUTCOMES, MOST PATIENTS REFERRED OR
14 RETURNED TO THEIR REFERRING OBSTETRICIANS FOR FUTURE OBSTETRIC
15 CARE, AND THEREFORE YOU WEREN'T ABLE TO ASSESS THE SUBSEQUENT
16 PREGNANCY OUTCOMES FOR THOSE PATIENTS, RIGHT?
17 A. NOT WITH RELIABLE DATA.
18 Q. IN FACT, OF THE 383 PATIENTS, YOU WERE ONLY ABLE TO ASSESS
19 SUBSEQUENT OUTCOMES FOR 62 PATIENTS?
20 A. BASED ON OUR STUDY DESIGN, YES.
21 Q. AND BECAUSE OF THE DIFFICULTY OR INABILITY TO FOLLOW UP ON
22 MORE PATIENTS, IN TERMS OF THEIR SUBSEQUENT PREGNANCY OUTCOMES,
23 ONE OF THE PEER REVIEWERS INDICATED THAT YOUR CONCLUSIONS ON
24 THAT ISSUE WERE ESSENTIALLY MEANINGLESS, RIGHT?
25 A. THAT IS THE OPINION OF ONE OF THE PEER REVIEWERS.

1 Q. AND AM I CORRECT THAT ONE OF THE PEER REVIEWERS WROTE IN
2 THE COMMENTS THAT WERE IN THE E-MAIL OF DECEMBER 12TH THAT WAS
3 SENT TO YOU, THAT, QUOTE:
4 "SINCE THE MAJORITY OF THESE WOMEN" --
5 MS. PARKER: I WILL OBJECT TO THIS AS HEARSAY, YOUR
6 HONOR.
7 MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH?
8 THE COURT: I AM SORRY. I WAS WRITING SOMETHING.
9 LET ME READ.
10 I WILL PERMIT THE QUESTION.
11 MR. QUINLIVAN: MAY I APPROACH THE WITNESS?
12 THE COURT: YES.
13 MS. PARKER: CAN WE HAVE A COPY?
14 MR. QUINLIVAN: IT IS PLAINTIFFS' EXHIBIT 20.
15 MS. PARKER: I BELIEVE WE TOOK IT OUT OF OUR FILES.
16 MR. QUINLIVAN: I AM SORRY. I AM SHOWING THE
17 WITNESS WHAT HAS BEEN MARKED AS PLAINTIFFS' EXHIBIT 20.
18 BY MR. QUINLIVAN:
19 Q. DOCTOR, IF YOU COULD TURN YOUR ATTENTION TO PAGE 2, AND THE
20 REVIEWER NUMBER TWO, THE SECOND PARAGRAPH OF THAT REVIEWER'S
21 COMMENTS READS:
22 "THE AUTHORS" -- QUOTE -- "THE AUTHORS ALSO
23 COMMENT ABOUT THE PREGNANCY OUTCOMES OF SOME
24 PATIENTS WHO ARE INCLUDED IN THIS STUDY. SINCE THE
25 MAJORITY OF THESE PATIENTS WERE NOT FOLLOWED UP AT

1 THIS INSTITUTION, THIS INFORMATION IS SO LIMITED AS
2 TO BE SUPERFLUOUS TO THIS PAPER."
3 DO YOU REMEMBER RECEIVING THAT E-MAIL?
4 A. I DO.
5 Q. AND IN RESPONSE TO THAT PEER REVIEWER'S COMMENT, AND SOME
6 OTHERS, YOU ADDED A SENTENCE TO YOUR ARTICLE ACKNOWLEDGING YOUR
7 LACK OF POWER TO ASSESS SUBSEQUENT PREGNANCY OUTCOMES, CORRECT?
8 A. WE ACKNOWLEDGED THAT IN THE PAPER. THAT WAS ADDED, YES.
9 Q. TURNING BACK TO PAGE 4 OF YOUR ARTICLE, LEFT-HAND COLUMN,
10 LAST FULL PARAGRAPH, LAST SENTENCE, YOU WROTE, QUOTE.
11 "THOUGH WE ARE REASSURED BY THE LOW NUMBER OF
12 COMPLICATIONS IN SUBSEQUENT PREGNANCIES IN BOTH
13 GROUPS, WE ACKNOWLEDGE OUR LACK OF POWER TO CONCLUDE
14 THAT SUBSEQUENT PREGNANCY OUTCOMES ARE NOT
15 DIFFERENT."
16 THAT WAS THE SENTENCE YOU ADDED IN RESPONSE TO THAT
17 PEER REVIEW COMMENT, AND OTHERS, RIGHT, DOCTOR?
18 A. YES.
19 Q. NOW, DOCTOR, IT IS TRUE, ISN'T IT, THAT THE RATE OF
20 PRE-TERM BIRTHS FOR WOMEN WHO UNDERWENT AN INTACT D&X PROCEDURE
21 WAS MERELY THREE TIMES THAT AS FOR WOMEN WHO UNDERWENT THE D&E
22 PROCEDURE?
23 A. IT WAS A NONSTATISTICALLY SIGNIFICANT DIFFERENCE, BUT IT
24 WAS BETWEEN TWO AND THREEFOLD.
25 Q. 11.8 PERCENT AS COMPARED TO 4.4 PERCENT? 11.8 PERCENT FOR

1 THE INTACT D&X GROUP AS COMPARED TO 4.4 PERCENT FOR THE D&E
2 GROUP?
3 A. THAT'S CORRECT.
4 Q. AND I UNDERSTAND YOU DON'T BELIEVE THAT THAT IS A
5 STATISTICALLY SIGNIFICANT DIFFERENCE, RIGHT, DOCTOR?
6 A. STATISTICAL SIGNIFICANCE ISN'T MY UNDERSTANDING. IT IS,
7 AND THE P VALUE OF .3, IT DOES NOT APPROACH THE LEVEL OF
8 STATISTICAL SIGNIFICANCE.
9 Q. ARE YOU AT LEAST CONCERNED ABOUT THE DIFFERENCE THIS THOSE
10 RATES, DOCTOR?
11 A. I AM NOT FOR REASONS THAT I HAVE EXPLAINED IN TESTIMONY.
12 Q. AND I UNDERSTAND YOUR TESTIMONY ON THAT POINT. BUT IT IS
13 POSSIBLE, IS IT NOT, DOCTOR, THAT THE TWO WOMEN WHO HAD
14 SUBSEQUENT PREGNANCY OR PRE-TERM BIRTHS THAT THAT RESULT FROM
15 THE INTACT D&X PROCEDURE ITSELF AND NOT FROM THE OTHER FACTORS
16 THAT YOU MENTIONED?
17 A. IT COULD ALSO BE POSSIBLE THAT THEY HAD MARKEDLY IMPROVED
18 PREGNANCY OUTCOMES AS A RESULT OF UNDERGOING A D&X PROCEDURE.
19 Q. SO I TAKE IT THE ANSWER TO MY QUESTION IS: YES, IT IS
20 POSSIBLE THAT THE CAUSE OF THE SUBSEQUENT PRE-TERM BIRTHS WAS
21 THE INTACT D&X PROCEDURE?
22 A. THAT IS ONE POSSIBILITY.
23 Q. SO THE ANSWER TO MY QUESTION IS: YES?
24 A. YES.
25 Q. DOCTOR, SINCE WE ARE ON THE SUBJECT OF COMPLICATION RATES

1 OF SUBSEQUENT PREGNANCIES, AM I CORRECT THAT IN THE FIRST DRAFT
2 OF YOUR ARTICLE YOUR CONCLUSION WAS, QUOTE:
3 "DILATION AND EVACUATION WITH INTACT EXTRACTION
4 IS AS SAFE AS DILATION AND EXTRACTION WITH
5 DISARTICULATION AFTER 20 WEEKS GESTATION"?
6 A. I BELIEVE THAT WAS IN THE FIRST DRAFT, YES.
7 Q. AND THAT CONCLUSION WAS CRITICIZED BY ONE OF THE PEER
8 REVIEWERS, RIGHT?
9 A. YES.
10 Q. AND YOU ULTIMATELY CHANGED THAT SENTENCE IN THE ARTICLE;
11 ISN'T THAT RIGHT?
12 A. YES.
13 Q. AND TURNING AGAIN TO PAGE 4 OF YOUR ARTICLE, YOU STATED,
14 QUOTE:
15 "OUTCOMES APPEAR SIMILAR BETWEEN PATIENTS
16 UNDERGOING DILATION AND EVACUATION AND DILATION AND
17 EXTRACTION AFTER 20 WEEKS GESTATION," RIGHT?
18 A. IN THAT SENTENCE OUTCOMES REPRESENTS COMPLICATIONS AND
19 SUBSEQUENT PREGNANCY OUTCOMES.
20 Q. RIGHT.
21 A. RATHER THAN JUST COMPLICATIONS. BUT THAT IS WHAT IT SAYS.
22 THE COURT: WHERE ARE YOU LOOKING?
23 MR. QUINLIVAN: I AM SORRY, YOUR HONOR. NOW, I HAVE
24 LOST IT.
25 THE COURT: PAGE 4.

1 THE WITNESS: THE LINES ARE NUMBERED LIKE IN A
2 DEPOSITION.
3 THE COURT: DO YOU HAVE THE ARTICLE IN FRONT OF YOU?
4 THE WITNESS: I DO.
5 THE COURT: WHAT LINE NUMBER?
6 THE WITNESS: I DON'T KNOW. I CAN'T FIND IT, BUT I
7 KNOW IT SAYS THAT.
8 MR. QUINLIVAN: YOUR HONOR, IT WILL TAKE ME A
9 MINUTE, BUT IT IS SMALL TYPE. I SAW IT A SECOND AGO.
10 THE WITNESS: I THINK IT IS IN THE LAST PARAGRAPH
11 AROUND LINE 285. THAT MAY NOT BE WHAT YOU ARE REFERRING TO.
12 MR. QUINLIVAN: I AM SORRY, YOUR HONOR. IT IS MY
13 MISTAKE. IT IS ON PAGE 1 IN THE CONCLUSION SECTION.
14 THE WITNESS: IT IS IN THE ABSTRACT.
15 MR. QUINLIVAN: I AM SORRY, THE ABSTRACT.
16 THE WITNESS: OKAY.
17 THE COURT: OKAY.
18 BY MR. QUINLIVAN:
19 Q. SO JUST TO CLARIFY, IN THE ABSTRACT SECTION UNDER
20 "CONCLUSION" IT STATES:
21 "OUTCOMES APPEAR SIMILAR BETWEEN PATIENTS
22 UNDERGOING DILATION AND EVACUATION AND INTACT
23 DILATION AND EXTRACTION AFTER 20 WEEKS GESTATION"?
24 A. SO YOU WERE REFERRING TO CHANGES IN THE ABSTRACT BETWEEN
25 THE VERSIONS OF THE MANUSCRIPT. YOU WERE REFERRING TO CHANGES

1 IN THE ABSTRACT BETWEEN VERSIONS OF THE MANUSCRIPT.
2 Q. ACTUALLY, I BELIEVE I -- THAT WAS MY ERROR, DOCTOR. I
3 BELIEVE THAT WHAT YOU WERE REFERRING TO IS ON PAGE 4, LINES 285
4 TO 287:
5 "THE OBSERVED COMPLICATION RATES IN SUBSEQUENT
6 OBSTETRIC OUTCOMES APPEAR COMPARABLE BETWEEN THE TWO
7 TECHNIQUES."
8 IT WAS THAT SENTENCE THAT WAS CHANGED FROM THE
9 EARLIER DRAFT; IS THAT RIGHT, DOCTOR?
10 A. YES, I BELIEVE SO.
11 THE COURT: MR. QUINLIVAN, CAN I INTERRUPT YOU FOR A
12 SECOND? WE ARE NOW AT THE TIME THAT WE WOULD NORMALLY BE
13 TAKING OUR SECOND BREAK OF THE MORNING, HOWEVER, SINCE WE ARE
14 GOING TO HAVE A FULL DAY, WE WILL NEED TO TAKE A FULL LUNCH
15 BREAK. AND I AM TRYING TO FIGURE OUT WHAT THE BEST TIME FOR
16 THAT WOULD BE.
17 DO YOU HAVE ANY ESTIMATE AS TO HOW MUCH LONGER YOU
18 THINK YOU WILL NEED?
19 MR. QUINLIVAN: IT WILL BE LESS THAN 15 MINUTES,
20 YOUR HONOR. IT WOULD PROBABLY BE SOMEWHERE IN THE RANGE OF
21 FIVE TO 10.
22 THE COURT: TO FINISH YOURS?
23 MR. QUINLIVAN: YES.
24 THE COURT: THEN, I THINK PERHAPS -- DIANE, ARE YOU?
25 OKAY?

1 THE REPORTER: YES.
2 THE COURT: I THINK WE SHOULD, PERHAPS, IF WE CAN,
3 FINISH WITH DR. CHASEN BEFORE WE TAKE A LUNCH BREAK. LET'S
4 CONTINUE.
5 MR. QUINLIVAN: VERY WELL, YOUR HONOR. THANK YOU.
6 BY MR. QUINLIVAN:
7 Q. DOCTOR, LET'S JUST MOVE ON TO ANOTHER SUBJECT. THAT IS
8 SOME OF THE MATERNAL FETAL ISSUES THAT YOU TALKED ABOUT ON YOUR
9 DIRECT EXAMINATION TODAY.
10 YOU TESTIFIED THAT YOU HANDLED CASES INVOLVING BOTH
11 FETAL ABNORMALITIES AND MATERNAL CONDITIONS FOR WHICH YOU THINK
12 THE INTACT D&X PROCEDURE MIGHT OFFER SOME SAFETY ADVANTAGES; IS
13 THAT RIGHT?
14 A. YES.
15 Q. AND IN CASES IN WHICH A WOMAN IS SEEKING TO TERMINATE HER
16 PREGNANCY BECAUSE OF EITHER A MATERNAL HEALTH CONDITION OR A
17 FETAL ANOMALY, YOU PERFORM BOTH THE D&E AND THE INTACT D&X
18 PROCEDURE, RIGHT?
19 A. YES.
20 Q. AND YOU CONSIDER D&E'S WITH DISARTICULATION TO BE VERY
21 SAFE; IS THAT RIGHT, DOCTOR?
22 A. I CONSIDER IT A SAFE PROCEDURE.
23 Q. YOU CONSIDER INDUCTIONS TO BE A SAFE PROCEDURE?
24 A. IN MOST WOMEN.
25 Q. DOCTOR, WOULD YOU AGREE THAT IN YOUR STUDIES SHOWS THAT THE

1 INTACT D&X PROCEDURE IS RARELY USED IN CASES OF MATERNAL
2 MEDICAL CONDITION?
3 A. PREOPERATIVE INDICATION THAT MATERNAL MEDICAL CONDITIONS
4 ARE A SMALL MINORITY OF THE CASES THAT WE DO.
5 Q. YOU WOULD ALSO AGREE, DOCTOR, THAT IF A WOMAN WAS
6 EXPERIENCING A SEVERE MEDICAL CONDITION OR HAD A FETAL ANOMALY
7 THAT WOULD IMPACT YOUR CHOICE OF EITHER PERFORMING AN INTACT
8 D&X OR D&E PROCEDURE; IS THAT RIGHT?
9 A. THAT'S RIGHT. IT WOULD BE BASED ON MY INTRAOPERATIVE
10 JUDGMENT ABOUT WHAT WOULD BE SAFEST.
11 Q. AND, IN FACT, YOU DON'T TAKE STEPS IN ANY CASES INVOLVING
12 MATERNAL HEALTH CONDITIONS OR FETAL ANOMALIES TO ENSURE THAT
13 YOU WERE GOING TO END UP WITH AN INTACT D&X PROCEDURE, DO YOU?
14 A. NO, BECAUSE I CAN'T ENSURE THAT.
15 Q. NOW, YOU ALSO TESTIFIED THAT IN SOME CASES OF FETAL
16 ANOMALIES YOU THINK THE INTACT D&X PROCEDURE OFFERS SOME
17 ADVANTAGES IN TERMS OF PATHOLOGY?
18 A. YES.
19 Q. BUT A LABOR INDUCTION, YOU ACKNOWLEDGE, WOULD ALSO OFFER AN
20 INTACT SPECIMEN FOR PURPOSES OF PATHOLOGICAL ASSESSMENT,
21 CORRECT?
22 A. IN MOST CASES IT WOULD.
23 Q. AM I CORRECT, DOCTOR, THAT THERE ARE SOME FETAL ANOMALIES
24 WHERE IT IS IMPORTANT TO EXAMINE THE CONTENT OF THE BRAIN
25 MATTER?

1 A. YES.
2 Q. QUITE A FEW; ISN'T THAT RIGHT?
3 A. THERE ARE SOME.
4 Q. AND IF YOU WERE TO DO AN INTACT D&X PROCEDURE ON A FETUS
5 AND OPEN THE HEAD WITH SCISSORS AND SUCK OUT THE FETUS' BRAINS
6 YOU WOULDN'T BE ABLE TO DO THAT ASSESSMENT, WOULD YOU?
7 A. NO, I WOULD NOT.
8 Q. BY CONTRAST, IF THE FETUS WAS ABORTED BY MEANS OF A LABOR
9 INDUCTION, YOU MIGHT BE ABLE TO EXAMINE THE CONTENTS OF THE
10 BRAIN MATERIALS; ISN'T THAT RIGHT?
11 A. IN SOME CASES.
12 Q. DOCTOR, DO I READ YOUR STUDY CORRECTLY AS SUPPORTING THE
13 CONCLUSION THAT CHROMOSOMAL ABNORMALITIES ARE MORE LIKELY TO BE
14 DIAGNOSED EARLY IN THE PREGNANCY, AND THAT ABORTION FOR SUCH
15 ABNORMALITIES WILL OCCUR AT GESTATIONAL AGES BEFORE WHEN A D&E
16 CAN BE PERFORMED?
17 A. MOST CHROMOSOMAL ABNORMALITIES ARE DIAGNOSED IN THE
18 SECOND-TRIMESTER AND SURGICAL ABORTION WOULD BE WITH D&E.
19 Q. DOCTOR, YOU ALSO MENTIONED THE CASE OF A HYDROCEPHALIC
20 FETUS. AND YOU HAD SOME DISCUSSIONS ABOUT THE CEPHALOCENTESIS
21 PROCESS. YOU WOULD BE ABLE TO DRAIN THE FLUID BY -- THAT
22 ACCUMULATES IN A HYDROCEPHALY IN A CEPHALOCENTESIS PROCESS;
23 ISN'T THAT RIGHT?
24 A. I WOULD. IN SO DOING, I WOULD PROBABLY INDUCE FETAL DEATH.
25 Q. AND THERE ARE SOME SITUATIONS IF THE FLUID REACCUMULATES

1 YOU COULD DO THE CEPHALOCENTESIS PROCESS AGAIN; ISN'T THAT
2 RIGHT?
3 A. IT COULD, AND I HAVE.
4 Q. DOCTOR, AM I CORRECT THAT IN YOUR OPINION AN INTACT D&X
5 PROCEDURE IS NEVER THE ONLY AVAILABLE PROCEDURE TO TERMINATE A
6 SECOND-TRIMESTER PREGNANCY?
7 A. THAT IS CORRECT.
8 MR. QUINLIVAN: MOVING ON TO MY LAST SUBJECT, YOUR
9 HONOR.
10 BY MR. QUINLIVAN:
11 Q. LET'S TALK ABOUT INJECTIONS FOR A LITTLE BIT. YOU
12 TESTIFIED YOU DON'T NORMALLY USE AN INJECTION OF POTASSIUM
13 CHLORIDE OR DIGOXIN, RIGHT?
14 A. IN MOST CASES I DO NOT.
15 Q. BUT YOU DO OFFER INJECTIONS OF POTASSIUM CHLORIDE IF THE
16 WOMAN REQUESTS IT, CORRECT?
17 A. THAT'S CORRECT.
18 Q. YOUR INSTITUTION HAS A POLICY OF OFFERING INJECTIONS OF
19 POTASSIUM CHLORIDE AFTER 24 WEEKS; ISN'T THAT RIGHT?
20 A. WE DON'T DO ABORTIONS ON FETUSES AFTER 24 WEEKS.
21 Q. WELL, DOCTOR, I BELIEVE THAT ONE OF THE CASES IN YOUR STUDY
22 WAS A FETUS AT 26 WEEKS AND 27 WEEKS GESTATIONAL AGE?
23 A. SPONTANEOUS FETAL DEMISE.
24 Q. AFTER 23 WEEKS GESTATIONAL AGE YOU OFFER THE WOMAN THE
25 OPTION OF HAVING AN INJECTION BY POTASSIUM CHLORIDE; IS THAT

1 CORRECT?
2 A. YES.
3 Q. AND YOU HAVE, IN FACT, GIVEN INJECTIONS OF POTASSIUM
4 CHLORIDE TO WOMEN WHO WANT IT?
5 A. AT 23 WEEKS I INITIATE THE DISCUSSION, AND I SUGGEST
6 REASONS WHY IT COULD BE THE RIGHT THING DO.
7 Q. AND TAKING THOSE SITUATIONS AND SITUATIONS EARLIER THAN 23
8 WEEKS WHERE THE WOMAN HAS REQUESTED IT, YOU HAVE DONE DOZENS OF
9 INJECTIONS OF POTASSIUM CHLORIDE, RIGHT?
10 A. I HAVE.
11 Q. AND IF YOU ENSURED FETAL DEMISE WITH AN INJECTION OF
12 POTASSIUM CHLORIDE, YOU DON'T BELIEVE THAT YOU WOULD BE IN
13 VIOLATION OF THE ACT, ISN'T THAT RIGHT?
14 A. IF I WERE ABLE TO INDUCE FETAL DEMISE, THEN IT WOULD NOT BE
15 IN VIOLATION OF THE ACT.
16 Q. DOCTOR, WHEN YOU DO AN INJECTION OF POTASSIUM CHLORIDE INTO
17 THE FETAL HEART YOU DO THAT UNDER ULTRASOUND GUIDANCE; IS THAT
18 RIGHT?
19 A. I DO.
20 Q. IN THE CASE IN WHICH YOU WERE ABLE TO GIVE THE INJECTION OF
21 POTASSIUM CHLORIDE YOU HAVE BEEN ABLE TO SEE THE FETUS UNDER
22 ULTRASOUND GUIDANCE, CORRECT?
23 A. YES.
24 Q. AND AM I CORRECT, DOCTOR, THAT IN EVERY SINGLE CASE IN
25 WHICH YOU HAVE GIVEN AN INJECTION OF POTASSIUM CHLORIDE,

1 INCLUDING IN CASES OR SITUATIONS WERE ALL SITUATIONS BEFORE 24
2 WEEKS YOU HAVE SEEN THE FETUS RECOIL AND WITHDRAW ON THE
3 ULTRASOUND WHEN THE NEEDLE CONTACTS THE FETAL CHEST?
4 A. THAT IS TYPICALLY WHAT I SEE.
5 Q. YOU'VE SEEN THAT IN EVERY SINGLE CASE?
6 A. I AM NOT SURE I HAVE NOTED IT OR MADE A MENTAL NOTE OF IT
7 IN EVERY CASE, BUT I TYPICALLY SEE THAT.
8 MR. QUINLIVAN: YOUR HONOR, LET ME JUST TAKE A
9 MOMENT.
10 THIS IS TRANSCRIPT FROM THE TRIAL IN THE NEW YORK
11 CASE, PAGES 1570 TO 1571.
12 BY MR. QUINLIVAN:
13 Q. DOCTOR, DIRECTING YOUR ATTENTION TO PAGE 1570 TO 1571,
14 STARTING AT LINE 17, AND CONTINUING TO PAGE 1571, LINE 10. IN
15 PARTICULAR, LINES SEVEN THROUGH TEN ON 1571.
16 A. YES.
17 Q. DOES THAT REFRESH YOUR RECOLLECTION IN EVERY ONE OF THE
18 CASES YOU SEE THE FETUS RECOIL OR WITHDRAW WHEN THE NEEDLE
19 IMPACTS THE FETAL CHEST?
20 A. YES.
21 MR. QUINLIVAN: NOTHING FURTHER, YOUR HONOR.
22 THE COURT: ALL RIGHT.
23 THANK YOU.
24 CAN YOU MAKE IT QUICK?
25 MS. PARKER: YES, YOUR HONOR, VERY.

1 REDIRECT EXAMINATION
2 BY MS. PARKER:
3 Q. DR. CHASEN, MR. QUINLIVAN ASKED YOU ABOUT THE STUDY THAT IS
4 GOING TO BE PUBLISHED THIS SPRING. DID YOUR PARTICIPATION IN
5 THE NEW YORK LITIGATION INTRODUCE BIAS INTO THAT STUDY IN ANY
6 WAY?
7 A. NO.
8 Q. AND WHY IS THAT?
9 A. MY PURPOSE IN PARTICIPATING AS A PLAINTIFF WAS TO ENSURE
10 THAT I COULD TAKE CARE OF MY PATIENTS CONSISTENT WITH MY
11 MEDICAL JUDGMENT IN THE BEST WAY I CAN TO TAKE -- PROVIDE THE
12 BEST CARE I COULD.
13 MY OBJECTIVE IN DOING THE STUDY, AS IN ANY STUDY, IS
14 TO ANSWER A QUESTION OR ATTEMPT TO CONTRIBUTE -- OR NOTHING
15 RESOLVES CERTAIN CONTROVERSIES -- BUT TO CONTRIBUTE TO THE
16 LITERATURE IN A WAY THAT COULD GIVE RELEVANT OR MEANINGFUL
17 INFORMATION REGARDING ANYTHING THAT ISN'T RESOLVED, AND FEW
18 THINGS IN MEDICINE ARE RESOLVED.
19 IT GIVES ME NO PLEASURE IN DOING D&E, WHATEVER
20 TECHNIQUE I DO. AND THERE IS -- YOU KNOW, THE ONLY REASON WHY
21 I WANT TO BE ABLE TO USE MY JUDGMENT AND PERFORM A D&E WITH
22 INTACT EXTRACTION WHEN I CAN IS BECAUSE BASED ON MY EXPERIENCE
23 AND EXPERTISE, THAT IS THE BEST WAY I CAN TAKE CARE OF MY
24 PATIENTS.
25 I DID THE STUDY BECAUSE THERE IS NO PUBLISHED DATA.

1 NOW, BASED ON MY OPINION AND EXPERIENCE PRIOR TO DOING THE
2 STUDY, I DIDN'T PERCEIVE THE RISKS THAT HAVE BEEN ASSERTED IN
3 THE ABSENCE OF ANY DATA REGARDING THIS PROCEDURE.
4 BUT, IF THOSE RISKS DID EXIST, OR THERE WERE
5 CIRCUMSTANCES WHERE THIS VARIATION OF D&E WERE TO APPEAR RISKY
6 TO SOME WOMEN, OR TO BE DISADVANTAGEOUS RELATIVE TO D&E WITH
7 DISARTICULATION, THAT WOULD BE VERY MEANINGFUL INFORMATION TO
8 ME, AND PERHAPS TO MY COLLEAGUES IN THE PROFESSION, WHO DO
9 THESE PROCEDURES IN TERMS OF HOW WE CAN BEST TAKE CARE OF OUR
10 PATIENTS.
11 MY CAPACITY AS A RESEARCHER AND AN AUTHOR, MY
12 CAPACITY AS A PHYSICIAN WHO TAKES CARE OF PATIENTS, AND MY
13 CAPACITY AS A PLAINTIFF IN ANY JUDICIAL PROCEEDINGS ARE NOT IN
14 ANY WAY CONFLICTED WITH EACH OTHER.
15 AND, AGAIN, I DON'T TAKE ANY PLEASURE FROM DOING
16 INTACT EXTRACTION COMPARED TO DISARTICULATION. I DO TAKE
17 SATISFACTION IN PROVIDING THE BEST CARE I CAN TO MY PATIENTS
18 AND HELPING THEM IN WHAT IS VERY DIFFICULT TIME IN THEIR LIVES
19 AND TRYING NOT TO MAKE IT ANY HARDER.
20 Q. ARE ANY OF THE OTHER AUTHORS OF THAT STUDY PLAINTIFFS IN
21 THE NEW YORK LITIGATION?
22 A. NO, THEY ARE NOT.
23 Q. MR. QUINLIVAN ALSO ASKED YOU SOME QUESTIONS ABOUT YOUR
24 EXPERTISE WITH INDUCTION ABORTIONS.
25 A. YES.

1 Q. IS THAT A PROCEDURE THAT YOU TEACH IN YOUR TEACHING
2 CAPACITIES?
3 A. YES, IT IS.
4 Q. AND DO YOU HAVE EXPERTISE IN PERFORMING INDUCTION
5 ABORTIONS?
6 A. I DO. WHAT I STATED WAS I DON'T HAVE SPECIAL EXPERTISE
7 COMPARED TO MY COLLEAGUES. AND THERE ARE MANY MORE
8 OBSTETRICIANS IN MY DEPARTMENT WHO HAVE EXPERTISE IN INDUCTION
9 WHO DON'T DO D&E'S. I DO HAVE SPECIAL EXPERTISE IN D&E. I
10 HAVE EQUIVALENT EXPERTISE TO MANY PHYSICIANS IN PERFORMING
11 INDUCTIONS. SO -- BUT THAT IS THAT.
12 Q. AND WHY DON'T YOU PERFORM INDUCTION ABORTIONS MORE
13 REGULARLY?
14 A. AGAIN, IN MY CAPACITY AS A MATERNAL FETAL MEDICINE
15 SPECIALIST AND MY TEACHING, ADMINISTRATIVE AND RESEARCH
16 CAPACITIES, I DON'T HAVE A WHOLE LOT OF TIME TO DO A LOT OF
17 ABORTION PROCEDURES. THAT DOESN'T CONSTITUTE THE MAIN ASPECT
18 OF MY CLINICAL CARE. IT IS A SMALL MINORITY OF IT.
19 AND, AGAIN, I DO THOSE CASES FOR WHICH I HAVE
20 SPECIAL EXPERTISE. AND D&E CERTAINLY QUALIFIES AS THAT. AND
21 GIVEN I DON'T HAVE AN OBSTETRIC PRACTICE, I DON'T HAVE MY OWN
22 PRIVATE PRENATAL PATIENTS. AND WOMEN WHO WANT TO HAVE AN
23 INDUCTION, IN GENERAL, THEY ARE CARED FOR BY THEIR
24 OBSTETRICIANS AND THEY ARE NOT REFERRED TO ME FOR AN INDUCTION.
25 THAT'S WHY ALMOST ALL THE CASES I DO ARE D&E AND NOT

1 INDUCTIONS. IT'S NOT BECAUSE I LACK ANY REQUISITE EXPERTISE IN
2 INDUCTION.
3 Q. ON CROSS YOU TESTIFIED IN RESPONSE, AGAIN, TO SOME
4 QUESTIONS ABOUT THE SAFETY STUDY THAT THE DATA DON'T SUPPORT A
5 CONCLUSION THAT INTACT D&E PREVENTED ADVERSE OUTCOMES GIVEN THE
6 RETROSPECTIVE NATURE OF THE STUDY; IS THAT RIGHT?
7 A. I THINK I SAID "WE CAN'T CONCLUDE WITH CERTAINTY."
8 Q. BUT DO YOU HAVE A MEDICAL OPINION ABOUT THAT?
9 A. I DO.
10 Q. AND WHAT IS THE MEDICAL OPINION?
11 A. MY MEDICAL OPINION IS THAT THESE 120 CASES THAT WERE ABLE
12 TO BE COMPLETED WITH INTACT EXTRACTION AT A MEDIAN GESTATIONAL
13 AGE AT 23 WEEKS THAT, NUMBER ONE, I THINK IT IS VERY IMPRESSIVE
14 THAT NO MAJOR COMPLICATIONS WAS SEEN IN ANY OF THESE WOMEN.
15 AND THAT IF I OR MY COLLEAGUE IN DOING THESE
16 PROCEDURES DID NOT HAVE THE ABILITY TO IMPLEMENT OUR BEST
17 MEDICAL JUDGMENT, AND SPECIFICALLY WERE PRECLUDED FROM
18 PERFORMING INTACT EXTRACTION, THAT I REALLY DON'T HAVE MUCH
19 DOUBT, HAVING DONE THESE PROCEDURES, THAT SOME OF THESE 120
20 PATIENTS, NOT MOST, BUT SOME, WOULD HAVE EXPERIENCED MAJOR
21 COMPLICATIONS.
22 Q. AND YOU ALSO WERE ASKED SOME QUESTIONS ABOUT, I BELIEVE, 62
23 PATIENTS WHO HAD SUBSEQUENT PREGNANCIES IN THE SECOND STUDY
24 THAT YOU CONDUCTED. GIVEN THE LIMITED NUMBER OF THOSE FOR WHOM
25 YOU COULD ASSESS THE SUBSEQUENT PREGNANCY OUTCOMES AFTER D&E'S,

1 WHY DID YOU INCLUDE THE DATA IN YOUR STUDY?
2 A. I INCLUDED THE DATA -- AND, AGAIN, I THINK THIS WAS
3 CONTAINED IN A LETTER TO THE RESPONDING -- TO THE PEER REVIEW,
4 THERE ISN'T ANY DATA OUT THERE. SOME DATA IS ALWAYS BETTER
5 THAN NO DATA.
6 WOULD IT HAVE BEEN BETTER IF WE HAD TRIPLE OR
7 QUADRUPLE NUMBER OF PATIENTS? SURE. BUT GIVEN THE LARGE
8 LACUNA IN THE MEDICAL KNOWLEDGE REGARDING THIS SPECIFIC --
9 THE COURT: WHAT WAS THAT WORD, DOCTOR?
10 THE WITNESS: "LACUNA." IT MEANS A GAP. SORRY.
11 THAT GIVEN THAT I THINK IT IS VALUABLE DATA, AND I
12 THINK -- AND IT WAS ACCEPTABLE TO THE EDITORS OF THIS JOURNAL
13 WHO DID NOT THINK IT SHOULD BE REMOVED.
14 AND, AGAIN, I THINK I WOULD EMPHASIZE THAT NONE OF
15 THE PATIENTS WHO WOULDN'T HAVE BEEN CONSIDERED HIGH RISK BASED
16 ON THEIR OBSTETRIC HISTORY THAT DIDN'T EVEN EXPERIENCE
17 SPONTANEOUS PRE-TERM BIRTH IN THE NEXT PREGNANCY WHO HAD INTACT
18 EXTRACTION.
19 BY MS. PARKER:
20 Q. AND THERE WERE ALSO SOME QUESTIONS ABOUT THE TWO WOMEN WHO
21 HAD INTACT D&E'S AND SUBSEQUENTLY HAD PRE-TERM BIRTH?
22 A. YES.
23 Q. DO YOU RECALL THAT? AND IN YOUR CLINICAL JUDGMENT, WHAT IS
24 THE MOST LIKELY REASON THAT THEY HAD PRE-TERM BIRTHS?
25 A. WELL, HONESTLY, THERE IS A NOBEL PRIZE FOR WHOEVER CAN

1 UNRAVEL THE MYSTERY OF PRE-TERM BIRTH. SO I DON'T KNOW. BUT
2 WHAT I DO KNOW IS THAT WHEN YOU ARE ASSESSING RISK FOR PRE-TERM
3 BIRTH, THE STRONGEST RISK FACTOR YOU CAN HAVE IS A HISTORY OF A
4 PRIOR PRE-TERM BIRTH OR A PRIOR SECOND-TRIMESTER PREGNANCY
5 LOSS.
6 SO, ANY MATERNAL FETAL MEDICINE SPECIALIST SHOULD
7 LOOK AT THIS AND CONCLUDE THAT, AGAIN, WITHOUT EVEN TOUCHING
8 THESE PATIENTS OR REGARDLESS OF HOW THEIR PREGNANCIES ENDED
9 WITH WHATEVER PROCEDURE, OR NATURALLY, THAT THESE WOMEN WOULD
10 BE CONSIDERED VERY HIGH RISK TO DELIVER IN THE FUTURE.
11 AND THAT I HAVE NO DOUBT THAT THESE -- AND THAT
12 RELATED TO WHAT HAPPENED OR COMPARED TO WHAT HAPPENED IN THE
13 PREGNANCIES THAT WERE ENDED WITH D&E, THAT THEY HAD MARKEDLY
14 IMPROVED PREGNANCY OUTCOMES IN THEIR NEXT PREGNANCY.
15 MS. PARKER: I HAVE NO FURTHER QUESTIONS.
16 THE COURT: ALL RIGHT. ANY RECROSS?
17 MR. QUINLIVAN: ONE QUESTION, YOUR HONOR.
18 THE COURT: OKAY.
19 RECROSS-EXAMINATION
20 BY MR. QUINLIVAN:
21 Q. DOCTOR, HOW MANY LABOR INDUCTIONS HAVE YOU PERFORMED OVER
22 THE LAST FIVE YEARS?
23 A. OVER THE LAST FIVE YEARS? I WOULD ESTIMATE 20.
24 MR. QUINLIVAN: NOTHING FURTHER, YOUR HONOR.
25 THE COURT: ALL RIGHT. DR. CHASEN, THANK YOU.

1 THE WITNESS: THANK YOU.
2 THE COURT: YOU ARE EXCUSED. YOU CAN GO BACK TO NEW
3 YORK.
4 THE WITNESS: THANK YOU.
5 THE COURT: AND THAT CONCLUDES THE EVIDENCE PORTION
6 OF THE TRIAL. I BELIEVE ALL THE EXHIBITS ARE IN; IS THAT
7 CORRECT?
8 MS. PARKER: THAT'S CORRECT, YOUR HONOR.
9 THE COURT: ONLY OUT STANDING QUESTION WOULD BE THE
10 EXHIBIT RAISED ABOUT MS. CLARK. I WILL WAIT FOR YOU ALL NEXT
11 WEEK TO SUBMIT SOMETHING IN WRITING TO ME WITH REGARD TO -- SO
12 THAT YOU CAN ATTACH WHATEVER DOCUMENTS YOU WANT ME TO LOOK AT.
13 AND MS. CLARK, I WILL GIVE YOU AN OPPORTUNITY TO
14 RESPOND IN WRITING. SO I WILL GIVE YOU BY THE END OF THE WEEK.
15 AND GET YOURS IN BY WEDNESDAY AND YOURS IN BY
16 FRIDAY. I WILL MAKE A DECISION AS TO WHETHER THAT WILL BE
17 INCLUDED AS PART OF THE RECORD OR NOT.
18 OTHERWISE, THE RECORD IS CLOSED. WE WILL COMMENCE
19 CLOSING ARGUMENTS AT 1:15.
20 AS I INDICATED PLAINTIFF -- PLANNED PARENTHOOD
21 PLAINTIFFS MAY HAVE AN HOUR. AS THE CITY AND COUNTY OF SAN
22 FRANCISCO HAS BEEN PRETTY QUIET THROUGHOUT THE ENTIRE TRIAL,
23 THEY MAY ALSO HAVE AN HOUR.
24 YOU CERTAINLY DON'T HAVE TO USE IT, AND I WOULD
25 CERTAINLY HOPE THAT YOU WOULDN'T REPEAT THE SAME ARGUMENT.

1 AND THE GOVERNMENT MAY HAVE AN HOUR. I WON'T BE
2 ENTERTAINING ANY REBUTTAL. I THINK I HAVE ACTUALLY HEARD
3 ENOUGH, BUT I WOULD LIKE ALL OF YOU TO KIND OF PULL IT TOGETHER
4 FOR ME.
5 SO WE WILL SEE YOU AT 1:15.
6 (LUNCHEON RECESS WAS TAKEN AT 12:08 P.M.)
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1 AFTERNOON SESSION 1:15 P.M.
2
3 THE COURT: ALL RIGHT.
4 WHO WILL ARGUE ON BEHALF OF THE PLANNED PARENTHOOD
5 PLAINTIFFS?
6 MS. GARTNER: I WILL, YOUR HONOR.
7 THE COURT: ALL RIGHT. MS. GARTNER?
8 CLOSING ARGUMENT
9 MS. GARTNER: THANK YOU.
10 THANK YOU VERY MUCH, YOUR HONOR, AND THANK YOU VERY
11 MUCH ON BEHALF OF PLANNED PARENTHOOD FOR LISTENING PATIENTLY TO
12 US THROUGHOUT THIS CASE AND FOR EXTENDING TO US THE COURTESIES
13 THAT YOU HAVE THROUGHOUT THE LITIGATION.
14 PLANNED PARENTHOOD HAS SHOWN DURING THIS TRIAL THAT
15 THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 VIOLATES THE
16 CONSTITUTIONAL RIGHTS OF OUR PATIENTS AND PHYSICIANS WHO
17 PROVIDE ABORTIONS AT OUR AFFILIATES.
18 I WILL START WITH THE UNDUE BURDEN CLAIM. IN CASEY
19 THE SUPREME COURT HELD THAT A LAW THAT PLACES A SUBSTANTIAL
20 OBSTACLE IN THE PATH OF A WOMAN SEEKING AN ABORTION IMPOSES AN
21 UNCONSTITUTIONAL UNDUE BURDEN. AND IN STENBERG, THE COURT
22 RECOGNIZED THAT A LAW THAT BANS D&E'S IS A PER SE UNDUE BURDEN
23 ON A WOMAN'S RIGHT TO CHOOSE BECAUSE IT IS THE MOST COMMON
24 SECOND-TRIMESTER ABORTION METHOD.
25 THERE WAS UNDISPUTED TESTIMONY AT THIS TRIAL FROM

1 PLANNED PARENTHOOD'S EXPERTS THAT ESTABLISHES THAT D&E BY
2 EITHER VARIANT CAN PROCEED SO AS TO VIOLATE THE ACT DEPENDING
3 ON A RANGE OF FACTORS INCLUDING HOW MUCH DILATION IS ACHIEVED,
4 WHEN FETAL DEMISE OCCURS, HOW FAR THE INTROITUS COMES DOWN -- I
5 AM SORRY, HOW FAR THE CERVIX COMES DOWN TOWARDS THE INTROITUS
6 WITH THE TRACTION FROM THE TENACULUM, AND HOW MUCH OF THE FETUS
7 IS EXTRACTED ON THE INITIAL PASSES OF INSTRUMENTS INTO THE
8 UTERUS.
9 AND THERE WAS ALSO UNDISPUTED TESTIMONY THAT
10 ESTABLISHES THAT INDUCTIONS IN THE TREATMENT OF SECOND
11 TRIMESTER SPONTANEOUS MISCARRIAGE ALSO SOMETIMES VIOLATES THE
12 TERMS OF THIS LAW.
13 NOW, I WANT TO FOCUS SPECIFICALLY ON, JUST FOR A
14 MINUTE, INTACT D&E'S IN PARTICULAR. THE TESTIMONY ESTABLISHED
15 THAT WHILE THE PROTOCOLS FOR DILATING THE CERVIX VARY BY
16 PHYSICIAN AND EVEN BY PATIENT, THERE WAS UNDISPUTED UNIFORM
17 TESTIMONY THAT PHYSICIANS PREFER TO GET AS MUCH DILATION AS
18 POSSIBLE.
19 AND EACH OF THE PLAINTIFFS' EXPERTS TESTIFIED THAT
20 THEY SOMETIMES ARE ABLE TO REMOVE THE FETUS INTACT AT LEAST UP
21 TO THE CALVARIUM AND THAT THEY CONSIDER THAT TO BE A FORTUITOUS
22 OCCURRENCE IN TERMS OF COMPLETING THE PROCEDURE WITH MAXIMUM
23 SAFETY AND SPEED. AND THIS HAPPENS MORE FREQUENTLY SINCE
24 PHYSICIANS HAVE STARTED TO USE MISOPROSTOL AS A CERVICAL
25 RIPENING AGENT IN CONJUNCTION WITH OSMOTIC DILATORS BECAUSE IT

1 CAUSES UTERINE CONTRACTIONS AS WELL AS DILATION, AND THIS CAN
2 SOMETIMES CAUSE A PARTIAL EVACUATION OF THE LIVING FETUS OUT OF
3 THE UTERUS TO THE POINT WHERE THE FETUS IS OUT UP TO THE NAVEL
4 BEFORE THE PHYSICIAN HAS EVEN USED INSTRUMENTS, AND THEN THE
5 PHYSICIAN MUST USE INSTRUMENTS TO COMPLETE THE DELIVERY BECAUSE
6 THE CALVARIUM IS TOO BIG TO PASS THROUGH THE CERVIX.
7 AND THE TESTIMONY ESTABLISHED THAT THE FREQUENCY IN
8 WHICH INTACT EXTRACTION OCCURS VARIES A LOT DEPENDING IN LARGE
9 PART ON THE GESTATIONAL AGE OF THE FETUS AND THE AMOUNT OF
10 DILATION ACHIEVED. IT CAN HAPPEN AT ANY GESTATIONAL AGE.
11 DR. CHASEN TESTIFIED THIS MORNING THAT HE HAS SEEN IT HAPPEN AS
12 EARLY AS 14 OR 15 WEEKS. I BELIEVE DR. BROEKHUIZEN SAID IT HAD
13 HAPPENED TO HIM AS EARLY AS 12 WEEKS IN PREGNANCY.
14 THE PHYSICIANS WHO REPORTED THE LARGEST PERCENTAGE
15 OF INTACT EXTRACTIONS SAID THAT THEY HAD INTACT EXTRACTIONS
16 BEGINNING AT ABOUT 19 OR 20 WEEKS AND ANYWHERE FROM 25 TO
17 40 PERCENT OF ABORTIONS IN WHICH THEY WERE USING THE D&E
18 METHOD. AND THOSE PHYSICIANS ALL REPORTED THAT THEY PREPARE
19 THE CERVIX THE SAME WAY FOR ALL D&E'S AFTER 18 TO 20 WEEKS,
20 IT'S JUST THAT IN SOME FAIRLY SIGNIFICANT PERCENTAGE OF CASES
21 THEY ARE ABLE TO REMOVE THE FETUS INTACT UP TO THE HEAD, AND
22 THEY DON'T MAKE THAT DECISION WHETHER OR NOT TO USE THAT
23 PARTICULAR TECHNIQUE UNTIL THEY HAVE ACTUALLY COMPLETED THE
24 DILATION PROCESS, REMOVED THE LAMINARIA, AND DETERMINED HOW
25 MUCH DILATION THEY HAVE ACHIEVED. AS I THINK DR. CHASEN

1 TESTIFIED, IT'S AN INTRAOPERATIVE DECISION WHICH TECHNIQUE TO
2 USE.
3 AND THIS WAS ALSO CONFIRMED BY DEFENDANT'S EXPERT
4 DR. LOCKWOOD WHO REPORTED AT NYU WHEN HE OVERSAW THAT
5 DEPARTMENT THE DECISION WAS MADE WHETHER TO PROCEED WITH WHAT I
6 THINK HE CALLED D&X OR D&E BASED ON THE AMOUNT OF DILATION.
7 OTHER EXPERTS IN PLAINTIFFS' CASE HAD A LOWER
8 PERCENTAGE OF CASES IN WHICH THEY ACHIEVE INTACT EXTRACTION,
9 LOWER THAN THE 25 TO 40 PERCENT, BUT EVERY ONE OF OUR EXPERTS
10 EXPERIENCED INTACT EXTRACTION IN SOME PERCENTAGE. I THINK
11 DR. PAUL TALKED ABOUT FIVE TO 10 PERCENT IN HER ABORTIONS,
12 DR. DOE TALKED ABOUT 15 TO 20 PERCENT IN HIS ABORTIONS, I THINK
13 DR. SHEEHAN SPOKE SPECIFICALLY ABOUT A CLINIC SESSION SHE HAD
14 DONE THE WEEK BEFORE SHE TESTIFIED WHERE THREE OF THE 12 CASES
15 OF D&E SHE DID RESULTED IN AN INTACT EXTRACTION UP TO THE
16 CALVARIUM, AND DR. CREININ I THINK SAID IT HAPPENED TO HIM 50
17 TO 100 TIMES IN HIS APPROXIMATELY TEN-YEAR CAREER.
18 BUT EVEN IF THE LAW IS ONLY VIOLATED IN FIVE PERCENT
19 OF A PHYSICIAN'S D&E'S, WHAT HIGHLY TRAINED, WELL-CREDENTIALED,
20 WELL-RESPECTED PHYSICIAN IS GOING TO DO A MEDICAL PROCEDURE
21 KNOWING THAT ONCE EVERY 10 OR 20 TIMES THEY WILL BE COMMITTING
22 A FELONY.
23 THE TESTIMONY ALSO CONFIRMED THAT THIS PROCEDURE,
24 THIS WAY OF DOING D&E'S WITH INTACT EXTRACTION IS NOT A NEW
25 TECHNIQUE. DR. SHEEHAN SAID SHE'S BEEN DOING D&E'S THE WAY SHE

1 CURRENTLY DOES THEM IN WHICH SOME SIGNIFICANT PERCENT COME OUT
2 WITH INTACT EXTRACTION SINCE SHE TRAINED IN THE PROCEDURE IN
3 THE 1980'S. DR. BROEKHUIZEN SAYS THAT HE HAS USED THIS TYPE OF
4 INTACT PROCEDURE IN PARTICULAR CASES ALSO SINCE THE 1980'S WHEN
5 HE HAS CONSIDERED IT NECESSARY DUE TO A SPECIFIC MATERNAL
6 HEALTH CONDITION OR FETAL ANOMALY.
7 WHAT WAS CLEAR, AND I THINK I'VE ALREADY SAID THIS,
8 IS THAT WHEN BEGINNING A D&E, PHYSICIANS DON'T KNOW IF IT WILL
9 PROCEED WITH DISARTICULATION OR INTACT EXTRACTION, AND I THINK
10 WHAT DR. WESTHOFF SAID, I DON'T KNOW IF IT WILL BE INTACT UNTIL
11 IT IS OVER BECAUSE IN EACH D&E YOU TAKE EACH STEP AT A TIME AND
12 ONLY WHEN IT'S OVER DO YOU KNOW HOW, IN FACT, IT HAS PROCEEDED.
13 BUT THIS IS SIGNIFICANT BECAUSE IF PHYSICIANS DON'T
14 KNOW UNTIL THE END OF THE PROCEDURE IF IT WILL GO IN SUCH A WAY
15 AS TO VIOLATE THE LAW, THE ONLY WAY TO AVOID VIOLATION IS NOT
16 TO DO ANY PROCEDURES THAT COULD POSSIBLY VIOLATE THE LAW.
17 AND I THINK IT WAS ALSO CLEAR FROM THE TESTIMONY
18 HERE THAT THE LAW COULD VERY WELL BE VIOLATED NOT ONLY IN THESE
19 INTACT PROCEDURES, BUT ALSO IN D&E PROCEDURES THAT RESULT IN
20 DISARTICULATION.
21 OBVIOUSLY NOWHERE IN THE DEFINITION OF PARTIAL-BIRTH
22 ABORTION DOES THE WORD "INTACT" APPEAR. IN FACT, IN EVERY D&E,
23 THE PHYSICIAN ATTEMPTS TO EVACUATE THE FETUS AS INTACT AS
24 POSSIBLE IN ORDER TO REDUCE INSTRUMENTATION IN THE UTERUS WHICH
25 ALL OF THE PHYSICIANS AGREED WAS THE SAFEST WAY TO DO A D&E,

1 AND I BELIEVE MOST OF THE DEFENDANT'S EXPERTS ALSO INDICATED
2 THAT YOU WANT TO REDUCE INSTRUMENTATION IN THE UTERUS TO AVOID
3 THE RISK OF PERFORATION, AND THAT BY DOING THE PROCEDURE AS
4 INTACT AS POSSIBLE, YOU MAKE THE PROCEDURE QUICKER AND YOU ALSO
5 REDUCE THE LIKELIHOOD OF LEAVING PARTS INSIDE THE UTERUS.
6 SO ANY D&E MAY PROCEED SUCH THAT A LIVING FETUS IS
7 INTENTIONALLY EXTRACTED TO THE POINT WHERE THE FETAL TRUNK PAST
8 THE NAVEL IS OUTSIDE THE BODY OF THE WOMAN. AND, AGAIN, IT
9 WILL DEPEND ON THE LENGTH OF THE VAGINAL CANAL, THE DISTANCE
10 BETWEEN THE CERVIX AND THE INTROITUS, ALL THINGS THAT WILL VARY
11 FROM PROCEDURE TO PROCEDURE AND CERTAINLY CAN'T BE PREDICTED
12 BEFORE THE LAMINARIA ARE EVEN INSERTED.
13 I BELIEVE SEVERAL, EVEN DEFENDANT'S EXPERTS, I THINK
14 DR. BOWES STATED THAT DURING THE COURSE OF A DISARTICULATION
15 D&E, IT MAY HAPPEN THAT THE PHYSICIAN CAN EXTRACT THE FETUS.
16 AND I GUESS IT WAS ACTUALLY DR. SHADIGIAN WHO TESTIFIED THAT IT
17 WAS POSSIBLE TO REMOVE THE FETUS UP TO THE TORSO AND THEN THE
18 APPROPRIATE THING TO DO AT THAT POINT WOULD BE TO
19 DISARTICULATE.
20 AND THERE WAS ALSO TESTIMONY -- SO THE ACT WOULD
21 COVER D&E'S IN WHICH THE FETUS WAS INTACT EXTRACTION, IT WOULD
22 COVER D&E'S IN WHICH THERE WAS A DISARTICULATION OF A SMALL
23 PART THAT DIDN'T RESULT IN DEMISE, AND THEN SUBSEQUENT PASSES
24 LED TO AN INTACT EXTRACTION UP TO THE CALVARIUM. AND THERE WAS
25 ALSO TESTIMONY FROM SOME PHYSICIANS THAT BECAUSE OF THE

1 AMBIGUITY IN THE LAW, EVEN A DISARTICULATION D&E WHERE THE
2 INITIAL PASS RESULTED IN BRINGING OUT, FOR EXAMPLE, A PART OF
3 THE ARM AND THE SHOULDER, WHICH IS A PART OF THE FETAL TRUNK
4 PAST THE NAVEL, THAT THAT ITSELF, IN ONE READING OF THE LAW,
5 COULD BE A VIOLATION IF IT DIDN'T IMMEDIATELY -- IF IT DIDN'T
6 IMMEDIATELY CAUSE FETAL DEATH, BUT THE FETUS LIVED LONG ENOUGH
7 FOR THE PHYSICIAN TO TAKE A SUBSEQUENT OVERT ACT THAT ACTUALLY
8 KILLED THE FETUS.
9 SO, EVEN UNDER DISARTICULATION OR INTACT EXTRACTION,
10 THIS LAW COULD BE VIOLATED AND PHYSICIANS WOULDN'T KNOW AHEAD
11 OF TIME.
12 SEVERAL PHYSICIANS, DR. BROEKHUIZEN AND CHASEN, IN
13 PARTICULAR ON OUR SIDE OF THE CASE, ALSO TESTIFIED THAT
14 INDUCTION ABORTIONS COULD VIOLATE THIS LAW, AND, AGAIN, THE
15 PHYSICIAN WOULDN'T KNOW AHEAD OF TIME WHEN THAT WOULD HAPPEN.
16 INDUCTIONS WOULD VIOLATE THE LAW LESS OFTEN, BUT STILL, ANY
17 INDUCTION CAN FAIL AND ALSO ANY INDUCTION COULD LEAD TO THE
18 POINT WHERE THE FETUS HAS BEEN EXPELLED TO THE POINT WHERE THE
19 HEAD IS ENTRAPPED AND ESPECIALLY IF THE WOMAN BEGINS TO BLEED
20 OR BECOMES INFECTED. THE PHYSICIAN WOULDN'T WANT HER TO LABOR
21 INDEFINITELY UNDER THOSE SCENARIOS, AND ESPECIALLY IF IT WAS
22 PREVIABILITY, THE OBVIOUSLY THING TO DO WOULD BE TO HASTEN THE
23 DELIVERY BY DOING A DESTRUCTIVE ACT SIMILAR TO WHAT'S DONE IN
24 THE INTACT EXTRACTION PROCEDURE.
25 AND, IN FACT, EVEN DR. COOK ACKNOWLEDGED THAT THERE

1 ARE SITUATIONS LIKE THAT WHERE YOU NEED TO DELIVER THE HEAD
2 MORE QUICKLY AND YOU WOULDN'T WANT TO WAIT FOR THE INDUCTION TO
3 PROCEED ON ITS OWN. HE DISAGREES WITH OUR PLAINTIFFS ABOUT
4 WHAT YOU WOULD DO, BUT I THINK THERE WAS NO DISAGREEMENT THAT
5 IN AN INDUCTION CAN OCCUR IN SUCH A WAY YOU NEED TO DELIVER THE
6 HEAD MORE RAPIDLY. DR. LOCKWOOD ALSO TESTIFIED TO THAT EFFECT
7 IN HIS DEPOSITION.
8 SO, TO AVOID PROSECUTION UNDER THIS LAW, PHYSICIANS
9 WOULD HAVE TO STOP DOING ANY D&E'S BY EITHER DISARTICULATION OR
10 INTACT VARIANTS, THEY WOULD HAVE TO STOP DOING ALL INDUCTIONS,
11 AND IN ADDITION, THERE'S BEEN TESTIMONY THAT EVEN THE TREATMENT
12 OF SECOND-TRIMESTER MISCARRIAGE COULD PLACE THE DOCTOR AT RISK
13 OF PROSECUTION.
14 DR. PAUL TESTIFIED, AND I THINK OTHER PHYSICIANS AS
15 WELL HAVE TESTIFIED, THAT TOGETHER D&E AND INDUCTION ACCOUNT
16 FOR APPROXIMATELY 99 PERCENT OF ALL SECOND-TRIMESTER ABORTIONS
17 AND THAT D&E ALONE ACCOUNTS FOR APPROXIMATELY 95 PERCENT OF ALL
18 ABORTIONS AFTER 12 WEEKS.
19 UNDER ROE, UNDER CASEY, UNDER STENBERG, A BAN ON D&E
20 ABORTIONS, LET ALONE A BAN ON D&E AND INDUCTION ABORTIONS IS A
21 PER SE UNDUE BURDEN. INDEED, IN THIS CASE, I THINK WE HAVE
22 SEEN A SNAPSHOT OF THE BURDEN THAT THE LAW WOULD IMPOSE IF IT
23 WERE ENFORCED, AND I HAVE TO SAY THAT I THINK I WAS SURPRISED
24 MYSELF OF SOME OF THE IMPACTS THE LAW IS ALREADY HAVING ON
25 MEDICAL PRACTICE.

1 DR. DOE AND DR. GRUNEBAUM TESTIFIED THAT THEY HAVE
2 ACTUALLY STOPPED PERFORMING D&E'S AFTER BECOMING INVOLVED IN
3 THE CASE AND REALLY BEGINNING TO UNDERSTAND THE IMPACT THAT
4 THIS LAW COULD HAVE AND THE RANGE OF CASES IN WHICH THEY COULD
5 BE PROSECUTED.
6 DR. DREY TESTIFIED THAT SHE HAD MADE CHANGES IN HOW
7 SHE TREATS PATIENTS AS A RESULT OF THE ACT. FOR EXAMPLE, SHE
8 NO LONGER ENCOURAGES PATIENTS TO BRING FAMILY MEMBERS WITH THEM
9 INTO THE PROCEDURE ROOM.
10 DR. WESTHOFF TESTIFIED ABOUT USING KCL WITH A
11 PATIENT RIGHT BEFORE THE TRO WAS ISSUED IN THE NEW YORK CASE
12 WHICH LED TO THE COMPLICATION OF RETAINED TISSUE AND A
13 SUBSEQUENT HOSPITALIZATION.
14 OTHER PHYSICIANS, I THINK THE MAJORITY OF THE
15 PHYSICIANS WHO TESTIFIED SAID THEY HAD NOT YET MADE UP THEIR
16 MINDS ABOUT HOW THEY WOULD DEAL WITH THIS IF THE LAW ACTUALLY
17 TOOK EFFECT, BUT DR. SHEEHAN TALKED ABOUT THE IMPACT THIS WOULD
18 HAVE ON HER PATIENTS IF SHE WERE FORCED TO OBTAIN CONSENT FROM
19 THE FATHER, OR THE FATHER OF THE YOUNG WOMAN, OR THE MOTHER OF
20 THE YOUNG WOMAN IF SHE WERE A MINOR, OR A SPOUSE IF SHE WERE
21 MARRIED, AND HOW THIS WOULD REALLY IMPACT HER RELATIONSHIP WITH
22 HER PATIENTS TO THE DETRIMENT OF THAT RELATIONSHIP.
23 ALL OF THIS CONSTITUTES AN UNDUE BURDEN ON A WOMAN'S
24 RIGHT TO CHOOSE ABORTION PRIOR TO VIABILITY. AND FOR THIS
25 REASON ALONE, THE ACT MUST BE PERMANENTLY ENJOINED.

1 I WANT TO MENTION A FEW POINTS ABOUT THE UNDUE
2 BURDEN CLAIM BECAUSE THERE HAS BEEN SO MUCH TESTIMONY IN THIS
3 CASE ABOUT HEALTH REASONS AND FETAL ANOMALY REASONS, AND THAT
4 IS REALLY MORE TARGETED TOWARDS THAT HEALTH EXCEPTION CLAIM, SO
5 I THINK THAT MAYBE THERE ARE CERTAIN ASPECTS OF THE LAW AROUND
6 UNDUE BURDEN THAT MIGHT NOT BE ENTIRELY CLEAR.
7 FOR PURPOSES OF AN UNDUE BURDEN CLAIM, IT'S
8 IRRELEVANT WHY A WOMAN CHOOSES TO HAVE A SECOND-TRIMESTER
9 PREVIABILITY ABORTION. THE SUPREME COURT MADE CLEAR IN CASEY
10 THAT A WOMAN HAS THE CONSTITUTIONAL RIGHT TO CHOOSE ABORTION
11 PRIOR TO FETAL VIABILITY WITHOUT UNDUE GOVERNMENTAL
12 INTERFERENCE FOR ANY REASON THAT SHE CHOOSE SO LONG AS HER
13 DECISION IS AN INFORMED PERSONAL DECISION THAT IS TRULY HER
14 OWN.
15 AS SEVERAL OF OUR EXPERTS HAVE TESTIFIED, PATIENTS
16 CHOOSE SECOND-TRIMESTER ABORTIONS FOR A VARIETY OF PERSONAL AND
17 SOCIAL CATASTROPHES, NOT ALL OF THEM, THOUGH SOME OF THEM,
18 RELATED TO MATERNAL OR FETAL CONDITIONS.
19 IN ADDITION, WITH RESPECT TO THE UNDUE BURDEN CLAIM,
20 IT IS IRRELEVANT WHETHER THE D&E, AS I SAID, PRECEDES WITH
21 DISARTICULATION OR INTACT EXTRACTION. A LOT OF OUR TESTIMONY
22 HAS FOCUSED ON INTACT D&E'S, BUT REALLY FOR PURPOSES OF THE
23 UNDUE BURDEN CLAIM, IT'S JUST THAT DISTINCTION IS NOT A
24 RELEVANT ONE.
25 AND, FINALLY, FOR PURPOSES OF THE UNDUE BURDEN

1 CLAIM, THERE IS NOT EVEN A QUESTION ABOUT DEFERENCE TO THE
2 CONGRESSIONAL FINDINGS BECAUSE THE FINDINGS FOCUSED EXCLUSIVELY
3 ON JUSTIFYING WHY A HEALTH EXCEPTION WAS EXCLUDED FROM THE
4 BILL. THE FINDINGS SAID NOTHING OR PURPORTED TO SAY NOTHING
5 ABOUT THE SCOPE OF THE LAW.
6 IN DEFENSE OF THIS CASE, ATTORNEY GENERAL ASHCROFT
7 HAS APPARENTLY DELIBERATELY DECIDED NOT TO CLARIFY THE SCOPE OF
8 THE LAW TO MAKE CLEAR WHETHER, IN FACT, THIS IS INTENDED TO BAN
9 ALL D&E'S, ALL INDUCTIONS, OR SOME NARROWER SET OF THESE
10 PROCEDURES. NOWHERE IN THE LEGAL ARGUMENTS AND TESTIMONY
11 PRESENTED IN THIS CASE EITHER AT TRIAL OR IN THE BRIEFS HAS
12 MR. ASHCROFT ARTICULATED HOW THE GOVERNMENT INTENDS TO ENFORCE
13 THIS CRIMINAL LAW.
14 DEPUTY ATTORNEY GENERAL JUAN KIM TESTIFIED IN HIS
15 DEPOSITION THAT HIS OFFICE, WHICH IS CHARGED WITH THE
16 ENFORCEMENT OF THE ACT, HAD NOT YET TACKLED THE SCOPE OF
17 PROCEDURES BANNED BY THE ACT AND THAT HE WAS UNAWARE OF A FINAL
18 POLICY DECISION ABOUT WHETHER THE ACT APPLIES TO ONLY ONE
19 METHOD OF ABORTION.
20 THE WAY THAT THIS CASE HAS BEEN LITIGATED SUGGESTS
21 VERY STRONGLY THAT THE ACTUAL GOAL IS TO BAN D&E'S BY EITHER
22 VARIANT; EITHER THE INTACT EXTRACTION OR THE DISARTICULATION
23 VARIANT.
24 THIS IS SUGGESTED TO US IN SEVERAL RESPECTS. FIRST,
25 MUCH OF THE FOCUS OF DEFENDANT'S TESTIMONY OVER THE LAST WEEK

1 HAS BEEN TO SHOW THE SUPPOSED SUPERIORITY OF INDUCTION OVER D&E
2 AFTER 20 WEEKS' GESTATION. DRS. SPRANG, SHADIGIAN, AND COOK
3 ALL EXPRESSED THIS VIEW VERY STRONGLY. BUT IF THE ACT DOES NOT
4 BAN D&E'S BY EITHER METHOD, ALL OF THIS EVIDENCE SEEMS TO BE
5 LEGALLY IRRELEVANT.
6 SECOND, AND REALLY QUITE REMARKABLY, ON
7 CROSS-EXAMINATION BOTH DRS. COOK AND SPRANG APPEARED TO SAY
8 THAT THE RISKS OF D&E AND INTACT D&E ARE COMPARABLE AT THE SAME
9 GESTATIONAL AGES; IMPLICITLY SUGGESTING THAT IF INTACT D&E
10 NEEDED TO BE BANNED DUE TO MATERNAL HEALTH CONCERNS, AS
11 CONGRESS FOUND IN ITS FINDINGS, PERHAPS D&E'S BY
12 DISARTICULATION SHOULD BE BANNED AS WELL.
13 AND SIMILARLY DR. BOWES AND DR. SHADIGIAN ALSO
14 TESTIFIED THAT THEY DON'T FIND D&E'S WITH INTACT EXTRACTION TO
15 BE ANY MORE OBJECTIONABLE THAN D&E'S WITH DISARTICULATION AT
16 THE SAME GESTATIONAL AGE; AGAIN, SUGGESTING THAT IF ONE SHOULD
17 BE BANNED, THE OTHER ONE SHOULD BE, TOO.
18 IN ADDITION, UNDER DR. ANAND'S SPECULATIVE THEORY
19 ABOUT FETAL PAIN, D&E BY DISARTICULATION IS HYPOTHETICALLY MORE
20 PAINFUL THAN D&E BY INTACT EXTRACTION. BUT IF THE GOVERNMENT
21 WERE NOT TRYING TO BAN BOTH TECHNIQUES, IT IS INEXPLICABLE HOW
22 THIS TESTIMONY OR DR. ANAND'S OPINIONS IN THIS CASE ACTUALLY
23 SUPPORT THEIR CASE.
24 FINALLY, MUCH OF DR. SHADIGIAN'S TESTIMONY WAS BASED
25 ON HER OPINION THAT ALL ABORTIONS, NOT SPECIFICALLY INTACT D&E

1 ABORTIONS ARE DANGEROUS FOR WOMEN. THE FACT THAT SHE WAS
2 CALLED TO TESTIFY ABOUT HER THEORY IN THIS CASE FURTHER
3 SUGGESTS THAT ATTORNEY GENERAL ASHCROFT INTENDS TO USE THIS LAW
4 TO BAN ALL D&E'S.
5 SO, IN SUM, THE WAY THE GOVERNMENT HAS LITIGATED
6 THIS CASE HAS ONLY HEIGHTENED THE CONCERNS THAT IF ENFORCED,
7 THIS LAW WOULD BE USED TO PROSECUTE PHYSICIANS FOR ANY D&E THEY
8 PERFORM.
9 THE ONLY ARGUMENT ASSERTED BY DEFENDANT TO ATTEMPT
10 TO REBUT PLAINTIFFS' UNDUE BURDEN CLAIM WAS THE SUGGESTION THAT
11 PHYSICIANS COULD AVOID THE IMPACT OF THIS LAW BY INJECTING THE
12 FETUS WITH EITHER DIGOXIN OR KCL TO CAUSE FETAL DEMISE BEFORE
13 THE EVACUATION PART OF THE PROCEDURE BEGINS, BUT THE GOVERNMENT
14 HAS PUT ON VIRTUALLY NO EVIDENCE TO SUPPORT THIS THEORY WHICH
15 UNDOUBTEDLY ACCOUNTS FOR THEIR ATTEMPT THIS MORNING TO
16 SUPPLEMENT THE RECORD WITH A LETTER FROM AN ATTORNEY.
17 BUT EVEN IF WE GIVE CREDENCE TO THE THEORY THAT
18 DOCTORS THEORETICALLY COULD ATTEMPT TO AVOID THE UNDUE BURDEN
19 OF THIS LAW, THERE ARE SEVERAL PROBLEMS WITH THE DIGOXIN/KCL
20 THEORY.
21 DR. DREY'S STUDY ESTABLISHED THAT DIGOXIN DOES NOT
22 IMPROVE THE SAFETY OF THE ABORTION, DOES NOT REDUCE THE TIME OF
23 THE ABORTION, DOES NOT MAKE THE PROCEDURE EASIER TO PERFORM,
24 AND DOES NOT REDUCE THE DISCOMFORT TO THE PATIENT OF THE
25 PROCEDURE; ACCORDINGLY, INJECTING THE FETUS THROUGH THE WOMAN'S

1 ABDOMEN HAS NO EFFECT WHATSOEVER FOR THE WOMAN.
2 AND DR. BOWES AGREED IT HAD NO MEDICAL BENEFIT; IT
3 SERVES ONLY THE DOCTOR AVOID CRIMINAL SANCTION.
4 AS DR. DREY VERY ELOQUENTLY STATED, SHE WOULDN'T
5 EVEN KNOW HOW TO CONSENT A PATIENT FOR A PROCEDURE THAT SHE
6 KNEW SERVED NO BENEFIT WHATSOEVER FOR THE PATIENT.
7 AND BOTH DR. BROEKHUIZEN AND DR. DOE AND POSSIBLY
8 OTHERS TESTIFIED ABOUT PATIENTS TERMINATING PREGNANCIES IN THE
9 CASE OF LETHAL ANOMALIES WHO AFFIRMATIVELY DID NOT WANT TO
10 INDUCE FETAL DEMISE BEFORE THE ABORTION EVEN WHEN THEY WERE
11 OFFERED THAT OPTION.
12 BUT THERE ARE ADDITIONAL PROBLEMS WITH THIS CHEMICAL
13 INJECTION THEORY. FIRST, IT REQUIRES PHYSICIANS TO -- MANY
14 PHYSICIANS, NOT ALL PHYSICIANS, BUT SOME PHYSICIANS WOULD HAVE
15 TO CHANGE THEIR PRACTICES. AND AS DR. WESTHOFF EXPERIENCED,
16 WHEN YOU CHANGE YOUR PRACTICE FROM SOMETHING THAT YOU ARE
17 COMFORTABLE DOING AND YOU HAVE BEEN DOING A CERTAIN WAY FOR
18 MANY YEARS AND YOU WERE TRAINED TO DO, INEVITABLY YOU ARE MORE
19 LIKELY TO HAVE A COMPLICATION, AS OCCURRED IN DR. WESTHOFF'S
20 PRACTICE RIGHT AROUND THE TIME THIS LAW TOOK EFFECT.
21 EVEN DEFENDANT'S EXPERTS, FRANKLY, TO THE EXTENT
22 THAT THEY EVER PERFORM ABORTIONS WHERE THE FETUS IS LIVING AT
23 THE OUTSET OF THE PROCEDURE, THEY WOULD HAVE TO CHANGE THEIR
24 PRACTICES TOO BECAUSE NONE OF THEM SAID THAT THEY EVER IN THE
25 RARE CASES THAT THEY DO D&E'S OR INDUCTIONS ON LIVE FETUSES,

1 NONE OF THEM EVER USE THIS TYPE OF INJECTION IN THEIR PRACTICE.
2 IN ADDITION, NOT ALL THE PHYSICIANS HAVE THE SKILL
3 TO DO THIS. DR. SPRANG TESTIFIED ABOUT THE NEW POLICY AT
4 EVANSTON HOSPITAL, BUT HE SAID THAT MATERNAL FETAL MEDICINE
5 SPECIALISTS ARE THE ONES THAT DO THE INJECTIONS.
6 DR. WESTHOFF SAID IN THE CASE WHEN SHE USED THE KCL
7 SHE HAD A MATERNAL FETAL MEDICINE SPECIALIST COME IN TO DO THE
8 PROCEDURE. AND DR. BOWES TESTIFIED THAT AT UNIVERSITY OF NORTH
9 CAROLINA, AGAIN, IT'S A MATERNAL FETAL MEDICINE SPECIALIST THAT
10 INJECTS THE KCL.
11 NOT EVERY PLANNED PARENTHOOD CLINIC CERTAINLY HAS A
12 MATERNAL FETAL MEDICINE ON STAFF OR AVAILABLE TO THEM TO DO
13 THIS KIND OF SPECIALIZED PROCEDURE, BUT EVEN WITH THE REQUISITE
14 SKILL, IT'S NOT ALWAYS TECHNICALLY POSSIBLE TO INJECT THE
15 CHEMICAL. WE'VE HEARD A LOT ABOUT, YOU KNOW, OBESE WOMEN AND
16 THE DIFFICULTIES THAT WOULD BE THERE TO ATTEMPT AN INJECTION IN
17 THAT SITUATION. EVEN WHERE THE INJECTION IS TECHNICALLY
18 POSSIBLE, IT'S NOT 100 PERCENT EFFECTIVE. SOMETIMES IT SIMPLY
19 FAILS.
20 FOR ALL WOMEN, THE INJECTION WOULD BE UNCOMFORTABLE.
21 UNDER DR. DREY'S STUDY, FOR A VERY HIGH PERCENTAGE OF WOMEN,
22 THE INJECTION WOULD CAUSE NAUSEA AND VOMITING, WHICH, OF
23 COURSE, ARE NOT VERY SERIOUS COMPLICATIONS, BUT AS DR. BOWES
24 AGREED, THOSE ARE UNPLEASANT SIDE EFFECTS THAT YOU WOULD WANT
25 TO AVOID IN YOUR PATIENTS IF YOU COULD.

1 FOR ALL WOMEN, THERE IS A SMALL RISK OF INFECTION OR
2 OTHER COMPLICATION. DR. SHEEHAN DID TESTIFY ABOUT ONE PATIENT
3 THAT SHE HAD WHERE SHE, THE WOMAN DID DEVELOP A UTERINE
4 INFECTION AS A RESULT OF THE DIGOXIN INJECTION.
5 AND LAST, BUT ABSOLUTELY NOT LEAST, WHERE THERE IS A
6 SMALL PERCENTAGE OF WOMEN FOR WHOM THE INJECTION WOULD HAVE
7 VERY DISTINCT MEDICAL RISKS. THESE WOMEN INCLUDE, AS DR. COOK
8 TESTIFIED, WOMEN WITH HIV OR HEPATITIS WHO ARE AT SPECIAL RISK
9 IF THEY BECOME INFECTED.
10 DR. LOCKWOOD, IN HIS DEPOSITION, SAID, "WELL, I
11 CERTAINLY WOULDN'T GIVE DIGOXIN TO A WOMAN WITH
12 WOLF-PARKINSON-WHITE SYNDROME," WHICH IS A HEART CONDUCTIVITY
13 DISORDER. DR. BOWES SAID THAT HE WOULD AVOID DIGOXIN IN WOMEN
14 WITH SEVERE HEART DISEASE.
15 INDEED, FOR ALL THESE REASONS, A LAW THAT REQUIRES
16 AN INJECTION OF A CHEMICAL AGENT PRIOR TO FETAL VIABILITY WOULD
17 ITSELF IMPOSE AN UNDUE BURDEN ON A WOMAN'S RIGHT TO CHOOSE
18 ABORTION, AND, IN FACT, TWO OF THE DISTRICT COURTS THAT HEARD
19 THE STATE LAW CASES SO FOUND. THAT WAS THE EVANS V. KELLY AND
20 PLANNED PARENTHOOD OF NEW JERSEY CASE.
21 SO, FOR ALL THESE REASONS, THE ACT VIOLATES WOMEN'S
22 RIGHT TO CHOOSE ABORTION PRIOR TO VIABILITY.
23 NOW, OUR SECOND CLAIM IS THAT NOT ONLY DOES THIS
24 VIOLATE WOMEN'S RIGHT, BUT THE LAW ALSO VIOLATES THE RIGHT OF
25 PHYSICIANS WHO PERFORM ABORTIONS TO DUE PROCESS BECAUSE THE LAW

1 IS UNCONSTITUTIONALLY VAGUE.
2 NOW, AS THE COURT NOTES, THERE ARE TWO RESPECTS IN
3 WHICH A LAW CAN BE UNCONSTITUTIONALLY VAGUE. THE FIRST IS IF
4 THE LAW FAIL TO CLEARLY DEFINE THE CONDUCT THAT IS PROHIBITED,
5 AND THE SECOND, IF THE LAW ENCOURAGES ARBITRARY AND
6 DISCRIMINATORY ENFORCEMENT. BOTH COMPONENTS OF VAGUENESS ARE
7 PRESENT HERE.
8 FIRST, AS ALL OF PLANNED PARENTHOOD'S EXPERTS
9 EXPLAINED, THE TERM "PARTIAL-BIRTH ABORTION" IS NOT A MEDICAL
10 TERM AND THE ACT'S DEFINITION OF THAT TERM DOESN'T USE
11 TERMINOLOGY THAT TRACKS ANY PARTICULAR PROCEDURE THAT THEY ARE
12 AWARE OF; RATHER, AS OUR EXPERTS EXPLAIN, THE DEFINITION SETS
13 OUT ELEMENTS THAT OCCUR IN ANY ABORTION PROCEDURE.
14 AND NOTABLY, DESPITE THE FACT THAT JUSTICE O'CONNOR
15 MADE SPECIFIC SUGGESTIONS IN HER CONCURRENCE IN STENBERG THAT A
16 POSSIBLE WAY OF LIMITING THE LAW WOULD BE TO SPECIFICALLY
17 EXCLUDE CERTAIN PROCEDURES, THERE IS NO SUCH SPECIFIC EXCLUSION
18 IN THE ACT. ACCORDINGLY, PLAINTIFFS DON'T HAVE FAIR NOTICE OF
19 THE CONDUCT THAT'S PROSCRIBED.
20 SECOND, GIVEN THE BREADTH OF THE LAW AND ITS LACK OF
21 DEFINED PROCEDURES, IT COULD BE USED BY DIFFERENT PROSECUTORS
22 IN DIFFERENT WAYS. PLAINTIFFS' EXPERTS EXPLAINED THAT THEY
23 FEAR BEING SECOND-GUESSED BY OTHERS IN THEIR JUDGMENT ABOUT
24 WHETHER A PARTICULAR PROCEDURE WAS BANNED BY THE ACT. AND
25 THERE IS SO MUCH -- IF YOU LOOK AT THE TERMS OF THE LAW AND YOU

1 LOOK AT ANY PART OF "THE FETAL TRUNK PAST THE NAVEL," YOU
2 REALIZE THIS COULD BE SUBJECT TO SO MANY DIFFERENT
3 INTERPRETATIONS, SO MANY DIFFERENT SITUATIONS WHERE A DOCTOR
4 SAID IT OCCURRED THIS WAY AND SOMEBODY ELSE SAID IT OCCURRED
5 THAT WAY, AND IT WASN'T REALLY PAST THE NAVEL, IT WASN'T REALLY
6 TO THE NAVEL. AND ALL OF THIS, AS I THINK DR. PAUL SAID, TO DO
7 A PROCEDURE WONDERING IF IT WAS PAST THE NAVEL, OR TO THE
8 NAVEL, OR WHETHER IT WAS OUTSIDE THE BODY OF THE MOTHER OR JUST
9 CLOSE TO OUTSIDE THE BODY OF THE MOTHER IS LIKE HAVING AN
10 ELEPHANT IN THE ROOM WITH YOU WHILE YOU'RE DOING THE ABORTION
11 WONDERING IF SOME PROSECUTOR IS GOING TO INTERPRET IT IN A
12 CERTAIN WAY.
13 NOW, THAT FEAR ABOUT HOW THE ACT MIGHT BE
14 INTERPRETED OR WHAT DOCTORS MAY BE ACCUSED OF DOING, WHETHER
15 TRUE OR NOT, IS OF SPECIAL CONCERN WHEN PROCEDURES ARE BEING
16 DONE IN POTENTIALLY LIFE-SAVING SITUATIONS. IN THAT SITUATION
17 ESPECIALLY, DOCTORS NEED TO BE ABLE TO USE THEIR GOOD FAITH
18 MEDICAL JUDGMENT TO DETERMINE WHAT IS IN THEIR PATIENT'S BEST
19 INTEREST AT THAT MOMENT WITHOUT CONCERN ABOUT PROSECUTION.
20 AND WE DON'T HAVE -- I DON'T HAVE THE LIFE EXCEPTION
21 UP HERE, BUT THE LIFE EXCEPTION ONLY ALLOWS THE PHYSICIAN TO
22 USE A LIFE-SAVING PROCEDURE IF IT IS NECESSARY TO SAVE THE
23 WOMAN'S HEALTH. AND MANY OF PLANNED PARENTHOOD'S EXPERTS SAID
24 THAT "IS NECESSARY" STANDARD IS OF PARTICULAR CONCERN TO THEM
25 BECAUSE WHO DECIDES WHAT IS NECESSARY.

1 IT DOESN'T SAY IS NECESSARY IN THE PHYSICIAN'S BEST
2 MEDICAL JUDGMENT; IT JUST SAYS IS NECESSARY. AND PHYSICIANS,
3 BY USING PROCEDURES THAT THEY, IN THEIR JUDGMENT, BELIEVE ARE
4 NECESSARY TO SAVE A WOMAN'S LIFE, PUT THEMSELVES AT RISK OF
5 BEING SECOND-GUESSED BY ANOTHER PHYSICIAN WHO SAID THAT REALLY
6 WASN'T LIFE SAVING.
7 AND, OBVIOUSLY, I THINK THERE WAS TESTIMONY TO THIS
8 EFFECT, WHAT IS LIFE SAVING TO ONE PERSON IS CERTAINLY NOT LIFE
9 SAVING TO ANOTHER PERSON. IN FACT, DR. BOWES THINKS THAT AN
10 ABORTION ISN'T NEEDED FOR A WOMAN'S LIFE UNTIL THERE IS A
11 50 PERCENT CHANCE THAT A WOMAN WOULD DIE. THAT IS A FAIRLY
12 HIGH STANDARD. ANOTHER DOCTOR COULD EASILY MAKE THE JUDGMENT
13 THAT THERE IS A 10 PERCENT CHANCE THAT THE WOMAN WOULD DIE,
14 THAT THAT WOULD BE A PROCEDURE NECESSARY TO SAVE THE WOMAN'S
15 LIFE.
16 NOW, IN SOME CASES, SCIENTER REQUIREMENTS HAVE BEEN
17 HELD TO CURE VAGUENESS IN A LAW, BUT IN THIS CASE, THE
18 SCIENTER-TYPE REQUIREMENTS ACTUALLY MAGNIFY THE UNCERTAINTY OF
19 THE SCOPE OF THE ACT. THE TERM, AND ACTUALLY WHAT WE DON'T
20 HAVE UP ON THE BOARD IS THE VERY BEGINNING.
21 ACTUALLY, DO YOU MIND, YOUR HONOR, IF I --
22 THE COURT: I HAVE IT RIGHT HERE IN FRONT OF ME.
23 MS. GARTNER: I'LL BRING IT UP HERE.
24 BUT IN THE INTRODUCTORY SECTION TO THE OPERATIVE
25 PART OF THE LAW, IT SAYS THAT A PHYSICIAN WHO KNOWINGLY

1 PERFORMS A PARTIAL-BIRTH ABORTION SHALL BE FINED UNDER THIS
2 TITLE, ET CETERA.
3 SO IN THE BEGINNING PART OF THE LAW, THERE IS A
4 KNOWINGLY STANDARD. IN THE DEFINITION, IN SUBSECTION A, THERE
5 IS A DELIBERATELY AND INTENTIONALLY STANDARD.
6 IT'S, I THINK, UNCLEAR TO SAY THE LEAST, WHETHER THE
7 DELIBERATELY AND INTENTIONALLY LANGUAGE APPLIES TO ANYTHING
8 OTHER THAN THE WORDS THAT COME IMMEDIATELY THEREAFTER, THE
9 "VAGINALLY DELIVERS A LIVING FETUS" PART OF THE LAW.
10 AND ESPECIALLY BECAUSE THERE IS A SCIENTER
11 REQUIREMENT THAT APPLIES TO THE LAW AS A WHOLE, THERE IS NO
12 REASON TO READ THE DELIBERATELY AND INTENTIONAL LANGUAGE OTHER
13 THAN TO THOSE WORDS THAT COME IMMEDIATELY THEREAFTER, MEANING
14 THAT IT'S UNCLEAR WHETHER DELIBERATELY OR INTENTIONALLY APPLIES
15 TO HOW FAR THE FETUS IS EXTRACTED, FOR WHAT PURPOSE THE FETUS
16 IS EXTRACTED, OR THE PERFORMING THE OVERT ACT PART.
17 IN FACT, I THINK IT'S CLEAR THAT BECAUSE THE
18 DELIBERATELY AND INTENTIONALLY LANGUAGE APPEARS IN SUBSECTION A
19 AND NOT IN SUBSECTION B, THAT IT'S REALLY LIMITED TO THAT PART
20 OF THE STATUTE AND THEN WHICH PART OF SUBSECTION A IT APPLIES
21 TO, AGAIN, COULD BE SUBJECT TO DIFFERENT INTERPRETATION BY
22 DIFFERENT PROSECUTORS, AND PHYSICIANS SIMPLY DON'T KNOW.
23 NOR DOES THE "FOR THE PURPOSE OF" LANGUAGE HELP AT
24 ALL. AS PLANNED PARENTHOOD'S EXPERTS EXPLAINED, REGARDLESS OF
25 THE METHOD OF ABORTION, PHYSICIANS DO NOTHING FOR THE PURPOSE

1 OF KILLING THE FETUS; RATHER, EVERYTHING THEY DO IN ANY
2 ABORTION IS FOR THE PURPOSE OF COMPLETING THE PROCEDURE SAFELY
3 WHICH THEY KNOW WILL RESULT IN FETAL DEMISE.
4 SO, GIVEN THE ACT'S VAGUE DEFINITION, WHICH DOESN'T
5 TRACK ANY PARTICULAR MEDICAL PROCEDURE, THERE WOULD ALWAYS BE
6 THE ELEPHANT IN THE ROOM, THE POTENTIAL FOR PROSECUTION, THE
7 PERSON LOOKING OVER YOUR SHOULDER, THE PERSON WHO COULD SAY,
8 YES, THERE WAS A PART OF THE FETAL TRUNK PAST THE NAVEL THAT
9 CAME OUTSIDE THE BODY OF THE MOTHER, AND THEN THE PHYSICIAN
10 WOULD BE AT RISK OF PROSECUTION. AND THE ONLY WAY TO AVOID
11 THAT IS TO STOP PROVIDING SAFE SECOND-TRIMESTER ABORTION
12 PROCEDURES.
13 OUR THIRD CLAIM IS THAT EVEN IF THE COURT FINDS THAT
14 THE TERMS OF THE ACT ARE CLEAR AND THAT THE BAN APPLIES ONLY TO
15 D&E'S BY THE INTACT VARIANT, THE LAW WOULD STILL BE
16 UNCONSTITUTIONAL BECAUSE IT LACKS A HEALTH EXCEPTION.
17 OBVIOUSLY, THE HEALTH EXCEPTION CLAIM IS GOVERNED BY
18 STENBERG VERSUS CARHART. IN THAT CASE, AFTER ASSESSING THE
19 EVIDENCE, THE COURT RULED, AND THIS IS AT PAGE 932 OF THAT
20 RULING, "THE RECORD SHOWS THAT SIGNIFICANT MEDICAL AUTHORITY
21 SUPPORTS THE PROPOSITION THAT IN SOME CIRCUMSTANCES D&X WOULD
22 BE THE SAFEST PROCEDURE."
23 THE COURT WENT ON AT PAGE 938 TO SAY, "A STATUTE
24 THAT ALTOGETHER FORBIDS D&X, CREATES A SIGNIFICANT HEALTH RISK.
25 THE STATUTE CONSEQUENTLY MUST CONTAIN A HEALTH EXCEPTION."

1 NOW, AS YOUR HONOR KNOWS, FROM THE BEGINNING OF THE
2 CASE, WE READ STENBERG TO MEAN THAT ANY STATUTE THAT BANS D&X
3 OR INTACT D&E PROCEDURES AS A MATTER OF LAW CREATES A
4 SIGNIFICANT HEALTH RISK AND, THEREFORE, MUST AS A MATTER OF LAW
5 CONTAIN A HEALTH EXCEPTION.
6 WE UNDERSTAND THAT DEFENDANT'S POSITION ON THIS AND
7 YOUR HONOR AGREED THAT THIS WASN'T REALLY A PER SE RULING, AND
8 THAT AS DEFENDANTS ARGUED, THAT HOLDING -- NOT THAT YOUR HONOR
9 AGREED WITH US, BUT THE DEFENDANTS ARGUED THAT THAT HOLDING IN
10 STENBERG WAS DISPLACED BY THE CONGRESSIONAL FINDINGS TO THIS
11 ACT. BUT AS WE HAVE BRIEFED, THIS IS SIMPLY NOT THE CASE.
12 NOW, WITHOUT DOUBT, THE QUESTION OF HOW MUCH
13 DEFERENCE SHOULD BE ACCORDED TO THESE CONGRESSIONAL FINDINGS IS
14 IN GENERAL A VERY COMPLEX AND UNSETTLED AREA OF THE LAW.
15 BUT ON THE FACTS PRESENTED HERE, IT SIMPLY DOES NOT
16 MATTER WHETHER THE COURT APPLIES THE NO DEFERENCE RULE FROM THE
17 CITY OF BURNEY CASE, THE INDEPENDENT EVALUATION STANDARD FROM
18 THE STABLE COMMUNICATIONS CASE, AND THE OTHER FIRST AMENDMENT
19 CASES, THE HARD LOOK STANDARD THAT THE LAW SCHOOL PROFESSORS
20 WHO APPEARED AS AMICI PROPOSED OR THE TURNER II STANDARD. YOUR
21 HONOR REALLY SUGGESTED THAT IN YOUR FOOTNOTE IN THE TRO RULING.
22 UNDER ANY OF THESE LEGAL ANALYSES THAT HAVE BEEN
23 PROPOSED, THE CONGRESSIONAL FINDINGS ARE SIMPLY ENTITLED TO NO
24 DEFERENCE.
25 THE LEGISLATIVE HISTORY TO THIS LAW SHOWS THAT

1 DURING THE POST-STENBERG REVIEW OF THIS ISSUE, CONGRESS WAS NOT
2 ATTEMPTING A GENUINE INVESTIGATION OF THE SORT THAT CONGRESS
3 UNDERTOOK WITH A LAW THAT WAS ISSUED -- AT ISSUE IN THE
4 TURNER II CASE; RATHER, AFTER STENBERG, CONGRESS MERELY
5 REHASHED TESTIMONY THAT IT HAD HEARD INITIALLY IN 1995 AND 1996
6 AND WHICH WAS JUST REPEATED OVER AND OVER AGAIN AND RESUBMITTED
7 INTO THE RECORD, UNCLEAR IF ANYONE READ IT, IT JUST GOT
8 RESUBMITTED INTO THE CONGRESSIONAL RECORD YEAR AFTER YEAR. AND
9 THE WHOLE PURPOSE OF THIS WAS TO UNDO A CONSTITUTIONAL RULING
10 WHICH CONGRESS DISAGREED.
11 IN FACT, SINCE STENBERG WAS DECIDED, CONGRESS HELD
12 ONLY TWO VERY SHORT HEARINGS; ONE IN 2002, ONE IN 2003.
13 ALTOGETHER THE HEARINGS TOOK A TOTAL OF FOUR HOURS OR LESS.
14 THE RESULTS OF THE 2002 HEARING WERE PREORDAINED AS THE
15 FINDINGS HAD ALREADY BEEN WRITTEN AND WERE PART OF THE
16 INTRODUCED BILL EVEN BEFORE THE HEARING WAS CONDUCTED.
17 ALTOGETHER, IN THOSE THREE HEARINGS, THREE DOCTORS
18 TESTIFIED AND ALL THREE SUPPORTED THE BAN. AFTER STENBERG, NOT
19 A SINGLE DOCTOR APPEARED LIVE IN CONGRESS TO GIVE THE OPPOSING
20 POINT OF VIEW TO THIS LAW. ONE OF THE THREE DOCTORS THAT
21 TESTIFIED AFTER STENBERG WAS DR. COOK. ANOTHER WAS
22 DR. NEERHOFF (PHONETIC), WHO IS A PARTNER OF DR. SPRANG'S AND
23 WHO IS DR. SPRANG'S CO-AUTHOR ON THE ARTICLE THAT WAS ADMITTED
24 INTO EVIDENCE IN THIS TRIAL. AND DR. NEERHOFF'S TESTIMONY TO
25 CONGRESS REALLY JUST RESTATED THE CONTENTS OF THAT ARTICLE.

1 AND THE THIRD DOCTOR WHO TESTIFIED WAS DR. KATHY
2 ALTMAN, WHO OFFERED TESTIFIED SIMILAR TO DOCTOR NEERHOFF AND
3 DR. COOK.
4 WHILE OTHER PHYSICIANS AND MEDICAL GROUPS MADE
5 WRITTEN SUBMISSIONS INTO THE RECORD IN CONGRESS IN 2002 AND
6 2003, NOBODY ELSE AN APPEARED IN PERSON AND NO NEW INFORMATION
7 IN SUPPORT OF THE BAN WAS PRESENTED TO CONGRESS AFTER THE
8 STENBERG RULING.
9 THERE WAS NO CHANGE OF CIRCUMSTANCE, THERE WAS NO
10 NEW MEDICAL DEVELOPMENT. IT WAS JUST THE SAME EVIDENCE THAT
11 CONGRESS HAD ALREADY HEARD BEFORE STENBERG AND WHICH THE
12 SUPREME COURT WAS WELL AWARE OF AT THE TIME IT ISSUED ITS
13 RULING IN STENBERG BECAUSE THE DISSENTING OPINIONS IN STENBERG
14 ARE REPLETE WITH REFERENCES TO THAT SAME CONGRESSIONAL RECORD.
15 CLEARLY IT WAS MEANINGFUL TO THE DISSENTING JUSTICES; IT DID
16 NOT PERSUADE THE JUSTICES IN THE MAJORITY TO REACH A DIFFERENT
17 RESULT.
18 BUT LEAVING THAT ASIDE, EVEN IF THE GOVERNMENT WERE
19 RIGHT AND TURNER II WERE THE APPLICABLE STANDARD HERE, NO
20 DEFERENCE WOULD BE DUE TO THESE FINDINGS BECAUSE CONGRESS DID
21 NOT DRAW REASONABLE INFERENCES BASED ON SUBSTANTIAL EVIDENCE,
22 THE TURNER II STANDARD.
23 INDEED, THERE IS A COMPLETE ALMOST SURREAL
24 DISCONNECT BETWEEN THE CONGRESSIONAL FINDINGS AND THE EVIDENCE
25 THAT WAS PRESENTED HERE AT TRIAL AND EVEN THE EVIDENCE THAT WAS

1 SUBMITTED TO CONGRESS. MOST BLATANTLY, IF ONE LOOKS AT THE
2 FIRST FINDING, THE FINDING THAT STATES THAT THERE IS A MORAL,
3 MEDICAL, AND ETHICAL CONSENSUS THAT THE PRACTICE OR PERFORMING
4 AN INTACT D&E IS NEVER MEDICALLY NECESSARY, THERE IS NO
5 POSSIBLE BASIS FOR CONGRESS TO HAVE REACHED THAT DETERMINATION.
6 AND IN THEORY, THIS TRIAL WAS ATTORNEY GENERAL
7 ASHCROFT'S OPPORTUNITY TO PROVE THE ACCURACY OF THESE FINDINGS,
8 BUT CERTAINLY HE HAS DONE NOTHING TO ESTABLISH THE TRUTH OF
9 THIS FIRST FINDING. INDEED, SEVERAL OF THE GOVERNMENT'S
10 WITNESSES AGREED THAT THE MEDICAL PROFESSION IS DIVIDED ON THIS
11 QUESTION AS, INDEED, THEY REALLY WOULD HAVE TO AGREE.
12 JUST LOOKING AT THE CONGRESSIONAL RECORD, IT IS
13 CLEAR THAT EVERY MAJOR MEDICAL GROUP THAT WEIGHED IN ON THE
14 FINAL VERSION OF THIS BILL, INCLUDING, BUT CERTAINLY NOT
15 LIMITED TO ACOG AND THE CMA OPPOSED THE BILL. THE ONLY MEDICAL
16 ORGANIZATION TO SUPPORT THE FINAL VERSION OF THIS BILL IN 2003
17 WAS DR. COOK'S GROUP PHACT.
18 MOREOVER, NUMEROUS LETTERS WERE WRITTEN TO CONGRESS
19 FROM PHYSICIANS ON BOTH SIDES OF THIS ISSUE CLEARLY SHOWING A
20 DIVISION OF OPINION ON THIS ISSUE, NOT A CONSENSUS.
21 YOUR HONOR HAD ASKED US SPECIFICALLY TO TALK ABOUT
22 THE INTERRELATION BETWEEN THE CONGRESSIONAL RECORD AND THE
23 RECORD BEFORE THIS COURT. OUR VIEW IS THAT THE FINDINGS ARE
24 ENTITLED TO NO DEFERENCE, BUT THAT THIS COURT SHOULD LOOK TO
25 THE CONGRESSIONAL RECORD AS A WHOLE AND, IN PARTICULAR, THE SIX

1 BINDERS THAT WE SUBMITTED WITH OUR DEFERENCE BRIEF, WHICH
2 INCLUDE ALL OF THE SUBMISSIONS FROM ALL THE MEDICAL
3 PROFESSIONALS AND ALL THE MEDICAL ORGANIZATIONS ON BOTH SIDES
4 OF THE ISSUE, AND FIND THAT THERE IS CLEAR EVIDENCE JUST FROM
5 THOSE BINDERS OF THE DIVISION OF OPINION IN THE MEDICAL
6 PROFESSION ON THIS ISSUE.
7 IF THERE IS CONSENSUS -- WHEN ONE LOOKS AT THAT, IF
8 THERE IS CONSENSUS ABOUT ANYTHING IN THE CONGRESSIONAL RECORD
9 OR IN THIS TRIAL, IT IS THAT THERE IS NO CONSENSUS ABOUT
10 WHETHER INTACT D&E IS SOMETIMES THE BEST PROCEDURE.
11 AND, IN FACT, IN THIS TRIAL, WE HAVE SEEN AT LEAST
12 TWO INSTANCES WHERE PHYSICIANS ON THE SAME FACULTY OF MAJOR
13 MEDICAL SCHOOLS DISAGREE ABOUT THE APPROPRIATENESS OF INTACT
14 D&E.
15 AS AN ADDITIONAL EXAMPLE OF THE LACK OF EVIDENCE FOR
16 THE FINDINGS, SEVERAL OF THE FINDINGS TALK ABOUT THE SUPPOSED
17 MATERNAL HEALTH RISKS FROM INTACT D&E, BUT THREE OF THE
18 GOVERNMENT'S WITNESSES IN THIS CASE, DR. BOWES, DR. CLARK AND
19 DR. LOCKWOOD, ALONG WITH ALL OF THE PLANNED PARENTHOOD'S
20 EXPERTS TESTIFIED THAT THEY DISAGREE WITH THESE PARTICULAR
21 FINDINGS OR THINK THAT THE WAY THE FINDINGS WERE WRITTEN WAS
22 OVERSTATED.
23 AND EVEN ON THE FACE OF THE LAW, THE PROTECTION OF
24 MATERNAL HEALTH FINDINGS SIMPLY MAKE NO SENSE. IF INTACT D&E
25 REALLY THREATENED MATERNAL HEALTH, CERTAINLY CONGRESS WOULD

1 HAVE SOUGHT TO BAN ITS USE REGARDLESS OF WHETHER THE FETUS WERE
2 LIVING OR FETAL DEMISE HAD BEEN INDUCED WITH KCL RIGHT BEFORE
3 THE ABORTION WERE PERFORMED.
4 FINALLY, WITH RESPECT TO THE CONGRESSIONAL FINDINGS,
5 FINDING 14B ASSERTS THAT NO HEALTH EXCEPTION IS NEEDED BECAUSE
6 THERE IS AN ABSENCE OF CONTROLLED STUDIES, AN ABSENCE OF
7 ARTICLES IN PEER-REVIEW JOURNALS AND BECAUSE NO MEDICAL SCHOOLS
8 TEACH INTACT D&E IN THEIR CURRICULUM. THERE'S SEVERAL THINGS
9 TO SAY ABOUT THIS.
10 FIRST, THE FINDING IS CLEARLY INCORRECT AS OF 2004.
11 DR. CHASEN HAS NOW DONE A CONTROLLED STUDY, WHICH IS ABOUT TO
12 BE RELEASED IN A PEER-REVIEWED JOURNAL, AND EXPERTS ON BOTH
13 SIDES AGREE THAT INTACT D&E IS TAUGHT IN MEDICAL SCHOOLS AT
14 NYU, COLUMBIA, CORNELL AND NORTHWESTERN AT A MINIMUM, PERHAPS
15 ELSEWHERE.
16 BUT THIS FINDING IS ESPECIALLY NOTABLE BECAUSE OF
17 ITS LEGAL IRRELEVANCE UNDER STENBERG. IN STENBERG, THE COURT
18 SPECIFICALLY ACKNOWLEDGED THE LACK OF CONTROLLED STUDY AND
19 CITED IT AS A REASON THAT A HEALTH EXCEPTION IS NECESSARY.
20 NOW, FOR CONGRESS TO COME BACK THREE YEARS LATER AND
21 USE LACK OF CONTROLLED STUDY AS A REASON NOT TO HAVE A HEALTH
22 EXCEPTION IS SIMPLY EVIDENCE THAT CONGRESS WAS NOT -- WAS
23 TRYING TO UNDO THE STENBERG RULING THROUGH LEGISLATION AS
24 OPPOSED TO APPLY IT AND SIMPLY MAKE ADDITIONAL FACT FINDING.
25 THEY WERE REALLY TRYING TO ALTER THE LEGAL STANDARD

1 IN THE WAY THAT THEY MADE THOSE FINDINGS WHICH, UNDER THE CITY
2 OF BURNEY CASE, IS AN ABUSE OF CONGRESSIONAL POWER.
3 SO, BECAUSE NO DEFERENCE IS DUE THE FINDINGS UNDER
4 ANY STANDARD, STENBERG'S HOLDING THAT A HEALTH EXCEPTION IS
5 REQUIRED REMAINS APPLICABLE AND UNDER OUR VIEW OF STENBERG, THE
6 ACT IS PER SE UNCONSTITUTIONAL BECAUSE OF THE LACK OF A HEALTH
7 EXCEPTION.
8 BUT EVEN IF THE HEALTH EXCEPTION IS NOT A PER SE
9 REQUIREMENT, THE EVIDENCE PRESENTED DURING THIS TRIAL
10 DEMONSTRATES THE NEED FOR A HEALTH EXCEPTION EVEN IF THE ACT IS
11 CONSTRUED AS APPLYING ONLY TO INTACT D&E'S.
12 IT'S IMPORTANT TO REMEMBER THAT UNDER STENBERG, AN
13 ABORTION BAN MUST CONTAIN A HEALTH EXCEPTION BOTH WHEN THE
14 PREGNANCY ITSELF CREATES A THREAT TO HEALTH AND ALSO WHERE
15 STATE REGULATIONS FORCE WOMEN TO USE RISKIER METHODS OF
16 ABORTION.
17 THIS MEANS THAT THE HEALTH EXCEPTION MUST APPLY BOTH
18 WHEN THE WOMAN IS TERMINATING HER PREGNANCY DUE TO A SERIOUS
19 MEDICAL CONDITION OF THE KIND THAT THE GOVERNMENT WITNESSES,
20 SUCH AS DR. COOK, FOCUSSED ON IN THEIR TESTIMONY, AS WELL AS
21 WHEN THE WOMAN ENDS HER PREGNANCY FOR ANOTHER REASON, AN INTACT
22 D&E IS SIMPLY THE SAFEST PROCEDURE FOR HER IN THE JUDGMENT OF
23 HER PHYSICIAN.
24 ATTORNEY GENERAL ASHCROFT REPEATEDLY USED THE TERM
25 "MEDICAL NECESSITY" THROUGHOUT THE FILINGS IN THE CASE AND

1 THROUGHOUT THE OPINIONS OF HIS EXPERTS. AND IN DOING SO, HE
2 APPEARS TO BE SUGGESTING THAT ALL SECOND-TRIMESTER ABORTIONS
3 OTHER THAN THOSE THAT ARE MEDICALLY NECESSARY ARE SOMEHOW FAIR
4 GAME FOR BEING BANNED, EVEN IF THEY ARE PREVIABILITY. BUT THAT
5 SIMPLY IS NOT THE CASE. MEDICAL NECESSITY IS NOT THE
6 APPLICABLE LEGAL STANDARD FOR PREVIABILITY ABORTIONS BY ANY
7 METHOD.
8 UNDER ROE, CASEY, AND STENBERG, AND MANY CASES IN
9 BETWEEN, REGARDLESS OF THE DEEPLY-HELD REASON THAT A WOMAN
10 CHOOSES TO HAVE A PREVIABILITY ABORTION, AND THAT DECISION IS
11 OBVIOUSLY HERS ALONE TO MAKE, SHE HAS THE CONSTITUTIONAL RIGHT
12 TO HAVE THE ABORTION BY THE SAFEST METHOD.
13 AND THEN, AGAIN, AS TO THE EVIDENCE THAT WAS
14 PRESENTED HERE, THE EVIDENCE SHOWS THAT THIS LAW WOULD BAN
15 D&E'S BOTH WHEN WOMEN NEED AN INTACT D&E FOR A PARTICULAR
16 MEDICAL CONDITION OF THE SORT THAT DR. BROEKHUIZEN TALKED
17 ABOUT, HE GAVE THREE VERY CONCRETE EXAMPLES OF SPECIFIC
18 SITUATIONS WHERE BECAUSE OF A MATERNAL OR FETAL CONDITION,
19 INTACT D&E WAS ABSOLUTELY THE SAFEST FOR THAT WOMAN AND HE TOOK
20 SPECIAL STEPS TO ENSURE ENOUGH DILATION THAT HE COULD ACHIEVE
21 THE ABORTION USING AN INTACT EXTRACTION.
22 BUT ALSO SEVERAL OTHER PHYSICIANS, INCLUDING
23 DRS. WESTHOFF AND CHASEN TESTIFIED THAT FOR ANY WOMAN, IN ANY
24 CIRCUMSTANCE, THEY SEE INTACT D&E AS THE SAFEST METHOD OF
25 ABORTION FOR ANY WOMAN AND THEY ATTEMPT TO DO SO IN EVERY

1 ABORTION AFTER 19 OR 20 WEEKS' GESTATION. AND THEY TESTIFIED
2 THAT WOMEN IN COMPROMISED MEDICAL CONDITIONS HAVE THE MOST TO
3 BENEFIT WHEN THEY SUCCEED IN OBTAINING AN INTACT EXTRACTION
4 BECAUSE WOMEN IN COMPROMISED MEDICAL CONDITIONS ARE LESS ABLE
5 TO TOLERATE EVEN A MINOR COMPLICATION FROM THE ABORTION.
6 AND, AGAIN, EVERYONE AT PLANNED PARENTHOOD'S EXPERTS
7 AGREED THAT INTACT EXTRACTION HAS SAFETY BENEFITS FOR EVERY
8 WOMAN BECAUSE IT REDUCES THE INSTRUMENTATION OF THE UTERUS, IT
9 MINIMIZES THE CHANCES OF CERVICAL LACERATION FOR BRINGING THE
10 BONEY PARTS THROUGH THE CERVIX, IT REDUCES THE CHANCE OF
11 RETAINED TISSUE, AND IT MAY REDUCE BLOOD LOSS AND OPERATING
12 TIME.
13 INTERESTINGLY, ALL OF PLAINTIFFS' EXPERTS, I
14 BELIEVE, TESTIFIED THAT AT SOME POINT IN THEIR CAREER THEY HAD
15 PERFORATED A WOMAN'S UTERUS OR LACERATED THE UTERUS IN THE
16 COURSE OF DOING A DISARTICULATION D&E, BUT NOT A SINGLE ONE OF
17 PLANNED PARENTHOOD'S EXPERTS HAD THAT TYPE OF A COMPLICATION
18 WHEN DOING AN INTACT EXTRACTION.
19 AND FINALLY, OBVIOUSLY, DR. CHASEN'S STUDY, WHICH WE
20 HEARD ABOUT THIS MORNING, SHOWED THE SAME COMPLICATION RATES
21 FOR THE TWO VARIANTS, BUT BECAUSE THE GESTATIONAL AGE FOR THE
22 INTACT VARIANT COHORT WAS SO MUCH GREATER, IT STRONGLY
23 SUGGESTED BOTH DR. CHASEN AND DR. WESTHOFF, WHO TESTIFIED ABOUT
24 IT, THAT THERE WERE SIGNIFICANT SAFETY ADVANTAGES TO USING THE
25 INTACT D&E BECAUSE YOU WOULD HAVE EXPECTED A MUCH HIGHER

1 COMPLICATION RATE IN THAT OLDER GESTATIONAL AGE COHORT, BUT
2 INSTEAD YOU FOUND THE SAME COMPLICATION RATE.
3 NOW, NOT ONLY ARE THESE VIEWS HELD BY PLAINTIFFS'
4 EXPERTS, THESE ARE THE VIEWS OF SIGNIFICANT MEDICAL
5 ORGANIZATIONS IN THIS COUNTRY, INCLUDING ACOG, CMA, THE APHA,
6 THE AMERICAN MEDICAL WOMEN'S ASSOCIATION -- I'M SORRY, THE APHA
7 IS THE AMERICAN PUBLIC HEALTH ASSOCIATION, AND MOREOVER, IN THE
8 DEPOSITION OF DR. JOANNE CAIN, WHO IS THE CHAIR OF THE OB/GYN
9 DEPARTMENT AT OREGON HEALTH SCIENCES UNIVERSITY AND WHO IS
10 ACOG'S DESIGNATED REPRESENTATIVE IN ITS DEPOSITION IN THIS
11 CASE, SHE TESTIFIED THAT ACOG ASSEMBLED A SELECT PANEL OF
12 EXPERTS TO LOOK AT THIS ISSUE, THAT THEY CONSIDERED 25 TO 30
13 DIFFERENT TYPES OF CASES WHERE INTACT D&E'S IS USED AND
14 CONCLUDED THAT THERE WERE INDIVIDUAL PATIENTS FOR WHOM THIS WAS
15 THE BEST CHOICE.
16 SO, GIVEN THE JUDGMENT OF THESE MEDICAL
17 ORGANIZATIONS, ALL OF THE ONES WHO I MENTIONED WERE ACTUALLY
18 DEPOSED IN THIS CASE AND YOUR HONOR HAS THE DEPOSITIONS, AND
19 THE OPINIONS OF PLAINTIFFS' EXPERTS ON THIS POINT, IT SEEMS
20 CLEAR THAT THERE IS A SIGNIFICANT BODY OF MEDICAL OPINION, THE
21 STANDARD IS STATED IN STENBERG, THAT INTACT D&E IS SOMETIMES
22 SAFER FOR THE PATIENT. AND INDEED, THE GOVERNMENT'S WITNESS,
23 DR. LOCKWOOD, AGREED AS MUCH IN HIS DEPOSITION.
24 AT A MINIMUM, THERE IS A DIVISION OF OPINION AMONG
25 MEDICAL EXPERTS, AN ABSENCE OF CONTROLLED STUDIES AND A HIGHLY

1 PLAUSIBLE RECORD BASED EXPLANATION OF WHY INTACT D&E MAY BE
2 SAFER. THUS, UNDER EITHER FORMULATION OF THE STENBERG TEST,
3 EITHER THE SIGNIFICANT BODY TEST OR THE DIVISION OF OPINION
4 TEST, CONGRESS WAS REQUIRED TO INCLUDE A HEALTH EXCEPTION IN
5 THIS LAW AND THE FAILURE TO DO SO IS YET A FURTHER REASON TO
6 FIND THE LAW UNCONSTITUTIONAL.
7 GIVEN THAT THERE IS A SIGNIFICANT BODY OF MEDICAL
8 OPINION ON THIS POINT THAT INTACT D&E IS SOMETIMES SAFER, IT IS
9 ACTUALLY LEGALLY IRRELEVANT UNDER STENBERG WHETHER OR NOT
10 DEFENDANT'S EXPERTS HOLD THE OPPOSITE OPINION.
11 STENBERG CONTEMPLATES THE DIVISION OF OPINION; THE
12 FACT DEFENDANT'S EXPERTS DISAGREE SIMPLY GOES TO THE FACT THERE
13 IS A DIVISION OF OPINION HERE. BUT IT STILL IS SOMEWHAT
14 ILLUMINATING TO LOOK AT THEIR OPINIONS ON THE RELATIVE SAFETY
15 OF INTACT D&E AS COMPARED WITH D&E.
16 IT IS NOTABLE THAT SOME OF THE GOVERNMENT'S
17 WITNESSES, LOCKWOOD, BOWES AND SHADIGIAN, ACTUALLY SEEM TO
18 AGREE THAT INTACT D&E IS AT LEAST COMPARABLY SAFE TO D&E AT THE
19 SAME GESTATIONAL AGES. AND DRS. SPRANG AND COOK SEEM TO AGREE
20 WITH THAT PROPOSITION IF YOU LEAVE ASIDE THEIR CONCERNS ABOUT
21 THE POTENTIAL LONG-TERM EFFECTS ON THE CERVIX ABOUT WHICH THERE
22 IS REALLY NO CONCLUSIVE EVIDENCE.
23 ON THE WHOLE, THERE WAS VIRTUALLY NO EVIDENCE ON THE
24 GOVERNMENT'S PART OF ANY SHORT-TERM HEALTH CONCERNS RELATED TO
25 INTACT D&E'S AS COMPARED TO D&E'S WITH DISARTICULATION.

1 NOTABLY, THE GOVERNMENT'S WITNESS DR. LOCKWOOD DEEMS
2 INTACT D&E SAFE ENOUGH TO ALLOW IT TO HAVE BEEN USED IN HIS
3 DEPARTMENT AT NYU AND HE WOULD HAVE NO PROBLEM WITH IT BEING
4 USED AT HIS DEPARTMENT AT YALE. SEVERAL OF THE GOVERNMENT'S
5 WITNESSES AGREED THAT REDUCING INSTRUMENTATION IN THE UTERUS
6 HAS INTUITIVE BENEFITS.
7 SO, I THINK ONLY -- ALTOGETHER ONLY ONE OF THE
8 GOVERNMENT'S WITNESSES, DR. CLARK, WHO DIDN'T APPEAR HERE AND
9 WHO WE DIDN'T REALLY HAVE A CHANCE TO CROSS-EXAMINE WAS
10 UNEQUIVOCAL IN HIS VIEW THAT D&E IS ALWAYS SAFER THAN INTACT
11 D&E, BUT HE ALSO BELIEVES D&E AND INTACT D&E ARE VERY DISTINCT
12 PROCEDURES AND THAT JUST HAS SIMPLY BEEN SHOWN UNTRUE BY THE
13 TESTIMONY IN THIS CASE.
14 THE PREDOMINANT CONCERN OF THE JUSTICE DEPARTMENT
15 WITNESSES ABOUT INTACT D&E SEEMS RELATED TO THE THEORETICAL
16 LONG-TERM IMPACT ON THE CERVIX OF THE DILATION PART OF THE
17 PROCEDURE.
18 BUT THERE IS TWO THINGS TO BE SAID ABOUT THAT. ONE
19 IS THAT NONE OF THE WITNESSES THAT TESTIFIED HERE TESTIFIED
20 THAT THEY DO THE DILATION PROCESS ANY DIFFERENTLY FOR D&E WITH
21 DISARTICULATION OR D&E WITH INTACT EXTRACTION. SO, AGAIN, IF
22 THERE ARE CERVICAL IMPLICATIONS, WHICH IS HIGHLY UNCERTAIN, IT
23 WOULD APPLY TO ALL D&E'S, NOT JUST TO INTACT D&E'S.
24 AND SECONDLY, THE ONLY STUDY THAT'S ACTUALLY
25 DIRECTLY ON POINT ON THIS WAS DR. CHASEN'S STUDIES WHICH WE

1 HEARD ABOUT THIS MORNING, WHICH INDICATES THAT THIS CONCERN IS
2 UNWARRANTED. IN FACT, IN DR. CHASEN'S SECOND STUDY, THE WOMEN
3 WHO HAD HAD MORE -- ACTUALLY, IN HIS FIRST STUDY, THE WOMEN WHO
4 HAD MORE CERVICAL DILATION HAD A LOWER RISK OF CERVICAL
5 PROBLEMS IN FUTURE PREGNANCIES.
6 I FEEL LIKE I NEED TO ADDRESS BRIEFLY THE WHOLE
7 ISSUE ABOUT THE STUDIES BECAUSE WE'VE HEARD SO MUCH EVIDENCE IN
8 THIS TRIAL ABOUT STUDIES AND RANDOMIZED STUDIES AND RANDOMIZED
9 CLINICAL TRIALS, AND IT IS REALLY UNCLEAR HOW IT FITS INTO THIS
10 PICTURE AT ALL ESPECIALLY BECAUSE THE SUPREME COURT ALREADY
11 RULED THAT THE ABSENCE OF CONTROLLED STUDIES IS A REASON TO
12 INCLUDE A HEALTH EXCEPTION, NOT A REASON TO EXCLUDE A HEALTH
13 EXCEPTION.
14 BUT CERTAINLY THE ABSENCE OF RANDOMIZED STUDIES --
15 WE NOW HAVE A RETROSPECTIVE STUDY, WE DON'T HAVE A RANDOMIZED
16 STUDY -- BUT THE ABSENCE OF RANDOMIZED STUDIES BY ITSELF
17 CERTAINLY CAN'T CAST DOUBT ON THE SAFETY OF INTACT D&E'S.
18 AS DR. PAUL EXPLAINED, UNDER THE SYSTEM OF
19 EVIDENCE-BASED MEDICINE WHERE THERE ARE GOOD STUDIES,
20 PHYSICIANS SHOULD APPLY THE RESULTS TO THEIR PRACTICE. AND
21 WHERE THERE ARE NO GOOD STUDIES, PHYSICIANS SHOULD USE THEIR
22 CLINICAL JUDGMENT.
23 AND THE FACT IS THAT MANY HIGHLY-TRAINED,
24 WELL-RESPECTED, WELL-CREDENTIALED PHYSICIANS, INCLUDING MANY OF
25 WHOM HAVE TESTIFIED HERE IN THIS COURT OR BY DEPOSITION,

1 BELIEVE IN THEIR CLINICAL JUDGMENT THAT INTACT D&E IS TIMES
2 SAFER.
3 CONGRESS HAS NO MEDICAL BASIS FOR BANNING THIS
4 TECHNIQUE BASED ON ITS POLITICAL JUDGMENT THAT THESE PHYSICIANS
5 HAVE MADE THE WRONG MEDICAL JUDGMENT. MOREOVER, EVEN IF A
6 RANDOMIZED STUDY OF INTACT D&E COULD BE PERFORMED, REGARDLESS
7 OF ITS RESULTS, SUCH A STUDY WOULD SAY NOTHING ABOUT THE
8 RELATIVE BENEFITS OF INTACT D&E FOR PARTICULAR WOMEN FOR WHOM
9 THIS VARIANT IS SAFER BASED ON A SPECIFIC MEDICAL CONDITION OR
10 PERSONAL SITUATION SUCH AS THE ONES THAT DR. BROEKHUIZEN
11 TESTIFIED ABOUT.
12 NO RANDOMIZED STUDY WOULD ADDRESS WHETHER A WOMAN
13 WITH SCLERODERMA AND CONGESTIVE HEART FAILURE WOULD BE
14 BENEFITED BY USE OF INTACT D&E BECAUSE CLEARLY IF THERE WERE A
15 RANDOMIZED STUDY OF THIS PROCEDURE, A WOMAN IN SUCH A SERIOUS
16 MEDICAL CONDITION WOULD BE EXCLUDED FROM THE STUDY.
17 AND I HAVE TO COMMENT ON THE EXTRAORDINARY IRONY
18 THAT THROUGHOUT THIS CASE, THE GOVERNMENT AND ITS WITNESSES
19 HAVE QUESTIONED THE VALIDITY OF PLAINTIFFS' EXPERTS OPINIONS
20 BECAUSE THEY ARE BASED ON CLINICAL JUDGMENT.
21 THE GOVERNMENT HAS REPEATEDLY SUGGESTED THAT
22 INTUITION, BASED ON CLINICAL EXPERIENCE, IS UNSCIENTIFIC AND
23 DOESN'T MEET THE STANDARDS OF EVIDENCE-BASED MEDICINE. YET,
24 YESTERDAY THE GOVERNMENT PUT ON DR. ANAND, WHOSE ENTIRE
25 TESTIMONY IS BASED NOT ON RANDOMIZED PROSPECTIVE STUDY, NOT ON

1 RETROSPECTIVE STUDY, NOT ON CLINICAL JUDGMENT, WHICH HE DOESN'T
2 HAVE IN THIS PARTICULAR AREA, BUT ONLY ON INFERENCE AND
3 EXTRAPOLATION.
4 NOW, NOT ONLY IS DR. ANAND'S TESTIMONY TOO
5 SPECULATIVE FROM A SCIENTIFIC STANDPOINT TO BE RELIED ON UNDER
6 RULE 702 AND 703, THE QUESTION OF WHETHER OR NOT A FETUS CAN
7 EXPERIENCE PAIN PRIOR TO VIABILITY IS IRRELEVANT AS A MATTER OF
8 LAW.
9 IN STENBERG, THE COURT HELD AT PAGE 931: "WE CANNOT
10 SEE HOW THE INTEREST RELATED DIFFERENCES COULD MAKE ANY
11 DIFFERENCE TO THE QUESTION AT HAND; NAMELY, THE APPLICATION OF
12 THE HEALTH REQUIREMENT."
13 AND THAT IS THE LAW, AND IT RENDERS DR. ANAND'S
14 OPINIONS SIMPLY IRRELEVANT HERE, NOR SHOULD THIS COURT CREDIT
15 CONGRESS' FINDING ON THIS SUBJECT THAT THIS IS A QUOTE "MEDICAL
16 FACT" UNQUOTE, BOTH GIVEN ITS LEGAL IRRELEVANCE AND THE FACTUAL
17 UNCERTAINTY SURROUNDING IT. CERTAINLY, THERE IS NOT
18 SUBSTANTIAL EVIDENCE TO SUPPORT THAT THIS IS A MEDICAL FACT.
19 SO FOR ALL OF THOSE REASONS THIS COURT SHOULD FIND
20 THAT A HEALTH EXCEPTION WAS NECESSARY IN THIS LAW AND THE FACT
21 THAT THERE IS NO HEALTH EXCEPTION IS GROUNDS, ADDITIONAL
22 GROUNDS FOR STRIKING THE LAW DOWN.
23 I WANT TO MENTION BRIEFLY THAT EVEN IF THIS COURT
24 CONCLUDES THAT THE ACT BANS ONLY INTACT D&E'S AND THAT SOMEHOW
25 INTACT D&E IS NOT SAFER THAN D&E WITH DISARTICULATION, BUT IS

1 ONLY COMPARABLY SAFE, WHICH WAS THE VIEW EXPRESSED BY MANY OF
2 THE GOVERNMENT'S WITNESSES, THE ACT WOULD STILL VIOLATE A
3 WOMAN'S RIGHT TO BODILY INTEGRITY, WHICH IS A COMPONENT OF THE
4 PRIVACY RIGHT, AND IT WOULD DO SO BUT BY DENYING THE WOMEN THE
5 OPPORTUNITY TO CHOOSE A SAFE ABORTION METHOD EVEN IF IT IS NOT
6 A SAFER ABORTION METHOD.
7 GIVEN THE SAFETY OF INTACT D&E, EVEN IF IT IS NOT
8 SAFER THAN DISARTICULATION D&E, THERE STILL IS NO REASON TO BAN
9 IT ESPECIALLY BECAUSE SOME WOMEN MAY HAVE VERY PERSONAL AND
10 PARTICULAR REASONS TO CHOOSING AN INTACT D&E SUCH AS THE DESIRE
11 FOR AN INTACT FETUS FOR PATHOLOGY REASONS AND THEY MAY WANT
12 THAT INTACT FETUS WITHOUT HAVING TO UNDERGO LABOR. TO PUT THE
13 WOMAN IN THE POSITION WHERE SHE HAS TO UNDERGO LABOR IN ORDER
14 TO GET AN INTACT FETUS FOR PATHOLOGY PURPOSES FORCES HER TO
15 PICK A MORE INTRUSIVE TYPE OF ABORTION THAN SHE WOULD OTHERWISE
16 CHOOSE AND VIOLATES HER CONSTITUTIONAL RIGHT TO BODILY
17 INTEGRITY.
18 NOW, LOOKING AT THE CREDIBILITY OF THE WITNESSES
19 THAT APPEARED HERE, PLAINTIFFS' CASE CONSISTED OF EIGHT
20 OBSTETRICIAN/GYNECOLOGISTS WHO TESTIFIED IN PERSON, AND THREE
21 OB/GYN'S WHO TESTIFIED BY DEPOSITION, AND A PATHOLOGIST WHO
22 TESTIFIED BY DEPOSITION.
23 THE OB/GYN'S ON PLANNED PARENTHOOD'S SIDE OF THE
24 CASE ARE CLEARLY LEADING EXPERTS IN THE SPECIALIZED FIELD OF
25 ABORTION AND CONTRACEPTION. MANY OF THE INSTITUTIONS AT WHICH

1 THEY PRACTICE ARE AT THE FOREFRONT OF PROVIDING AND TEACHING
2 ABORTION METHODS, MANY OF THEM THROUGH THE SPECIAL FAMILY
3 PLANNING FELLOWSHIP THAT THERE WAS TESTIMONY ABOUT.
4 IN ADDITION, DR. PAUL IS THE EDITOR IN CHIEF OF WHAT
5 EVEN DEFENDANT'S EXPERTS ACKNOWLEDGE IS THE LEADING TEXTBOOK IN
6 THE FIELD OF ABORTION CARE. FOR SOME OF OUR WITNESSES,
7 ESPECIALLY THE ONES WITH HIGH RISK OB/GYN PRACTICES, ABORTION
8 IS A SMALL BUT IMPORTANT PART OF THE CARE THAT THEY PROVIDE AND
9 IT'S PROVIDED EXCLUSIVELY IN A HOSPITAL SETTING. FOR OTHERS,
10 IT IS A LARGER PERCENTAGE OF THEIR PRACTICE AND THESE
11 PHYSICIANS PROVIDE ABORTIONS BOTH IN HOSPITAL AND CLINIC
12 SETTINGS.
13 MANY OF OUR EXPERTS PUBLISHED EXTENSIVELY IN THE
14 FIELD OF ABORTION CARE --
15 THE COURT: SLOW DOWN. I WILL GIVE YOU A FEW EXTRA
16 MINUTES SO YOU DON'T KILL OUR COURT REPORTER.
17 (LAUGHTER.)
18 MS. GARTNER: THANK YOU.
19 MANY OUR EXPERTS HAVE PUBLISHED EXTENSIVELY IN THE
20 FIELD OF ABORTION CARE AND HAVE PERFORMED STUDIES, INCLUDING
21 RANDOMIZED STUDIES RELATING TO ABORTION.
22 IN ADDITION, THREE OF PLAINTIFFS' EXPERTS,
23 DRS. PAUL, CREININ AND WESTHOFF, HAVE ADVANCED DEGREES IN
24 EPIDEMIOLOGY OR PUBLIC HEALTH WITH THE SPECIALIZATION IN
25 EPIDEMIOLOGY AND/OR HAVE PROFESSORSHIP IN PUBLIC HEALTH IN

1 ADDITION TO OBSTETRICS AND GYNECOLOGY.
2 YOUR HONOR HAD ASKED US TO COMPARE THE QUALITY OF
3 THE WITNESSES IN THIS TRIAL TO THOSE THAT TESTIFIED BEFORE
4 CONGRESS, AND AS I STATED EARLIER, NOT A SINGLE PHYSICIAN
5 TESTIFIED IN CONGRESS AFTER STENBERG, WHO ACTUALLY OPPOSED THE
6 BAN.
7 BUT EVEN BEFORE STENBERG, THERE WAS REALLY NO
8 TESTIMONY FROM SECOND-TRIMESTER ABORTION PROVIDERS WHO EVER
9 PERFORMED, AS FAR AS I KNOW, INTACT D&E PROCEDURES, AND THAT IS
10 GOING BACK TO 1995.
11 THE TESTIMONY THAT YOUR HONOR HEARD HERE BOTH IN
12 PERSON AND DEPOSITION SO FAR EXCEEDS THE QUALITY OF THE
13 EVIDENCE BEFORE CONGRESS IN TERMS OF BOTH THE BREADTH, THE
14 SCOPE, AND THE EXPERTISE OF THE PEOPLE THAT ARE TESTIFYING.
15 ON DEFENDANT'S SIDE OF THE CASE, THE GOVERNMENT
16 PRESENTED THE LIVE TESTIMONY HERE OF FOUR OB/GYN'S AND THE
17 DEPOSITION TESTIMONY OF TWO OB/GYN'S. OF THESE WITNESSES, NONE
18 HAS ABORTION AS AN AREA OF SPECIALIZATION. INDEED, FOR ALL OF
19 THE GOVERNMENT'S WITNESSES, ABORTION IS AN EXTRAORDINARILY RARE
20 PART OF THEIR PRACTICE, NONE HAS PUBLISHED IN THE FIELD OF
21 ABORTION METHODS, THOUGH DR. SHADIGIAN DID PUBLISH ON THE
22 LONG-TERM CONSEQUENCES OF ABORTION, NONE HAS DONE RESEARCH IN
23 THIS FIELD. IN ADDITION, NONE HAS AN ADVANCED DEGREE OR
24 SPECIALIZATION IN EPIDEMIOLOGY OR PUBLIC HEALTH.
25 IT'S NOT SURPRISING THAT NO PHYSICIAN WHO REGULARLY

1 PROVIDES SECOND-TRIMESTER SURGICAL ABORTIONS WAS WILLING TO
2 TESTIFY FOR THE GOVERNMENT IN THIS CASE. THE BOTTOM LINE IS
3 THAT ANY PHYSICIAN WHO HAS ANY SIGNIFICANT EXPERIENCE DOING
4 SECOND-TRIMESTER ABORTIONS WILL UNDERSTAND HOW DANGEROUS THIS
5 LAW IS. BUT, EVEN GIVEN THAT IT WAS HIGHLY DOUBTFUL THAT ANY
6 PHYSICIAN WHO ROUTINELY DOES SECOND-TRIMESTER ABORTIONS WOULD
7 TESTIFY IN SUPPORT OF THIS LAW, IT IS NOTABLE THAT SO MANY OF
8 THE GOVERNMENT'S EXPERTS, AND ALL OF THE ONES THAT CAME TO
9 TESTIFY LIVE IN THIS COURT ARE SUCH ZEALOUS AND VOCAL ADVOCATES
10 AGAINST INTACT D&E AND/OR AGAINST ABORTION IN GENERAL.
11 EACH AND EVERY ONE OF THE OB/GYN'S THAT TESTIFIED
12 LIVE FOR THE GOVERNMENT HAD PREVIOUSLY TESTIFIED IN OTHER
13 CASES, EITHER INVOLVING BANS ON SO-CALLED PARTIAL-BIRTH
14 ABORTION OR OTHER TYPES OF ABORTION RESTRICTIONS BY ANY METHOD.
15 IN CONTRAST, OF PLAINTIFFS' EIGHT EXPERT OB/GYN'S
16 WHO TESTIFIED HERE IN PERSON, ONLY TWO HAD EVER TESTIFIED
17 PREVIOUSLY IN ANY CASE INVOLVING ANY ABORTION RESTRICTION.
18 AGAIN, FOCUSING ON THE GOVERNMENT'S EXPERTS WHO
19 TESTIFIED HERE IN PERSON, THEIR BIASES AGAINST ABORTION
20 GENERALLY AND THEIR STRONG PREFERENCE IN FAVOR OF INDUCTION IN
21 THE RARE CASES THAT THEY THINK ABORTION IS NECESSARY, HAVE LED
22 THEM TO MEDICAL PRACTICES THAT DEPRIVE THEIR PATIENTS OF FULL
23 INFORMATION ABOUT THE RANGE OF SAFE CHOICES FOR ABORTION.
24 AND LET ME EXPLAIN WHAT I MEAN BY THAT BY FIRST
25 EXPLAINING OUR, THE PLANNED PARENTHOOD'S EXPERTS VIEWS ON THE

1 CHOICE OF ABORTION METHODS IN THE SECOND TRIMESTER AND
2 ESPECIALLY AFTER 20 WEEKS.
3 PLAINTIFFS' EXPERTS ALL STATED THAT D&E AND
4 INDUCTION ARE BOTH SAFE CHOICES FOR A WOMAN AFTER 20 WEEKS'
5 GESTATION SO LONG AS THERE IS NOT A SPECIAL CONTRAINDICATION TO
6 THE INDUCTION, SUCH AS A PRIOR UTERINE SCAR, AND THAT WOMAN
7 SHOULD CHOOSE THE METHOD THAT IS MOST APPROPRIATE FOR HER BASED
8 ON A RANGE OF CONSIDERATIONS AFTER BEING GIVEN FULL
9 INFORMATION.
10 PLAINTIFFS' EXPERTS ALL TESTIFIED THAT THEY PROVIDE
11 THEIR PATIENTS WITH A CHOICE BETWEEN D&E OR INDUCTION, AND I
12 THINK FOR THE MOST PART, BUT NOT ALL OF OUR EXPERTS SAID THAT
13 MOST OF THEIR PATIENTS CHOOSE D&E. DR. BROEKHUIZEN REALLY
14 CAN'T PERFORM D&E'S FOR HIS PATIENTS AND MOST OF HIS PATIENTS
15 ACTUALLY CHOOSE INDUCTION, BUT HE OFFERS THEM BOTH CHOICES AND
16 THEY CAN CHOOSE.
17 IN CONTRAST TO PLAINTIFFS' EXPERTS, DRS. COOK AND
18 SPRANG BOTH TESTIFIED THAT THEY CONSIDER D&E AFTER 20 WEEKS TO
19 BE VERY RISKY. INDEED, DR. COOK EXPRESSED A VIEW THAT AFTER 20
20 WEEKS, D&E PRESENTS SIGNIFICANT RISKS FOR MATERNAL MORTALITY
21 AND IN HIS VIEW, HYSTEROTOMY IS SAFER IN THAT TIME FRAME EVEN
22 RECOGNIZING THAT HYSTEROTOMY HAS SERIOUS IMPLICATIONS FOR THE
23 WOMAN'S FUTURE CHILDBEARING.
24 THIS TESTIMONY ABOUT THE RISKINESS OF D&E COMPARED
25 TO INDUCTION AND ESPECIALLY DR. COOK'S PREFERENCE FOR

1 HYSTEROTOMY OVER D&E FLIES IN THE FACE OF 30 YEARS OF DATA FROM
2 THE CDC AND ELSEWHERE AS DR. PAUL AND OTHERS TESTIFIED, AND THE
3 HYSTEROTOMY OPINION IS DIRECTLY CONTRADICTED BY, AMONG MANY
4 OTHER THINGS, INCLUDING THE TESTIMONY OF VIRTUALLY ALL OF OUR
5 EXPERTS, BUT THE REPORT OF THE AMA TASK FORCE ON LATE ABORTION
6 OF WHICH DR. SPRANG WAS A MEMBER.
7 AND PERHAPS MOST DISTURBINGLY, NEITHER DR. COOK NOR
8 DR. SPRANG EVEN ADVISED THEIR PATIENTS OF THE OPTION OF D&E BY
9 EITHER VARIANT AFTER 20 WEEKS' GESTATION, AND THIS IS
10 ESPECIALLY NOTABLE FOR DR. SPRANG BECAUSE HE ACKNOWLEDGES THAT
11 TWO OF HIS FACULTY MEMBERS AT NORTHWESTERN PROVIDE D&E'S TO
12 APPROXIMATELY 24 WEEKS, SO IF ONE OF HIS PATIENTS KNEW ABOUT
13 D&E AS AN OPTION AND PREFERRED THAT OPTION, HE COULD REFER THEM
14 TO ONE OF HIS FELLOW FACULTY MEMBERS. HE DOESN'T GIVE THEM
15 THAT OPTION.
16 DR. SPRANG WAS ALSO VERY CLEAR THAT HE THINKS
17 INDUCTION IS PREFERABLE FOR HIS PATIENTS, BUT HE DOESN'T ADVISE
18 HIS PATIENTS AHEAD OF TIME OF THE 10 TO 20 PERCENT STATISTICAL
19 LIKELIHOOD THAT RETAINED PLACENTA WILL OCCUR IN AN INDUCTION
20 AND THAT THE PROCEDURE WOULD NEED TO BE COMPLETED
21 INSTRUMENTALLY.
22 AND DR. COOK WAS SO CONVINCED THAT INDUCTION WAS
23 BETTER THAN D&E DESPITE THE DATA OUT THERE THAT SHOWED
24 FUNDAMENTALLY THAT THEY ARE COMPARABLE, THAT HE PROVIDES
25 PROSTAGLANDIN INDUCTIONS EVEN TO WOMEN WITH A PRIOR UTERINE

1 SCAR, EVEN THOUGH THIS PRACTICE IS DISCOURAGED BY ACOG.
2 NONE OF THE GOVERNMENT'S EXPERTS HAVE EVER
3 PERFORMED, SEEN, TAUGHT, BEEN TAUGHT, OR SUPERVISED AN INTACT
4 D&E IF YOU LEAVE ASIDE THE FACT THAT DR. COOK SAW A VIDEO A FEW
5 YEARS AGO THAT HE HAD A HARD TIME VISUALIZING.
6 THESE EXPERTS, THEREFORE, HAVE NO FIRSTHAND
7 KNOWLEDGE ABOUT HOW THIS TECHNIQUE IS PERFORMED OR ITS
8 POTENTIAL BENEFITS OR RISKS.
9 AS A RESULT OF THEIR LACK OF FIRSTHAND KNOWLEDGE,
10 THE GOVERNMENT'S WITNESSES HAVE A NARROW AND CARICATURED
11 UNDERSTANDING OF WHO WAS USING THIS TECHNIQUE, IN WHAT SETTINGS
12 IT'S BEING USED, UNDER WHAT CIRCUMSTANCES, AND THE POTENTIAL
13 BENEFITS OF DOING SO.
14 FOR EXAMPLE, MANY OF THE GOVERNMENT'S WITNESSES
15 EXPRESSED CONCERN ABOUT WHAT THEY REFER TO AS THE BLIND
16 INSTRUMENTATION OF THE PUNCTURE PART OF THE PROCEDURE. BUT
17 EVERY PHYSICIAN WHO ACTUALLY PERFORMS THIS TECHNIQUE TESTIFIED
18 THAT IT'S DONE UNDER DIRECT VISUALIZATION, IT IS NOT A BLIND
19 MANEUVER.
20 AS ANOTHER EXAMPLE, SEVERAL OF THE GOVERNMENT'S
21 WITNESSES, I THINK MOST NOTABLY DR. SPRANG, TALKED ABOUT THE
22 EXCESSIVE USE OF LAMINARIA. AND I THINK DR. SPRANG TALKED
23 ABOUT USING 20, 25 OR 30 LAMINARIA PRIOR TO AN INTACT D&E.
24 BUT, OF COURSE, DR. SPRANG DOESN'T KNOW SINCE HE HAS NEVER DONE
25 THIS TECHNIQUE.

1 AND, IN FACT, DR. CHASEN THIS MORNING SAID IN HIS
2 SECOND SET OF LAMINARIA INSERTIONS BEFORE A POST-20 WEEK D&E,
3 HE USES EIGHT TO 12 LAMINARIA.
4 I HAVE NO OPINION OF WHETHER 20, 25 OR 30 LAMINARIA
5 IS OR IS NOT TOO MUCH, IT'S JUST THAT THE EVIDENCE HERE WAS
6 THAT THAT IS NOT WHAT'S USED.
7 IN ASSESSING THE CREDIBILITY OF THE GOVERNMENT'S
8 WITNESSES, THIS COURT SHOULD CONSIDER NOT ONLY THAT THE
9 GOVERNMENT'S WITNESSES HAVE NO FIRSTHAND KNOWLEDGE, BUT ALSO
10 THAT THEY HAVE WILLFULLY CHOSEN TO LIMIT THEIR UNDERSTANDING OF
11 THIS PROCEDURE TO WHAT THEY CAN GLEAN FROM READING VERY OLD
12 PRESENTATIONS OF DR. HASKELL AND DR. MCMAHON.
13 DR. SPRANG TESTIFIED THAT HE NEVER SPOKE TO HIS
14 COLLEAGUES AT NORTHWESTERN WHO DO THIS PROCEDURE ABOUT IT.
15 DR. SHADIGIAN TESTIFIED THAT SHE RESPECTS THE CHAIR OF HER
16 DEPARTMENT, DR. JOHNSON, WHO IS A PLAINTIFF IN THE NEW YORK
17 CASE, BUT SHE'S NEVER TALKED TO HIM ABOUT WHY HE IS A PLAINTIFF
18 IN THAT CASE.
19 DR. BOWES RECOGNIZED DR. GRIMES' EXPERTISE IN THE
20 AREA OF D&E, BUT SAID HE NEVER TALKED TO HIM ABOUT IT.
21 AND DR. COOK TESTIFIED THAT HE'S ASKED MANY OTHER
22 HIGH RISK OB/GYN'S ABOUT THE MEDICAL NECESSITY OF INTACT D&E,
23 AND HE SAYS NOT ONE OF THEM HAS EVER SEEN A MEDICAL NECESSITY
24 FOR IT, BUT YET HE HAS NOT LEARNED ABOUT THE PRACTICES OF THE
25 VARIOUS HIGH RISK OB/GYN'S WHO ARE TESTIFYING IN THESE CASES,

1 SUCH AS DR. CHASEN, TO EDUCATE HIMSELF ABOUT HOW, IN FACT,
2 THESE PROCEDURES MAY BE BENEFICIAL.
3 SO FOR ALL OF THESE REASONS, THE COURT SHOULD FIND
4 PLAINTIFFS' EXPERTS MORE CREDIBLE THAN THE GOVERNMENT'S EXPERTS
5 ON THE TESTIMONY THAT WAS PRESENTED HERE.
6 SO, FOR ALL THESE REASONS, BECAUSE PLAINTIFFS HAVE
7 DEMONSTRATED THAT IN ADDITION TO BEING UNCONSTITUTIONAL, THE
8 LAW WOULD ALSO CLEARLY IMPOSE IRREPARABLE INJURY BOTH TO THE
9 HEALTH OF THEIR PATIENTS, TO THE DOCTORS' WELL-BEING, AND
10 BECAUSE IN THIS CIRCUIT, VIOLATION OF A CONSTITUTIONAL RIGHT IS
11 PER SE IRREPARABLE INJURY, THIS COURT SHOULD PERMANENTLY ENJOIN
12 ITS ENFORCEMENT.
13 I WANTED TO JUST TALK BRIEFLY ABOUT THE SCOPE OF THE
14 INJUNCTION, IF THAT IS PERMISSIBLE.
15 THE COURT: YES.
16 MS. GARTNER: IT IS OUR POSITION THAT THE RELIEF
17 NEEDED TO MAKE PLAINTIFFS WHOLE, GIVEN THE SERIOUS
18 CONSTITUTIONAL VIOLATIONS, IS A NATIONWIDE INJUNCTION. THE
19 NINTH CIRCUIT HAS MADE CLEAR THAT A NATIONWIDE INJUNCTION
20 BEYOND JUST THE PLAINTIFFS IS APPROPRIATE IF SUCH BREADTH IS
21 NECESSARY TO GIVE PREVAILING PARTIES THE RELIEF TO WHICH THEY
22 ARE ENTITLED. THAT'S THE RAZGAIL V. BROCK STANDARD.
23 DURING THE ARGUMENT ON THE MOTION FOR TEMPORARY
24 RESTRAINING ORDER LAST NOVEMBER, WE DISCUSSED WHETHER A
25 NATIONWIDE INJUNCTION IS NEEDED TO GIVE PLANNED PARENTHOOD

1 COMPLETE RELIEF. AND IN ISSUING THE TEMPORARY RESTRAINING
2 ORDER, YOUR HONOR INSERTED LANGUAGE THAT THE TRO APPLIES TO
3 PPFA, PLANNED PARENTHOOD GOLDEN GATE, THEIR MEMBERS, OFFICERS,
4 AGENTS, SERVANTS, AND EMPLOYEES, AND TO PERSONS IN ACTIVE
5 CONCERT OR PARTICIPATION WITH PLAINTIFFS, SUCH AS NONAFFILIATE
6 DOCTORS TO WHOM PLAINTIFFS' PATIENTS ARE PREFERRED, WHICH IS
7 THE LANGUAGE FROM RULE 65.
8 WE ARE CONCERNED, HOWEVER, YOUR HONOR, THAT THIS
9 LANGUAGE, EVEN WITH THE ADDITIONAL ACT OF CONCERT,
10 PARTICIPATION LANGUAGE, DOES NOT FULLY PROTECT PLANNED
11 PARENTHOOD AND ITS PATIENTS AND THAT WE WOULD NEED A NATIONWIDE
12 INJUNCTION IN ORDER TO MAINTAIN COMPLETE PROTECTION.
13 THERE ARE PLANNED PARENTHOOD PHYSICIANS WHO WORK
14 ELSEWHERE IN ADDITION TO AT THE PLANNED PARENTHOOD AFFILIATES.
15 TWO OF THE WITNESSES HERE ARE MEDICAL DIRECTORS AT PLANNED
16 PARENTHOOD, BUT HAVE SIGNIFICANT PRACTICES AT HOSPITALS THAT
17 ARE OBVIOUSLY NOT PART OF PLANNED PARENTHOOD AND THAT ARE NOT
18 PROTECTED BY THIS INJUNCTION.
19 IT'S UNCLEAR WHETHER THE ACT OF CONCERT OR
20 PARTICIPATION LANGUAGE PROTECTS THOSE PHYSICIANS WHEN THEY ARE
21 TREATING PATIENTS THAT ARE NOT REFERRED FROM PLANNED PARENTHOOD
22 WHEN THEY ARE AT THEIR HOSPITAL-BASED PRACTICES. IF THEY ARE
23 NOT PROTECTED BY THE INJUNCTION, THEY CAN BE PROSECUTED FOR THE
24 PROCEDURES THAT THEY ARE PERFORMING AT THOSE HOSPITALS.
25 OBVIOUSLY PLANNED PARENTHOOD CANNOT FULLY TAKE CARE

1 OF ITS PATIENTS OR SERVE ITS MISSION IF ITS PHYSICIANS ARE
2 BEING SUBJECT TO PROSECUTION FOR PROCEDURES THAT THEY ARE
3 PERFORMING ELSEWHERE. SO WE WOULD SUBMIT, IN ORDER TO MAKE
4 PLANNED PARENTHOOD WHOLE, A NATIONWIDE INJUNCTION IS NECESSARY.
5 AND I WOULD ALSO ADD THAT WE HAVE ALSO HEARD OF
6 OTHER PHYSICIANS IN THIS CASE, DR. DOE AND DR. GRUNEBAUM WHO
7 ARE NOT PROTECTED BY ANY INJUNCTION AND WHO HAVE SIMPLY STOPPED
8 PERFORMING ABORTIONS.
9 SO, IN CONCLUSION, WITHOUT AN INJUNCTION, PLANNED
10 PARENTHOOD AND ITS PHYSICIANS WHO PROVIDE ABORTIONS WILL BE
11 SUBJECT TO PROSECUTION FOR PROVIDING SAFE MEDICAL CARE. THIS
12 IS SIMPLY UNCONSTITUTIONAL UNDER THE UNDUE BURDEN STANDARD,
13 UNDER THE VAGUENESS TEST BECAUSE IT LACKS A HEALTH EXCEPTION
14 BECAUSE IT VIOLATES WOMEN'S RIGHT TO BODILY INTEGRITY.
15 I WOULD ALSO NOTE THAT, FINALLY, WITHOUT AN
16 INJUNCTION, THERE IS NO DOUBT THAT ATTORNEY GENERAL ASHCROFT
17 WILL SEEK TO ENFORCE THIS LAW AND WILL PROBABLY START BY
18 INVESTIGATING THE PEOPLE WHO HAVE BEEN BRAVE ENOUGH TO TESTIFY
19 IN THIS CASE AND IN THE OTHER TWO CASES BECAUSE THOSE ARE THE
20 PHYSICIANS WHO HAVE TAKEN THE STAND AND PUBLICLY STATED THAT
21 THE ABORTIONS THEY DO WOULD VIOLATE THIS LAW, AND THOSE ARE
22 ABORTIONS THEY DO BECAUSE THEY THINK THEY ARE THE SAFEST FOR
23 THEIR PATIENTS.
24 IN CONDUCTING THE INVESTIGATIONS, IT IS HIGHLY
25 LIKELY THAT ATTORNEY GENERAL ASHCROFT WILL USE THE SAME SORT OF

1 BROADBRUSH SUBPOENA OF MEDICAL RECORDS THAT THEY ATTEMPTED TO
2 USE IN THIS LITIGATION. IT IS, THUS, INEVITABLE THAT THE
3 ENFORCEMENT OF THIS LAW WILL NOT ONLY PUT PHYSICIANS AT RISK OF
4 PROSECUTION AND INFRINGE ON THE RIGHT OF SOME WOMEN TO OBTAIN
5 SECOND-TRIMESTER PREVIABILITY ABORTIONS, BUT WILL ALSO VIOLATE
6 THE INFORMATIONAL PRIVACY RIGHTS OF PLANNED PARENTHOOD'S
7 PATIENTS AS WELL.
8 FOR ALL OF THESE REASONS, WE RESPECTFULLY URGE THE
9 COURT TO PERMANENTLY ENJOIN THE PARTIAL-BIRTH ABORTION BAN ACT
10 OF 2003.
11 THANK YOU. THANK YOU FOR LETTING ME GO OVER.
12 THE COURT: MS. VAN RUNKLE, DO YOU THINK YOU WILL
13 NEED THE ENTIRE HOUR?
14 MS. VAN RUNKLE: NO, I WILL NOT.
15 THE COURT: WE WILL BREAK AFTER YOUR PRESENTATION.
16 MS. VAN RUNKLE: I ESTIMATE ABOUT A HALF HOUR MORE
17 OR LESS.
18 CLOSING ARGUMENT
19 MS. VAN RUNKLE: GOOD AFTERNOON, YOUR HONOR, COUNSEL
20 FOR DEFENSE, COUNSEL FOR PLAINTIFFS.
21 YOUR HONOR, THE CITY OF SAN FRANCISCO JOINED THIS
22 LAWSUIT CHALLENGING THE PARTIAL-BIRTH ABORTION BAN ACT --
23 THE COURT: HOLD THE MICROPHONE CLOSER. YOU HAVE A
24 SOFT TONE.
25 MS. VAN RUNKLE: SORRY. LET ME KNOW.

1 -- OF 2003 BECAUSE CRITICAL PUBLIC HEALTH ISSUES LIE
2 AT THE HEART OF THIS CASE. PRIMARILY AMONG THESE IS THE
3 PATIENT'S RIGHT TO ACCESS THE SURGICAL PROCEDURE THAT SHE AND
4 HER DOCTOR HAVE DECIDED IS THE SAFEST AND MOST MEDICALLY
5 APPROPRIATE COURSE OF ACTION GIVEN HER PERSONAL CIRCUMSTANCES.
6 UNDER THE CONSTITUTIONAL FRAMEWORK THAT APPLIES
7 HERE, THE QUESTIONS WHETHER THE PARTIAL-BIRTH ABORTION BAN ACT
8 OF 2003 CREATE THE UNDUE BURDEN ON A WOMAN'S RIGHT TO ACCESS
9 THIS SURGICAL PROCEDURE, AN ABORTION IN THE SECOND TRIMESTER.
10 THE SUPREME COURT IN STENBERG VERSUS CARHART AT 920
11 DEFINE THE PHRASE "UNDUE BURDEN" AS BEING SHORTHAND FOR THE
12 STATE REGULATION THAT HAS THE PURPOSE OR EFFECT OF PLACING A
13 SUBSTANTIAL OBSTACLE IN THE PATH OF WOMEN SEEKING AN ABORTION.
14 IN THIS CASE, YOUR HONOR, THE SUBSTANTIAL OBSTACLE
15 PRESENTED BY THE ACT, IF ENFORCED, IS ALL TOO APPARENT AT THE
16 WOMEN'S OPTION CENTER WHERE THEY PROVIDE ABORTION SERVICES.
17 NOW, WHAT PATIENT POPULATION DOES THE OPTION CENTER
18 SERVE? DR. ELEANOR DREY, MEDICAL DIRECTOR FOR THIS CENTER,
19 TESTIFIED THAT TWO BASIC GROUPS OF PATIENTS SEEK MEDICAL CARE
20 AT THE CENTER. THE FIRST GROUP ARE WOMEN WHO ARE REFERRED FROM
21 OTHER PROVIDERS BECAUSE THEY ARE HIGH RISK, MEDICALLY
22 COMPLICATED PATIENTS IN NEED OF ABORTION SERVICES. THE OPTION
23 CENTER IS ABLE TO SERVE THESE HIGH RISK PATIENTS BECAUSE IT'S
24 LOCATED IN SAN FRANCISCO GENERAL HOSPITAL, SO IT IS A GENERAL
25 HOSPITAL, IT IS ALSO A MAJOR TRAUMA CENTER ON THE WEST COAST;

1 THEREFORE, THE CENTER HAS THE SKILL AND EXPERTISE AND THE
2 RESOURCES AVAILABLE TO DEAL WITH THE COMPLEXITY THESE CASES
3 PRESENT.
4 SECOND, THE OPTION CENTER SERVES LOW INCOME WOMEN
5 FROM NOT JUST SAN FRANCISCO, BUT THROUGHOUT NORTHERN
6 CALIFORNIA, OTHER STATES, AND EVEN OTHER COUNTRIES. DR. DREY
7 TESTIFIED THAT IN PART, THE CENTER'S MISSION IS TO SERVE THE
8 POOR WOMEN OF NORTHERN CALIFORNIA AND ELSEWHERE WHO NEED
9 SECOND-TRIMESTER ABORTIONS, AS THESE WOMEN TYPICALLY DO NOT
10 HAVE ANOTHER PROVIDER TO TURN TO. THE OPTION CENTER IS THEIR
11 OPTION; OFTEN THEIR ONLY OPTION.
12 AS SHE TESTIFIED, ESSENTIALLY WE END UP TAKING CARE
13 OF ALL POOR WOMEN WHO NEED SECOND-TRIMESTER ABORTIONS AT 20
14 WEEKS AND ABOVE IN NORTHERN CALIFORNIA.
15 THE OPTION CENTER OFFERS A VARIETY OF ABORTION
16 PROCEDURES, BUT PROVIDES PRIMARILY DILATION AND EVACUATION OR
17 D&E ABORTIONS DURING THE SECOND TRIMESTER. LIKEWISE,
18 NATIONWIDE, THE D&E PROCEDURE ACCOUNTS FOR 95 PERCENT OF THE
19 SECOND-TRIMESTER ABORTIONS PERFORMED WITH THE OTHER 5 PERCENT
20 CONSISTING LARGELY OF INDUCED ABORTIONS.
21 DR. DREY ALSO TEACHES HOW TO PERFORM THE D&E
22 PROCEDURE DURING THE SECOND TRIMESTER. THE D&E IS THE
23 PROCEDURE THAT DR. DREY, IN HER MEDICAL JUDGMENT, HAS
24 DETERMINED AMONG THE ALTERNATIVES PRESENTS THE SAFEST, THE MOST
25 MEDICALLY APPROPRIATE CHOICE FOR MANY OF HER PATIENTS. INDEED,

1 A NUMBER OF EXPERT PHYSICIANS IN THIS CASE, INCLUDING
2 DR. CHASEN THIS MORNING TESTIFIED THAT THEY BELIEVE D&E'S AND
3 SPECIFICALLY INTACT D&E'S OFFER THE GREATEST SAFETY ADVANTAGE
4 AMONG THE ALTERNATIVES, INCLUDING DISARTICULATION D&E'S,
5 INDUCED ABORTIONS, AND HYSTEROTOMIES.
6 BUT WHEN ASKED ABOUT THE PARTIAL-BIRTH ABORTION BAN
7 ACT OF 2003, ACCORDING TO DR. DREY, ANY TIME YOU DO A D&E
8 ABORTION, THE PROCEDURE CAN EVOLVE IN SUCH A WAY TO POTENTIALLY
9 VIOLATE THE ACT.
10 THIS IS DUE LARGELY TO THE PHYSICIAN'S INABILITY TO
11 PREDICT HOW A D&E WILL PROCEED UNTIL THEY ARE ACTUALLY
12 PERFORMING THE PROCEDURE.
13 WHAT IMPACT WILL ENFORCEMENT OF THE ACT HAVE? IF
14 THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 IS ENFORCED,
15 DR. DREY TESTIFIED THAT THE PROVIDERS AT THE OPTION CENTER
16 WOULD NO LONGER BE COMFORTABLE PERFORMING D&E'S FACED WITH
17 CRIMINAL LIABILITY.
18 INDEED, THE OPTION CENTER, AS MS. GARTNER REFERRED
19 TO EARLIER, HAS ALREADY REVISED HOW IT PROVIDES ABORTION
20 SERVICES EVEN THOUGH THE ACT IS CURRENTLY ENJOINED BY THIS
21 COURT. NO LONGER ARE PATIENTS ENCOURAGED TO BRING A SUPPORT
22 PERSON, WHETHER THAT BE A SPOUSE, A FAMILY MEMBER, A COUNSELOR
23 INTO THE PROCEDURE. WHY? BECAUSE OF THE FEAR THAT A THIRD
24 PARTY WILL SOMEHOW MISINTERPRET HOW THE PROCEDURE IS GOING AND
25 DETERMINE THAT IT IS SOMEHOW IN VIOLATION OF THE ACT.

1 IF THE CENTER NO LONGER PERFORMS THE D&E PROCEDURE,
2 THE QUESTION IS WHERE WILL THE LOW INCOME WOMEN OF NORTHERN
3 CALIFORNIA AND ELSEWHERE GO TO ACCESS THESE MEDICAL SERVICES?
4 ACCORDING TO DR. DREY, IF YOU DO NOT HAVE INSURANCE,
5 IF YOU DO NOT HAVE MEDI-CAL -- I AM SORRY, IF YOU HAVE
6 MEDI-CAL, YOU SIMPLY NEED NOT BE ABLE TO FIND A PROVIDER IN
7 NORTHERN CALIFORNIA.
8 THE COURT RECEIVED TESTIMONY FROM OTHER PHYSICIANS
9 WHO TESTIFIED THAT THEY NO LONGER WILL PROVIDE THE D&E
10 PROCEDURE, INCLUDING DR. DOE AND DR. GRUNEBAUM, WHO HAVE
11 DISCONTINUED DOING SO AT THE PRESENT TIME.
12 DR. PAUL, FOR EXAMPLE, TESTIFIED THAT SHE HAD
13 OVERRIDING CONCERNS THAT IF SHE CONTINUES TO PRACTICE ABORTION
14 IN THE SECOND TRIMESTER, SHE WOULD BE IN PRISON. AND SHE WOULD
15 HAVE TO INFORM HER STUDENTS, BECAUSE SHE TEACHES MEDICAL
16 RESIDENTS AND STUDENTS, THAT THEY RISK IMPRISONMENT BY
17 PERFORMING SECOND-TRIMESTER ABORTIONS.
18 DR. SHEEHAN TESTIFIED THAT SHE HAD HEARD FROM A
19 NUMBER OF PROVIDERS THAT THEY WOULD FIND IT DIFFICULT TO
20 CONTINUE PROVIDING SECOND-TRIMESTER CARE.
21 THE ACT WILL HAVE A CHILLING EFFECT ON THESE
22 PHYSICIANS WHO NO LONGER PROVIDE SECOND-TRIMESTER CARE OR AT
23 LEAST THE D&E PROCEDURE IF THEY BELIEVE THEY MAY VIOLATE THE
24 LAW IN DOING SO.
25 NARROWING THE NUMBER OF PROVIDERS IN INSTITUTIONS

1 WILLING TO PERFORM THE PROCEDURE WILL NECESSARILY PLACE A
2 SUBSTANTIAL OBSTACLE IN THE PATH OF WOMEN SEEKING ABORTIONS.
3 THIS IS PARTICULARLY TRUE WITH WOMEN WITH FEW OPTIONS AS IT IS
4 THE POOR AND THOSE IN RURAL AND UNDERSERVED COMMUNITIES. THE
5 ACT MAY WELL ELIMINATE THEIR OPTIONS.
6 ALSO, BY REDUCING THE NUMBER OF PROVIDERS, THE
7 POSSIBILITY OF WOMEN ENCOUNTERING DELAY IN RECEIVING ABORTION
8 SERVICES INCREASES AS THEY MAY HAVE TO TRAVEL CONSIDERABLE
9 DISTANCES TO LOCATE A PROVIDER.
10 NOW, AS WE HAVE HEARD THROUGH THE COURSE OF THIS
11 TRIAL, THE DELAY IS THE ENEMY OF GOOD HEALTH WHERE ABORTION
12 SERVICES ARE CONCERNED. DR. SHEEHAN TESTIFIED THAT FOR EVERY
13 WEEK A WOMAN WAITS FURTHER INTO THE GESTATION, HER RISK OF
14 COMPLICATIONS GOES UP 50 PERCENT. SO EVERY WEEK, A 50 PERCENT
15 INCREASE.
16 IT IS ESSENTIAL THAT WOMEN SEEK ABORTION CARE AS
17 SOON AS POSSIBLE. WITH THE HIGH RISK, MEDICALLY COMPLICATED
18 PATIENTS WHO MUST NOW TRAVEL ELSEWHERE OTHER THAN THE OPTION
19 CENTER TO RECEIVE SERVICES, THE RESULTS COULD BE CATASTROPHIC.
20 THESE ARE WOMEN WHO ARE ALREADY OFTEN IN THE MID TO LATE SECOND
21 TRIMESTER; THEY SIMPLY CAN'T WAIT TO FIND TRAINED PROVIDERS.
22 YET, IF THE ACT IS ENFORCED, WAIT THEY MUST. THE
23 ACT'S ULTIMATE EFFECT OF DELAYING OR ELIMINATING A WOMAN'S
24 ACCESS TO ABORTION SERVICES CLEARLY CREATES A SUBSTANTIAL
25 OBSTACLE TO THEIR EXERCISING CONSTITUTIONAL RIGHT TO CHOOSE

1 ABORTION. INDEED, FOR SOME WOMEN, SUCH AS PATIENTS AT THE
2 OPTION CENTER, THE OBSTACLE MAY INDEED BE ABSOLUTE AND THE
3 BURDEN OVERWHELMING.
4 NEXT, I WOULD LIKE TO TURN TO THE BROADER PUBLIC
5 HEALTH IMPLICATIONS OF CONGRESS LEGISLATING AWAY A MEDICAL
6 PROCEDURE CHOSEN BY WOMEN IN CONSULTATION WITH THEIR DOCTOR AS
7 BEING THE SAFEST, MOST MEDICALLY APPROPRIATE COURSE OF ACTION
8 FOR THEIR PERSONAL CIRCUMSTANCES.
9 THIRTY-ONE YEARS AGO IN ROE V. WADE, THE SUPREME
10 COURT NOTED THAT THE ABORTION DECISION IN ALL ITS ASPECTS IS
11 INHERENTLY AND PRIMARILY A MEDICAL DECISION. THE BASIC
12 RESPONSIBILITY FOR ENSURING THAT A SOUND DECISION IS MADE LIES
13 WITH THE PHYSICIAN.
14 AS THE CALIFORNIA MEDICAL ASSOCIATION, AN AMICI IN
15 THIS CASE, SO APTLY DESCRIBED IN THEIR BRIEF, THE FEDERAL LAW
16 REQUIRES DOCTORS TO MAKE A CHOICE BETWEEN PERFORMING PROCEDURES
17 THAT THEY BELIEVE TO BE THE SAFEST AND MOST APPROPRIATE FOR
18 THEIR PATIENTS IN VIOLATING THE LAW OR OPTING FOR MORE RISKY
19 BUT LEGAL PROCEDURES.
20 UNDER THE LAW, PHYSICIANS WOULD CHOOSE NOT TO
21 PROVIDE PROCEDURES THAT THEY BELIEVE TO BE THE SAFEST AND MOST
22 APPROPRIATE FOR THEIR PATIENTS DESPITE YEARS OF PROFESSIONAL
23 TRAINING THAT WOULD BE EVEN TO DO SO. THIS, YOUR HONOR, IS
24 SIMPLY BAD MEDICINE.
25 IN THE RECORD BEFORE THIS COURT, 11 HIGHLY QUALIFIED

1 PHYSICIANS FROM VARIOUS INSTITUTIONS HAVE, ACROSS THE COUNTRY,
2 TESTIFIED THAT THEIR USE OF THE D&E AND IN SOME INSTANCES THE
3 INDUCTION PROCEDURE WOULD VIOLATE THE ACT IN SOME CASES.
4 THESE, AGAIN, ARE DOCTORS WHO PERFORM D&E'S BECAUSE THEY
5 BELIEVE THE PROCEDURE REPRESENTS THE BEST COURSE OF TREATMENT
6 FOR THEIR PATIENTS.
7 PHYSICIANS ARE ETHICALLY BOUND TO ASSIST THEIR
8 PATIENTS IN CHOOSING AMONG ALL THE SAFE MEDICAL FUNCTIONS.
9 THEY ARE ALSO ETHICALLY BOUND TO PROVIDE THE SAFEST CARE
10 POSSIBLE CONSISTENT WITH THE PATIENT'S WISHES.
11 TESTIMONY ON BOTH SIDES, IN FACT, FROM ALMOST EVERY
12 WITNESS, ACKNOWLEDGED THAT ULTIMATELY THE CHOICE OF WHICH
13 ABORTION PROCEDURE TO USE FOR A PARTICULAR PATIENT MUST REST
14 WITH THAT PHYSICIAN'S JUDGMENT.
15 THE STENBERG COURT AT 937 NOTED THAT, "MEDICAL
16 TREATMENTS AND PROCEDURES ARE OFTEN CONSIDERED APPROPRIATE OR
17 INAPPROPRIATE IN LIGHT OF ESTIMATED COMPARATIVE FAULT RISKS AND
18 BENEFITS IN PARTICULAR CASES."
19 NO DOCTOR TESTIFYING IN FAVOR OF THE BAN WAS
20 PHILOSOPHICALLY NEUTRAL, BUT BELIEVED THE INTACT D&E PROCEDURE
21 SHOULD BE BANNED FOR REASONS OF PROTECTING MATERNAL HEALTH. IN
22 FACT, THE DEFENDANTS PRESENTED NO EVIDENCE PROVING THAT D&E'S
23 BY INTACT EXTRACTION ARE UNSAFE.
24 CONGRESS' ATTEMPT TO LEGISLATIVELY ELIMINATE A
25 MEDICAL PROCEDURE BELIEVED BY MANY PHYSICIANS TO BE SAFE AND

1 APPROPRIATE FOR THEIR PATIENTS IS UNPRECEDENTED. THE LAW
2 STRIKES AT THE VERY HEART OF THE PHYSICIAN/PATIENT
3 RELATIONSHIP. PERFORMING A SURGICAL ABORTION, LIKE ANY OTHER
4 SURGERY, INVOLVES A COMPLEX ARRAY OF FACTORS, ALL OF WHICH VARY
5 WIDELY FROM PATIENT TO PATIENT.
6 AMONG ONE OF THE FACTORS, THE PHYSICIAN MUST
7 CONSIDER THE GESTATIONAL AGE OF THE FETUS, THE SIZE AND LIE OF
8 THE FETUS, THE AMOUNT OF CERVICAL DILATION ACHIEVED IN THE
9 PATIENT'S ANATOMICAL STRUCTURE, INCLUDING THE SIZE AND SHAPE OF
10 THE UTERUS AND CERVIX. FINALLY, THE PATIENT'S GENERAL HEALTH
11 AND MEDICAL CONDITION, ANY FETAL ABNORMALITIES ARE TAKEN INTO
12 ACCOUNT. THE COMPLEXITY OF THE SITUATION DEMANDS THAT THE
13 DECISION-MAKING PROCESS OF WHICH ABORTION PROCEDURE TO USE
14 ULTIMATELY MUST LIE WITH TWO INDIVIDUALS; THE PATIENT AND HER
15 DOCTOR.
16 IN PLANNED PARENTHOOD VERSUS CASEY, THE COURT NOTED
17 IT'S WELL-SETTLED, THE CONSTITUTION PLACES LIMITS ON A STATE'S
18 RIGHT TO INTERFERE WITH A PERSON'S MOST BASIC DECISIONS ABOUT
19 BODILY INTEGRITY. CONGRESS HAS NO PLACE IN THE
20 PHYSICIAN/PATIENT RELATIONSHIP WITH A PROCEDURE AT ISSUE IS
21 VIEWED BY MANY PROVIDERS AS THE BEST CHOICE FOR THEIR PATIENTS.
22 NOW, I WOULD LIKE TO TURN TO HOW THE PRACTICE OF
23 MEDICINE EVOLVES AND THE ACT'S IMPACT ON THAT EVOLUTION WHERE
24 ABORTION IS CONCERNED.
25 THE CLINICAL DECISION-MAKING PROCESS CONDUCTED OVER

1 TIME, THE DEVELOPMENT OF MEDICAL TECHNIQUES AND PROCEDURES
2 BELIEVED TO BE IN THE BEST INTEREST OF EACH INDIVIDUAL PATIENT
3 NEEDS TO BE ADVANCEMENT OF MEDICINE OVERALL.
4 AS NOTED BY DR. DREY EARLIER IN THIS CASE, MEDICINE
5 DEVELOPS IN A GRADUAL PROCESS. AT SOME POINT, RESPONSIBLE
6 PRACTITIONERS START DOING PROCEDURES, THEN THESE PROCEDURES ARE
7 EVALUATED SYSTEMATICALLY WHEN EXPERIENCE SHOWS IT IS WORTH
8 EVALUATING.
9 THE PRACTICE OF ABORTION TECHNIQUES HAS EVOLVED
10 SIGNIFICANTLY, ESPECIALLY SINCE IT BECAME LEGAL IN 1973. FOR
11 EXAMPLE, METHODS OF ACHIEVING DILATION HAVE EVOLVED FROM
12 MECHANICAL DILATION BEING A PRIMARY METHOD TO OSMOTIC DILATION
13 ALONE AUGMENTED BY PROSTAGLANDIN AGENTS. SIMILARLY, VACUUM
14 ASPIRATION HAS DEVELOPED AS A REPLACEMENT FROM DILATION AND
15 CURETTAGE AS ONE OF THE MOST COMMON AND SAFEST METHOD FOR
16 FIRST-TRIMESTER ABORTIONS.
17 THE DEFENSE SEEKS TO MAKE MUCH OF THE ABSENCE OF
18 STUDIES UNTIL VERY RECENTLY ON THE COMPARATIVE SAFETY OF THE
19 INTACT D&E PROCEDURE, BUT IN DOING SO, DEFENDANTS DISREGARD HOW
20 MEDICINE DEVELOPS.
21 INDEED, THE DEFENSE HAS BROUGHT UP SEVERAL ASPECTS
22 OF THE LABOR AND DELIVERY PROCESS THAT WERE FIRST WIDELY USED
23 FOR A PERIOD OF TIME BEFORE THEY WERE EXTENSIVELY STUDIED; THIS
24 WOULD BE FETAL HEART RATE MONITORING AND EPISIOTOMIES.
25 SUBSEQUENT STUDIES DETERMINED THAT THESE METHODS FAILED TO

1 ENHANCE THE SAFETY OF THE DELIVERY PROCESS. YET, THESE METHODS
2 HAVE NOT BEEN BANNED. IN FACT, THEY CONTINUE TO BE USED TODAY
3 WHEN A DOCTOR BELIEVES THEY ARE IN THE PATIENT'S BEST INTEREST.
4 ONE OF THE GOALS THE WOMEN'S OPTION CENTER IS TO
5 IMPROVE THE PRACTICE OF ABORTION CARE, AND TO DO SO BY
6 CONDUCTING RESEARCH ON ABORTIONS AND MAKING SURE THAT IT IS
7 OPTIMIZING THE SAFETY OF THE PROCEDURES PERFORMED.
8 INDEED, IF PHYSICIANS ARE ABLE TO CONTINUE REFINING
9 ALL ABORTION PROCEDURES, IT IS FORESEEABLE THAT DR. DREY'S
10 GOAL, OPTIMIZING THE SAFETY OF ABORTIONS, WILL BE CARRIED OUT
11 ALL TO THE ADVANTAGE OF MATERNAL HEALTH. YET, THE ACT HALTS
12 FURTHER DEVELOPMENT OF CLINICAL EXPERIENCE AND RESEARCH
13 CONCERNING SECOND-TRIMESTER ABORTIONS, AND SPECIFICALLY D&E'S.
14 IT, THEREFORE, THEREBY PRECLUDES THE DEVELOPMENT OF SAFETY
15 PROCEDURES. AGAIN, THE ACT IS BAD MEDICINE.
16 NOW, BECAUSE IT IS BAD MEDICINE AND CONSTITUTIONALLY
17 FLAWED, A NUMBER OF MAJOR MEDICAL ORGANIZATIONS OPPOSE THE BAN,
18 INCLUDING ACOG, AMERICAN COLLEGE OF OBSTETRICIANS AND
19 GYNAECOLOGISTS WITH 34,000 MEMBERS, ALL BOARD CERTIFIED
20 OBSTETRICIANS AND GYNECOLOGISTS, THE CMA, CALIFORNIA MEDICAL
21 ASSOCIATION WITH 40,000 LICENSED PHYSICIANS, THE AMWA, THE
22 AMERICAN AMERICAN WOMEN'S ASSOCIATION OF 10,000 MEDICAL
23 PROFESSIONALS, AND THE APHA, AMERICAN PUBLIC HEALTH ASSOCIATION
24 WITH 50,000 MEMBERS FROM ALL PUBLIC HEALTH PROFESSIONS
25 INCLUDING OBSTETRICIANS AND GYNECOLOGISTS. THE MEMBERSHIP OF

1 THESE MEDICAL ORGANIZATIONS TOTAL 144,000 TRAINED PROFESSIONALS
2 CONCERNED ABOUT THE BAN'S IMPACT ON PUBLIC HEALTH AND PRACTICE
3 OF MEDICINE.
4 FINALLY, HOW WILL A PATIENT'S INFORMATIONAL PRIVACY
5 RIGHTS BE IMPACTED BY THE ACT? EARLIER IN THIS CASE, THIS
6 COURT RECOGNIZED THE CRITICAL IMPORTANCE OF PROTECTING PATIENT
7 PRIVACY WHEN IT DENIED THE GOVERNMENT'S MOTION FOR THOUSANDS OF
8 CONFIDENTIAL MEDICAL RECORDS.
9 PATIENT CONFIDENTIALITY IN THIS HIGHLY PERSONAL AND
10 FAUGHT AREA OF CARE IS SQUARELY AT RISK UNDER THE ACT. HERE,
11 THE LAW REQUIRES A PHYSICIAN TO CHOOSE BETWEEN VIOLATING THEIR
12 DUTY OF CONFIDENTIALITY TO THEIR PATIENTS AND VIOLATING THE
13 LAW.
14 THE PHYSICIAN FACES SUBSTANTIAL CIVIL LIABILITY
15 UNLESS THE DOCTOR OBTAINS THE CONSENT OF THE PATIENT'S HUSBAND
16 OR PARENTS IF THE PATIENT IS UNDER 18. NO EXCEPTIONS ARE MADE.
17 FOR EXAMPLE, IF THE PATIENT IS A VICTIM OF DOMESTIC VIOLENCE OR
18 INCEST. IF THE PATIENT DOES NOT WANT HER CONFIDENTIAL MEDICAL
19 DECISION REVEALED TO A HUSBAND OR PARENTS TO TREAT THE
20 INTERVIEW PROVIDERS IN THE HOPES OF FINDING ONE WILLING TO RISK
21 LIABILITY TO ENSURE HER RIGHT TO MEDICAL PRIVACY. THE CONSENT
22 REQUIREMENT IS REALLY A TRAVESTY WITH THE BASIC PRINCIPLE OF
23 PRIVACY.
24 DR. SHEEHAN TESTIFIED SHE IS VERY CONCERNED ABOUT
25 REQUIRING A DOCTOR TO OBTAIN THE CONSENT FROM A SPOUSE OR

1 PARENT WILL CAUSE SIGNIFICANT DISRUPTION IN THE RELATIONSHIP
2 BETWEEN THE PHYSICIAN AND THE PATIENT. HAVING TO OBTAIN THE
3 CONSENT OF SOMEONE WHO'S NOT NECESSARILY LOOKING OUT FOR THE
4 PATIENT'S BEST INTEREST IS EXTREMELY PROBLEMATIC. LIKEWISE,
5 DR. PAUL TESTIFIED THAT HAVING TO OBTAIN CONSENT FROM A THIRD
6 PARTY WOULD VIOLATE THE PHYSICIAN/PATIENT CONFIDENTIALITY AND
7 SEVERELY COMPROMISE THE DOCTOR/PATIENT RELATIONSHIP.
8 AGAIN, THE ACT CREATES ANOTHER HOBSON'S CHOICE FOR A
9 PHYSICIAN. THE CONFLICT BETWEEN THEIR LONGSTANDING ETHICAL
10 RESPONSIBILITY TO THEIR PATIENT AND LIABILITY UNDER THE LAW.
11 THIS FUNDAMENTAL BREECH OF THE PATIENT'S RIGHT TO PRIVACY
12 CANNOT STAND.
13 IN SUM, YOUR HONOR, YOU HAVE HEARD THREE WEEKS OF
14 EXPERT MEDICAL TESTIMONY. EACH PHYSICIAN HAD DIFFERENT
15 TRAINING AND CLINICAL EXPERIENCE. EACH ESSENTIALLY TESTIFIED
16 THAT THEY WOULD PERFORM THE MEDICAL PROCEDURES THAT THEY
17 DETERMINED TO BE IN THE BEST INTEREST OF THEIR PATIENT IN
18 CONSULTATION WITH THEIR PATIENT.
19 EACH DOCTOR'S RANGE OF METHOD OF PRACTICE VARY TO
20 SOME DEGREE FROM OTHER PRACTICES. SOME DOCTORS PREFER D&E'S,
21 SOME DOCTORS BELIEVE INDUCTIONS TO BE SAFER. SOME DOCTORS USE
22 DIGOXIN; SOME DID NOT.
23 YET, IN QUESTIONING BY COUNSEL, THE MAJORITY OF
24 THESE PROVIDERS ACKNOWLEDGE WHICH PROCEDURE TO USE IN A
25 SPECIFIC CASE MUST REST WITH THE PHYSICIAN AND HER PATIENT,

1 WITH THE BODY OF MEDICAL EXPERIENCE HAS FOUND THE PROCEDURE AT
2 ISSUE TO BE SAFE, IF NOT SAFER THAN THE ALTERNATIVES.
3 CONGRESS CANNOT LEGISLATIVELY ELIMINATE A MEDICAL
4 PROCEDURE WHEN, IN THE PROVIDER'S ARRAY OF TREATMENT OPTIONS,
5 PREVENT THE CREATION OF BAD MEDICINE, COMPROMISING HEALTH CARE,
6 AND GROSSLY IMPAIRING THE PHYSICIAN/PATIENT RELATIONSHIP.
7 WITHOUT THE OPTION OF PROVIDING THE FULL RANGE OF
8 SECOND-TRIMESTER ABORTION PROCEDURES, MANY WOMEN, SUCH AS THE
9 LOW INCOME PATIENT POPULATION AT THE WOMEN'S OPTION CENTER WILL
10 FACE A PROHIBITIVE OBSTACLE IN EXERCISING THEIR CONSTITUTIONAL
11 RIGHT TO CHOOSE ABORTION.
12 FOR THESE REASONS, THE CITY AND COUNTY OF SAN
13 FRANCISCO ASKS THIS COURT TO FIND THE ACT TO BE
14 UNCONSTITUTIONAL AND PERMANENTLY ENJOIN ITS ENFORCEMENT.
15 THANK YOU.
16 THE COURT: ALL RIGHT. YOU'RE WELCOME.
17 AT THIS TIME WE WILL TAKE A SHORT BREAK BEFORE THE
18 DEFENSE MAKES THEIR CLOSING ARGUMENT. WE WILL BREAK FOR 15
19 MINUTES.
20 (RECESS TAKEN AT 2:50 P.M.)
21 (PROCEEDINGS RESUMED AT 3:10 P.M.)
22 THE COURT: ALL RIGHT. NOW, WHO FOR THE DEFENSE IS
23 GOING TO DO THE ARGUMENT?
24 MR. QUINLIVAN: YOUR HONOR, WITH THE COURT'S
25 PERMISSION, I AM GOING TO TAKE ABOUT FIVE MINUTES SOLELY

1 ADDRESSING THE DEFERENCE ISSUE AND ANSWERING YOUR HONOR'S
2 QUESTION. AND THEN, I'M GOING TO GIVE IT AWAY TO MY COLLEAGUE,
3 MR. SIMPSON.
4 THE COURT: THAT'S FINE.
5 CLOSING ARGUMENT
6 MR. QUINLIVAN: THANK YOU. THANK YOU, YOUR HONOR,
7 AND MAY IT PLEASE THE COURT.
8 THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 WAS
9 ENACTED BY A SUBSTANTIAL BIPARTISAN MAJORITY IN BOTH HOUSES OF
10 CONGRESS, AFTER CONGRESS HAD COMPILED AN EXTENSIVE LEGISLATIVE
11 RECORD SPANNING MORE THAN EIGHT YEARS.
12 IN PARTICULAR, AFTER HEARING FROM DOZENS OF
13 OBSTETRICIANS AND GYNECOLOGISTS, MATERNAL FETAL SPECIALISTS AND
14 OTHER PHYSICIANS, MEDICAL ETHICISTS AND LAWYERS AND OTHER
15 INTERESTED CITIZENS, CONGRESS FOUND THAT THE PARTIAL-BIRTH
16 ABORTION PROCEDURE IS NEVER MEDICALLY NECESSARY TO PROTECT THE
17 HEALTH OF THE MOTHER; THAT IT IMPOSES SUBSTANTIAL HEALTH RISKS;
18 THAT IT BLURS THE LINE BETWEEN ABORTION AND INFANTICIDE, AND
19 THAT CAUSES A FETUS, SOMETIMES INCHES AWAY FROM BIRTH, AN
20 EXCRUCIATING AMOUNT OF PAIN.
21 WE SUBMIT THAT A REVIEW OF THE LEGISLATIVE RECORD
22 BEFORE CONGRESS, AS SUPPLEMENTED BY THE TRIAL IN THIS CASE,
23 CONFIRMS THAT CONGRESS' JUDGMENT WAS REASONABLE AND BASED ON
24 SUBSTANTIAL EVIDENCE.
25 AND LET ME GO TO THAT STANDARD RIGHT NOW. WE SUBMIT

1 THAT THAT STANDARD WAS ARTICULATED BY THE SUPREME COURT IN THE
2 TURNER I AND TURNER II CASES.
3 IN PARTICULAR, IN TURNER II, THE SUPREME COURT
4 STATED -- AND I AM POINTING TO PAGE 211 OF THE 520 UNITED
5 STATES REPORTS. THE QUESTION IS WHETHER THE LEGISLATIVE
6 CONCLUSION WAS REASONABLE AND SUPPORTED BY SUBSTANTIAL EVIDENCE
7 IN THE RECORD BEFORE CONGRESS.
8 IN MAKING THAT DETERMINATION, WE ARE NOT TO REWEIGH
9 THE EVIDENCE DE NOVO OR TO REPLACE CONGRESS' FACTUAL
10 PREDICTIONS WITH OUR OWN. RATHER, WE ARE SIMPLY TO DETERMINE
11 IF THE STANDARD IS SATISFIED.
12 AND IN OUR VIEW, THAT FORMULATION ANSWERS YOUR
13 HONOR'S QUESTION FROM EARLIER THIS WEEK AS TO HOW THE
14 LEGISLATIVE RECORD THAT WAS COMPILED BEFORE CONGRESS, WHICH AS
15 YOUR HONOR NOTED, IS NOT BEFORE THE COURT FOR THE TRUTH OF THE
16 MATTER ASSERTED, HOW THAT PLAYS OR INTERPLAYS WITH THE EVIDENCE
17 PRESENTED AT TRIAL.
18 AND I WOULD POINT AGAIN TO SEVERAL PASSAGES FROM THE
19 SUPREME COURT'S DECISION IN TURNER II, WHICH WE THINK EXPLAIN
20 HOW THAT IS RESOLVED.
21 POINTING TO PAGE 196, THE COURT EXPLAINED THAT:
22 "WE EXAMINE FIRST THE EVIDENCE BEFORE CONGRESS,
23 AND THEN THE FURTHER EVIDENCE PRESENTED TO THE
24 DISTRICT COURT ON REMAND TO SUPPLEMENT THE
25 CONGRESSIONAL DETERMINATION."

1 ON PAGE 200, THE COURT STATED THAT:
2 "THE REASONABLENESS OF CONGRESS' CONCLUSION
3 WAS BORNE OUT BY THE EVIDENCE ON REMAND."
4 ON PAGE 204, THE COURT STATED:
5 "ADDITIONAL EVIDENCE DEVELOPED ON REMAND
6 SUPPORTS THE REASONABLENESS OF CONGRESS' JUDGMENT."
7 AND ON PAGE 209, THE COURT STATED THAT:
8 "THE EVIDENCE ASSEMBLED ON REMAND CONFIRMS THE
9 REASONABLENESS OF THE CONGRESSIONAL JUDGMENT."
10 IN OTHER WORDS, THE COURT'S ROLE IS TO SEE THROUGH
11 THE EYES OF CONGRESS TO DETERMINE IF CONGRESS' LEGISLATIVE
12 JUDGMENT WAS REASONABLE AND BASED ON SUBSTANTIAL EVIDENCE.
13 NOW, THAT IS NOT TO SAY THAT THIS COURT, OF COURSE,
14 HAS NO ROLE. THIS COURT HAS AND FEDERAL COURTS HAVE ALWAYS HAD
15 THE ROLE OF INTERPRETING THE CONSTITUTION. AND THIS COURT HAS
16 A ROLE, MOREOVER, IN DETERMINING IF THE RECORD BEFORE CONGRESS,
17 AS SUPPLEMENTED BY THE TRIAL IN THIS CASE, WAS REASONABLE AND
18 BASED ON SUBSTANTIAL EVIDENCE.
19 BUT THAT IS A DIFFERENT MATTER THAN STATING THAT THE
20 DETERMINATION ABOUT WHETHER A HEALTH EXCEPTION IS NECESSARY, OR
21 THE OTHER RELEVANT LEGAL QUESTIONS IN THIS CASE, ARE TO BE
22 TRIED DE NOVO BY THIS COURT.
23 AND, INDEED, YOUR HONOR, I WOULD POINT OUT THAT IN
24 MOST CONSTITUTIONAL CHALLENGES TO CONGRESSIONAL ENACTMENTS, THE
25 COURT EXAMINES THE LEGISLATIVE RECORD THAT WAS BEFORE CONGRESS

1 AND DOES NOT CONDUCT A DE NOVO TRIAL TO REWEIGH THE
2 CONGRESSIONAL DETERMINATION.
3 AND WE SUBMIT THAT THAT STANDARD, AS MOST RECENTLY
4 ARTICULATED BY THE SUPREME COURT IN TURNER II, IS THE RELEVANT
5 STANDARD TO APPLY HERE.
6 I WOULD ALSO POINT OUT VERY BRIEFLY THAT THE
7 PRINCIPLE OF JUDICIAL SELF-RESTRAINT REFLECTS NOT ONLY THE FACT
8 THAT CONGRESS IS A CO-EQUAL BRANCH OF GOVERNMENT, BUT ALSO THE
9 FACT THAT WHEN CONGRESS IS DEALING ON QUESTIONS OF MEDICAL OR
10 SCIENTIFIC JUDGMENT, THE COURTS HAVE RECOGNIZED THAT CONGRESS
11 HAS A SUPERIOR FACT-FINDING ABILITY THAN DO THE COURTS.
12 AS THE COURT STATED IN MARSHALL VERSUS UNITED
13 STATES:
14 "WHEN CONGRESS UNDERTAKES TO ACT IN AREAS
15 FRAUGHT WITH MEDICAL AND SCIENTIFIC UNCERTAINTIES,
16 LEGISLATIVE CHOICES MUST BE ESPECIALLY BROAD."
17 AND THIS PRINCIPLE FINDS, PERHAPS, IT'S MOST ELEGANT
18 FORMULATION IN JUSTICE BRANDEIS' OPINION FOR THE SUPREME COURT
19 IN THE LAMBERT CASE, WHICH WE CITED IN BOTH OUR OPENING AND OUR
20 REPLY DEFERENCE BRIEFS. AND I NOTE THE NEITHER THE PLAINTIFFS
21 NOR THE LAW PROFESSOR AMICI HAVE RESPONDED TO THAT CASE.
22 IN THAT CASE, A PHYSICIAN, WHO THE COURT RECOGNIZED
23 AS ONE OF THE MOST REPUTABLE PHYSICIANS IN NEW YORK CHALLENGED
24 CONGRESS' JUDGMENT THAT INTOXICATING LIQUOR SHOULD ONLY BE
25 ADMINISTERED IN CERTAIN AMOUNTS AND UNDER CERTAIN

1 CIRCUMSTANCES.
2 AND JUSTICE BRANDEIS, WRITING FOR THE COURT, HELD
3 THAT CONGRESS, BASED ON ITS JUDGMENT THAT ALCOHOLIC BEVERAGES
4 HAVE SOME MEDICAL VALUE, BUT ONLY IN CERTAIN CIRCUMSTANCES,
5 SAID THAT THIS DETERMINATION, EVEN IN THE FACE OF WELL-KNOWN
6 DIVERGING OPINIONS OF PHYSICIANS CANNOT BE SAID TO BE ARBITRARY
7 OR WITHOUT A REASONABLE BASIS.
8 YOUR HONOR, CONGRESS' JUDGMENT HERE DOES NOT SEEK TO
9 REWRITE CONSTITUTIONAL LAW. IT IS A JUDGMENT BASED ON A
10 FACTUAL DETERMINATION. AND I SUBMIT THAT PLAINTIFFS'
11 SUGGESTION THAT THE STENBERG VERSUS CARHART RECORD SOMEHOW
12 CONTROLS OR THAT THAT RECORD CONTROLS THIS CASE AND ANY FUTURE
13 LAW, NO MATTER HOW LONG IN THE FUTURE, IS PLAINLY WRONG.
14 AS THIS COURT HEARD MOST RECENTLY FROM DR. ANAND
15 YESTERDAY, MEDICAL EVIDENCE CHANGES SOMETIMES OVER THE COURSE
16 OF YEARS.
17 CONGRESS HAD A DIFFERENT RECORD BEFORE IT THAN DID
18 THE SUPREME COURT IN STENBERG. WE SUBMIT THAT THE RECORD
19 BEFORE CONGRESS MORE THAN VALIDATES CONGRESS' JUDGMENT IN
20 PASSING THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003.
21 THAT, WE SUBMIT THAT THE RECORD PRESENTED IN THIS
22 TRIAL CONFIRMS THE REASONABLENESS OF THAT DECISION.
23 AND I WILL NOW GIVE WAY TO MY COLLEAGUE,
24 MR. SIMPSON, WHO WILL EXPLAIN IN MORE DETAIL.
25 THANK YOU, YOUR HONOR.

1 THE COURT: YOU ARE WELCOME.
2 MR. SIMPSON.
3 CLOSING ARGUMENT
4 MR. SIMPSON: THANK YOU, YOUR HONOR.
5 AND IF I MAY, BEFORE I START WITH THE CLOSING HERE,
6 IF I MAY MAKE A PERSONAL COMMENT. OBVIOUSLY, THE FOUR-MONTH
7 TRIAL PREPARATION HERE HAS NOT BEEN A VERY ENJOYABLE
8 EXPERIENCE. BUT I DO HAVE TO SAY, YOUR HONOR, THAT APPEARING
9 BEFORE THIS COURT HAS BEEN A PLEASURE, AS MUCH A PLEASURE AS IT
10 COULD HAVE BEEN UNDER THE CIRCUMSTANCES.
11 YOUR HONOR, WE BELIEVE THAT THE EVIDENCE IN THIS
12 TRIAL HAS ESTABLISHED SEVEN BROAD PROPOSITIONS SHOWING THAT
13 CONGRESS' FINDINGS IN THE ACT ARE REASONABLE AND SUPPORTED BY
14 SUBSTANTIAL EVIDENCE.
15 AND IF I MAY, YOUR HONOR, I WOULD LIKE TO USE THE
16 OVERHEAD FOR THIS.
17 BEFORE I ADDRESS EACH OF THE THESE PROPOSITIONS,
18 YOUR HONOR, I WOULD LIKE TO MAKE A GLOBAL OBSERVATION. THERE
19 IS A FAIR AMOUNT OF INTERNAL CONTRADICTION WITHIN PLAINTIFFS'
20 POSITION IN THIS CASE, I THINK.
21 ON THE ONE HAND, SOME OF THEIR WITNESSES HAVE SAID
22 THAT THERE IS NO SUCH THING AS INTACT D&E AS A SEPARATE
23 PROCEDURE. THOSE WITNESSES SAY THAT THEY JUST DON'T KNOW
24 BEFOREHAND WHETHER A D&E IS GOING TO PROCEED BY DISARTICULATION
25 OR BY INTACT REMOVAL.

1 ON THE OTHER HAND, MANY OF THEIR WITNESSES SAY THAT
2 IT IS SAFER TO REMOVE THE FETUS INTACT, AND THAT INTACT REMOVAL
3 IS THEIR GOAL.
4 BUT IF INTACT REMOVAL IS SOMEWHAT SAFER, ONE WOULD
5 EXPECT THEM TO BE DOING MORE OFTEN THE THINGS THAT THEY NEED TO
6 DO TO GET AN INTACT REMOVAL. THEY ARE SAYING -- THERE IS A
7 SAYING, YOUR HONOR, THAT ACTIONS SPEAK LOUDER THAN WORDS.
8 BASED ON THOSE WITNESS' CONDUCT, EITHER INTACT REMOVAL IS NOT
9 HAPPENSTANCE OR INTACT REMOVAL IS NOT SO MUCH SAFER.
10 NOW, TO THE SEVEN PROPOSITIONS, IF I COULD. FIRST
11 INTACT D&X AND D&E ARE DISTINCT PROCEDURES. TWO REASONS
12 PARTICULARLY WHY THIS IS VERY IMPORTANT, IF I EMPHASIZE THIS
13 PARTICULARLY BY PUTTING IT FIRST.
14 FIRST OF ALL, INTACT D&X FALLS WITHIN THE ACT AND
15 D&E DOES NOT. AND SECOND, THE GOVERNMENT SEEKS TO PROHIBIT
16 INTACT D&X BUT NOT TO PROHIBIT D&E. WE HAVE AMPLE TESTIMONY,
17 YOUR HONOR, FROM SOME OF PLAINTIFFS' OWN WITNESSES THAT THESE
18 PROCEDURES ARE FUNDAMENTALLY DIFFERENT.
19 HERE IS D&E AS PLAINTIFFS' OWN WITNESSES HAVE
20 CHARACTERIZED IT. FIRST, MINIMAL CERVICAL DILATION. THE BASIC
21 RULE, YOUR HONOR, IS TO GET ENOUGH DILATION TO INSERT THE
22 INSTRUMENTS.
23 DR. PAUL, PLAINTIFFS' FIRST WITNESS, TESTIFIED:
24 "QUESTION: AND HOW DO YOU DETERMINE IF THE
25 DILATION THAT YOU HAVE ACHIEVED IS SUFFICIENT TO

1 CONTINUE WITH THE PROCEDURE?
2 "ANSWER: I NEED ENOUGH DILATION TO GET THE
3 INSTRUMENTS IN THAT I USE AND TO HAVE SOME EXTRA
4 MOBILITY TO BE ABLE TO MOVE THOSE INSTRUMENTS."
5 DR. SHEEHAN TESTIFIED THAT SHE AIMS TO DILATE
6 APPROXIMATELY ONE MILLIMETER FOR EVERY WEEK OF GESTATIONAL AGE.
7 AND DR. CREININ GAVE SIMILAR TESTIMONY.
8 THOSE AMOUNTS OF DILATION ARE OBVIOUSLY
9 SIGNIFICANTLY LESS THAN THE WIDEST PART OF THE FETUS, AND
10 DR. SHEEHAN SO TESTIFIED.
11 GOING ALONG WITH THAT MINIMAL DILATION OF THE
12 CERVIX, PLAINTIFFS' WITNESSES HAVE TESTIFIED THAT D&E IS
13 CHARACTERIZED BY DISMEMBERMENT OF THE FETUS.
14 DR. CREININ TELLS HIS PATIENTS, IN FACT, THAT THE
15 FETUS WILL BE REMOVED IN PIECES IN A D&E. AND
16 DR. BROEKHUIZEN -- BOTH OF THESE PLAINTIFFS' WITNESSES, OF
17 COURSE -- TELLS HIS PATIENTS THAT THE FETUS WILL PROBABLY BE
18 REMOVED IN PARTS.
19 DRS. CREININ AND SHEEHAN BOTH TESTIFIED THAT
20 DISMEMBERMENT OF THE FETUS OCCURS IN ABOUT 99 PERCENT OF THEIR
21 D&E'S.
22 AND, LASTLY, A NUMBER OF PLAINTIFFS' WITNESSES
23 TESTIFIED THAT THEY USE A TWISTING MOTION THEIR WORD "TWISTING
24 MOTION" -- IN DOING A D&E TO FACILITATE DISMEMBERMENT.
25 NOW, ACCORDING TO PLAINTIFFS' WITNESSES, INTACT D&X

1 HAS THESE CHARACTERISTICS: GREATER DILATION OCCURRING OVER
2 MULTIPLE DAYS AND SERIAL DILATION WITH MORE LAMINARIA BEING
3 PLACED EACH TIME.
4 DR. BROEKHUIZEN TESTIFIED:
5 "QUESTION: DOCTOR, DO YOU SOMETIMES CHOOSE TO
6 USE A SURGICAL ABORTION PROCEDURE IN WHICH YOU
7 PURPOSELY DELIVER THE FETUS INTACT UP TO THE HEAD?
8 "ANSWER: I HAVE CHOSEN, YES. THE ANSWER IS
9 'YES.' THE CASES IN PATIENTS WITH SCLERODERMA," HE
10 CONTINUED, "AND SKELETAL DYSPLASIA, IT WAS THE
11 SERIAL DILATATION PART THAT WOULD CONSIDER THE
12 SURGICAL -- IF ONE WERE TO DEFINE IT AS A SURGICAL
13 ABORTION OR PART OF A SURGICAL ABORTION, THAT WAS
14 THE MAINSTAY OF THAT APPROACH."
15 THAT TESTIMONY, YOUR HONOR, ALSO INDICATES, OF
16 COURSE, THAT DR. BROEKHUIZEN DOES SOMETIMES CHOOSE TO DO AN
17 INTACT D&X.
18 AND THEN, LATER THE SAME WITNESS TESTIFIED:
19 "QUESTION: THE INTACT D&E PROCEDURE, AS YOU
20 USE IT, IS CHARACTERIZED BY SERIAL USE OF OSMOTIC
21 DILATORS TO ACHIEVE A GREATER DEGREE OF DILATION
22 THAN YOU WOULD DO FOR A D&E BY DISMEMBERMENT,
23 CORRECT?
24 "ANSWER: THAT IS CORRECT."
25 THEN, A COUPLE OF QUESTIONS LATER:

1 "QUESTION: AND YOU ALWAYS USE SERIAL DILATION
2 WHEN YOU HAVE CHOSEN TO USE A PROCEDURE IN WHICH YOU
3 PURPOSELY DELIVER THE FETUS INTACT UP TO THE HEAD?
4 "ANSWER: YES."
5 THE NEXT CHARACTERISTIC ELEMENTS OF INTACT D&X,
6 INSERTING UP TO 25 DILATORS AT A TIME, AND DR. BROEKHUIZEN
7 SPECIFICALLY TESTIFIED TO THAT:
8 "GENERALLY TURNING THE LIE FETUS IF IT PRESENTS
9 HEAD FIRST. AND RATHER THAN USE A TWISTING MOTION
10 TO FACILITATE DISMEMBERMENT, THEY USE GENTLE
11 TRACTION."
12 THESE ARE, AGAIN, THE WORDS OF THE PLAINTIFFS'
13 WITNESSES:
14 "GENTLE TRACTION TO TEASE THE TISSUE OUT AND
15 SWEEPING THE ARMS DOWN ACROSS THE CHEST TO GET THE
16 ARMS OUT INTACT."
17 AND, FINALLY:
18 "EITHER PIERCING OR CRUSHING THE HEAD OR
19 CUTTING IT OFF WITH SCISSORS," AS DR. DOE TESTIFIED.
20 DR. CREININ SQUARELY TESTIFIED THAT THESE ARE TWO
21 SEPARATE PROCEDURES:
22 "QUESTION: IN YOUR OPINION, THE INTACT D&E OR
23 THE D&X IS A DIFFERENT PROCEDURE FROM THE D&E
24 PROCEDURE THAT YOU PERFORM; IS THAT RIGHT?
25 "ANSWER: YES."

1 THE PROCEDURE ON THE RIGHT, YOUR HONOR, CONSISTS OF
2 PERFORMING CERTAIN SEQUENTIAL STEPS TO DELIBERATELY AND
3 INTENTIONALLY DELIVER A LIVING FETUS TO A POINT OUTSIDE THE
4 BODY OF THE WOMAN, THEN TAKING A SEPARATE ACT TO KILL.
5 THE PROCEDURE ON THE LEFT DOES NOT FIT THAT
6 DESCRIPTION. THE LEGISLATIVE HISTORY, YOUR HONOR, OF THE ACT
7 REFLECTS THAT CONGRESS MEANT TO BAN ONLY THE INTACT D&X, AND
8 NOT THE D&E BY DISARTICULATION.
9 SECOND PROPOSITION THAT THE EVIDENCE AT TRIAL HERE
10 HAS ESTABLISHED IS INTACT SURGICAL ABORTION IS NOT NEEDED FOR
11 MATERNAL OR FETAL CONDITIONS.
12 DR. COOK AND DR. CLARK, BOTH BOARD CERTIFIED IN
13 MATERNAL FETAL MEDICINE, TESTIFIED THAT INTACT D&X WOULD NEVER
14 BE NECESSARY FOR ANY OF THE MATERNAL HEALTH CONDITIONS OR FETAL
15 ANOMALIES THAT THEY DEAL WITH AS MATERNAL FETAL MEDICINE
16 SPECIALISTS. AND THAT THEY ROUTINELY USE INDUCTION OF LABOR TO
17 TERMINATE PREGNANCY FOR MATERNAL CONDITIONS AND FETAL
18 ANOMALIES.
19 DR, CLARK, WHO TESTIFIED BY DEPOSITION, SAID, QUOTE:
20 "THERE ARE NO CONDITIONS, ACTUAL OR
21 HYPOTHETICAL, ANY ACTUAL DISEASE OR HYPOTHETICAL
22 CONSTRUCT OF DISEASES IN WHICH D&X WOULD BE
23 BENEFICIAL," CLOSE QUOTE.
24 AND, IN FACT, I SHOULD MENTION IN RELATION TO
25 SOMETHING THAT MS. GARTNER SAID, PLAINTIFFS DID HAVE AN

1 OPPORTUNITY TO EXAMINE DR. CLARK. MS. PARKER TOOK HIS
2 DEPOSITION.
3 INTACT D&X, YOUR HONOR, IS NOT MEDICALLY NECESSARY,
4 BECAUSE THERE ARE SAFE AND EFFECTIVE ALTERNATIVES AVAILABLE.
5 TWO OF THOSE ALTERNATIVES ARE INDUCTION AND D&E. AND INDUCTION
6 IS AVAILABLE WHERE AN INTACT FETUS IS NEEDED.
7 THAT, YOUR HONOR, IS THE PURPOSE OF THE TESTIMONY
8 FROM DEFENDANT'S WITNESSES AS TO THE SAFETY AND EFFECTIVENESS
9 OF INDUCTION, NOT TO SHOW THAT D&E SHOULD BE BANNED.
10 DR. COOK, ALSO CERTIFIED IN MATERNAL FETAL MEDICINE,
11 TESTIFIED THAT INDUCTION WOULD BE PREFERABLE WHERE THE PATIENT
12 NEEDS CLOSE MONITORING.
13 "QUESTION: DOCTOR, WHAT IS THE MOST COMMON
14 METHOD OF PREGNANCY TERMINATION YOU CURRENTLY
15 UTILIZE?
16 "ANSWER: WELL, IN OUR PRACTICE, BECAUSE MOST
17 OF THESE CONDITIONS" -- HE IS TALKING, OF COURSE,
18 ABOUT MATERNAL HEALTH PROBLEMS -- "MOST OF THESE
19 CONDITIONS DEVELOP LATER IN GESTATIONAL AGES. OUR
20 PREDOMINANT METHOD IS MEDICAL INDUCTION OF LABOR,
21 WHICH OFFERS US MULTIPLE OTHER BENEFITS THAT ARE
22 SOMEWHAT UNIQUE TO OUR SETTING IN THAT IT ALLOWS US
23 AN INTACT FETUS FOR PATHOLOGICAL EVALUATION, ALLOWS
24 US TO DELIVER THE MOTHER IN THE MOST SAFEST, MOST
25 NATURAL OR PHYSIOLOGIC WAY IN WOMEN THAT TYPICALLY

1 HAVE SIGNIFICANT OTHER MEDICAL CONDITIONS. AND IT
2 ALSO ALLOWS US TO MONITOR THE MOTHERS IN THE SAFEST
3 MANNER."
4 AND TWO OTHERS OF DEFENDANT'S WITNESSES ECHOED THAT
5 TESTIMONY THAT INDUCTION IS MORE OF A PHYSIOLOGICAL PROCESS.
6 PLAINTIFFS' WITNESSES, YOUR HONOR, HAVE GIVEN US, I
7 THINK, TWO SPECIFIC MEDICAL CASES IN WHICH THEY SAID THAT
8 INTACT SURGICAL REMOVAL WAS NECESSARY BECAUSE OF THE WOMEN'S
9 HEALTH CONDITION.
10 ONE OF THOSE WAS FROM DR. BROEKHUIZEN. THE OTHER
11 FROM DR. CREININ.
12 BUT IN NEITHER OF THOSE CASES WAS AN INTACT SURGICAL
13 REMOVAL ACTUAL ACCOMPLISHED. DR. BROEKHUIZEN TESTIFIED
14 REGARDING ONE CASE OF SCLERODERMA WHERE HE BELIEVED THAT INTACT
15 D&X WOULD BE THE BEST WAY TO PERFORM THE ABORTION. BUT HE ALSO
16 TESTIFIED THAT THE SERIAL USE OF LAMINARIA IN THAT CASE
17 ACTUALLY CAUSED UTERINE CONTRACTIONS TO START, WHICH RESULTED
18 IN THE FETUS BEING EXPELLED COMPLETELY WITHOUT ANY OTHER ACTION
19 BY DR. BROEKHUIZEN.
20 SO, INTACT D&X WAS OBVIOUSLY NOT NECESSARY IN THAT
21 INSTANCE BECAUSE THE ABORTION OCCURRED SAFELY WITHOUT IT.
22 MS. GARTNER SAID THAT DR. BROEKHUIZEN REFERRED TO
23 THREE CASES. ACTUALLY, ONLY ONE OF THOSE CASES, THE ONE I JUST
24 DESCRIBED, WAS A CASE OF MATERNAL HEALTH CONDITION. THE OTHER
25 TWO CASES DESCRIBED BY DR. BROEKHUIZEN WERE FETAL ANOMALIES.

1 AND DR. CREININ TOLD ABOUT A CASE IN WHICH THE
2 PATIENT WAS SUFFERING FROM LIVER FAILURE. SHE WAS PREGNANT,
3 AND THE FETUS DIED IN UTERO, AND DR. CREININ SAID HE, QUOTE:
4 "WOULD HAVE CHOSEN TO DO AN INTACT REMOVAL IF
5 WE GOT TO THAT POINT," CLOSE QUOTE.
6 BUT THE PATIENT DIED BEFORE HE COULD DO THE
7 ABORTION, SO HE ENDED UP NOT DOING THAT.
8 YOUR HONOR, IT SOUNDS LIKE DR. CREININ MAY HAVE
9 SIMPLY THOUGHT BACK OVER HIS PATIENTS TO COME UP WITH SOMEONE
10 WHO IS AT THE POINT OF DEATH WHO COULD NOT HAVE SUSTAINED MUCH
11 MEDICAL INTERVENTION TO REMOVE HER FETUS.
12 IN ANY EVENT, THAT FETUS HAD DIED IN UTERO, SO THE
13 ACT WOULD NOT APPLY. EVEN IF THE FETUS HAD NOT DIED, THE LIFE
14 EXCEPTION WOULD OBVIOUSLY HAVE COVERED THAT PATIENT IF SHE WAS
15 AS CLOSE TO DEATH AS HIS TESTIMONY SEEMS TO INDICATE.
16 TO QUOTE DR. CLARK, YOUR HONOR, SITUATIONS THAT
17 REQUIRE TERMINATION OF PREGNANCY FOR MATERNAL HEALTH CONDITIONS
18 ARE, QUOTE:
19 "RARE AS HEN'S TEETH," CLOSE QUOTE.
20 REGARDING FETAL ANOMALIES, PLAINTIFFS HAVE REFERRED
21 TO HYDROCEPHALY AS A SITUATION IN WHICH INTACT D&X WOULD BE
22 BEST. BUT SEVERAL WITNESSES, INCLUDING SOME OF PLAINTIFFS' OWN
23 WITNESSES, HAVE TESTIFIED THAT THE EXCESS FLUID IN A
24 HYDROCEPHALIC FETUS CAN BE REMOVED BEFORE DELIVERY BY
25 CEPHALOCENTESIS.

1 CEPHALOCENTESIS CAN BE PERFORMED TRANSABDOMINALLY
2 BEFORE THE PHYSICIAN DOES ANYTHING ELSE, OR CAN BE PERFORMED
3 TRANSCERVICALLY IF THE FETUS PRESENTS VERTEX, OR HEADFIRST.
4 DR. BROEKHUIZEN, PLAINTIFFS' WITNESS, DR. CLARK AND
5 DR. SPRANG, TESTIFIED THAT CEPHALOCENTESIS IS NOT NECESSARILY
6 FATAL TO THE FETUS.
7 IN ANY EVENT, EVEN IF A CEPHALOCENTESIS WERE TO KILL
8 THE FETUS, IT WOULD NOT VIOLATE THE ACT, SINCE THE REMOVAL OF
9 THE FETUS WOULD NOT HAVE STARTED YET.
10 FINALLY, DR. CHASEN TESTIFIED THIS MORNING THAT
11 INTACT D&X WOULD TO BE HELPFUL FOR AN ABORTION MUST BE
12 PERFORMED URGENTLY. BUT THERE IS NO EVIDENCE, YOUR HONOR,
13 INDICATING HOW A PROCEDURE COULD BE PERFORMED IN AN EMERGENCY
14 WHEN IT REQUIRES TWO OR THREE DAYS OF CERVICAL DILATION.
15 IN SHORT, YOUR HONOR, THE EVIDENCE HERE SUPPORTS
16 CONGRESS' FINDING THAT, QUOTE:
17 "PARTIAL-BIRTH ABORTION IS NEVER NECESSARY TO
18 PRESERVE THE HEALTH OF A WOMAN," CLOSE QUOTE.
19 THE THIRD PROPOSITION ESTABLISHED BY THE EVIDENCE,
20 THE CHARACTERISTIC ASPECTS OF D&X MAY PRESENT SIGNIFICANT RISKS
21 TO WOMEN.
22 THE CRUCIAL THING TO REMEMBER ABOUT SAFETY, YOUR
23 HONOR, I SUBMIT -- THIS IS IN RELATION TO BOTH .3 AND .4 -- IS
24 THAT D&E AND INDUCTION HAVE BEEN STUDIED EXTENSIVELY AND ARE
25 BOTH PROVEN SAFE, AS PLAINTIFFS' OWN WITNESSES HAVE SAID.

1 WHEREAS, D&X HAS NOT BEEN STUDIED HARDLY AT ALL, AND
2 THERE IS STRONG MEDICAL OPINION THAT IT MAY PRESENT SIGNIFICANT
3 RISKS.
4 UNDER THE CIRCUMSTANCES, WHERE SAFE AND EFFECTIVE
5 ALTERNATIVES EXIST, THE PRESUMPTION SHOULD BE AGAINST ANY NEED
6 TO USE THE D&X PROCEDURE.
7 AS PLAINTIFFS' FIRST WITNESS, DR. PAUL, TESTIFIED,
8 QUOTE:
9 "BASICALLY, EVIDENCE-BASED MEDICINE SAYS THAT
10 IF THERE IS GOOD EVIDENCE THAT ONE PARTICULAR METHOD
11 SHOULD BE USED, THEN IT IS OUR RESPONSIBILITY," SHE
12 SAID, "TO USE THAT METHOD," CLOSE QUOTE.
13 THE TESTIMONY REFLECTS, YOUR HONOR, SEVERAL RISKS TO
14 WOMEN PRESENTED BY INTACT D&X.
15 FIRST, CERVICAL INCOMPETENCE AND PRE-TERM LABOR.
16 THE REASON THAT THIS IS A PROBLEM, OBVIOUSLY, IS THE AMOUNT OF
17 DILATION NEEDED TO EFFECT INTACT REMOVAL, AND THE FACT THAT IT
18 IS USUALLY ACCOMPLISHED BY FORCING THE CERVIX OPEN WITH
19 LAMINARIA.
20 AND THAT WORD "FORCE" IS NOT MINE, NECESSARILY. IT
21 IS ONE THAT DR. BROEKHUIZEN AGREED TO.
22 DR. SPRANG, DR. SHADIGIAN, DR. COOK AND DR. CLARK
23 ALL TESTIFIED THAT THIS AMOUNT OF DILATION, USING OSMOTIC
24 DILATORS, PRESENTS A RISK OF CAUSING PROBLEMS IN FUTURE
25 PREGNANCIES.

1 EVEN DR. BROEKHUIZEN, PLAINTIFFS' WITNESS, ADMITTED
2 THAT SOME STUDIES HAVE FOUND AN ASSOCIATION BETWEEN INDUCED
3 ABORTION AND PRE-TERM DELIVERY OR CERVICAL INCOMPETENCE.
4 IN FACT, DR. BROEKHUIZEN ALWAYS ADVISES HIS PATIENTS
5 ABOUT THIS RISK IN CONNECTION WITH ANY ABORTION AFTER 20 WEEKS'
6 GESTATION.
7 HE TESTIFIED THAT HE COUNSELS PATIENTS IN THOSE
8 SITUATIONS THAT IF THEY GET PREGNANT LATER, THEY SHOULD HAVE
9 THEIR OBSTETRICIAN CHECK THEIR CERVIX SERIALLY -- HE SAYS
10 "SERIALLY" -- PRESUMABLY, MEANING MULTIPLE TIMES THROUGHOUT THE
11 PREGNANCY, SO THEY COULD, QUOTE:
12 "MAKE THE DIAGNOSIS MAYBE EARLY ENOUGH THAT
13 SURGICAL CERCLAGE COULD BE PLACED OR THE NEXT
14 PREGNANCY COULD BE SAVED IF THAT CONDITION WERE TO
15 OCCUR," CLOSE QUOTE.
16 DR. CREININ TESTIFIED THAT HE REMOVES THE FETUS IN
17 PIECES TO MINIMIZE CERVICAL DILATATION, AND THAT HE MINIMIZES
18 DILATATION TO MAKE THE ABORTION AS SAFE AS POSSIBLE.
19 DR. BROEKHUIZEN AND DR. WESTHOFF TESTIFIED THAT TO
20 STUDY WHETHER THE CERVICAL DILATATION FOR ABORTION INCREASES
21 THE RISK OF PROBLEMS IN LATER PREGNANCY, ONE WOULD HAVE TO
22 FOLLOW THE SUBJECTS INTO THEIR NEXT PREGNANCY, OBVIOUSLY.
23 DR. BROEKHUIZEN ALSO TESTIFIED THAT ONE WOULD NOT
24 WANT TO RELY SIMPLY ON THE SUBJECTS REPORTING BACK TO THE
25 AUTHORS OF THE STUDY VOLUNTARILY.

1 BUT ALL OF THIS STUDIES CITED BY PLAINTIFFS'
2 WITNESSES IN ASSERTING THAT CERVICAL DILATION FOR A SURGICAL
3 ABORTION DOES NOT CREATE A RISK OF PROBLEMS LATER IN PREGNANCY.
4 ALL OF THOSE STUDIES RELY ON -- TO CATCH SUBSEQUENT
5 PREGNANCIES, THEY RELY ON EITHER THE HAPPENSTANCE THAT THE
6 PATIENTS WOULD RETURN LATER TO THE SAME HOSPITAL WHERE THEY GOT
7 THEIR EARLIER ABORTION -- THAT IS TRUE OF THE CHASEN STUDY,
8 EXHIBIT 19, AND THE KALISH STUDY, EXHIBIT 17 -- OR THEY RELY ON
9 A REQUEST THAT THE PATIENTS, THE SUBJECTS OF THE STUDY REPORT
10 BACK TO THE AUTHORS WHEN THEY GOT PREGNANT LATER.
11 THAT IS TRUE OF THE SCHNEIDER STUDY, EXHIBIT 4.
12 YOUR HONOR, PLAINTIFFS' QUESTIONING OF WITNESSES HAS
13 SUGGESTED THAT THEY BELIEVE THAT DILATION FOR INDUCTION IS MORE
14 DANGEROUS THAN THE DILATION FOR INTACT D&X BECAUSE INDUCTION
15 INVOLVES A GREATER DEGREE OF DILATION.
16 BUT DR. SHADIGIAN, DR. COOK AND DR. SPRANG ALL
17 TESTIFIED THAT THE PREPARATION OF THE CERVIX FOR INDUCTION IS
18 SIMILAR TO THE PREPARATION FOR CHILDBIRTH.
19 INDUCTION AND CHILDBIRTH BOTH INVOLVED THE
20 PHYSIOLOGIC PROCESS OF DILATION AND EFFACEMENT IN CAUSING
21 UTERINE CONTRACTIONS TO EXPEL THE FETUS.
22 THE NEXT RISK OF INTACT D&X, PIERCING OR
23 DECAPITATING THE FETAL HEAD WITH SCISSORS OR TROCARS.
24 SEVERAL OF PLAINTIFFS' WITNESSES TESTIFIED THAT THEY
25 USE A PAIR OF SCISSORS OR TROCAR TO PIERCE THE BACK OF THE

1 FETAL HEAD. AND THESE ARE ACTIONS DONE, YOUR HONOR, WHILE THE
2 HEAD IS LODGED IN THE WOMAN'S CERVIX, RIGHT THERE WHERE THE
3 PHYSICIAN IS USING THE SCISSORS OR THE TROCAR.
4 BASED ON THE TESTIMONY OF DR. BROEKHUIZEN,
5 PLAINTIFFS' WITNESS, AND DR. SPRANG, THE MAIN UTERINE ARTERIES
6 ARE RIGHT THERE ON THE SIDES OF THE CERVIX IN THE 8:00 O'CLOCK
7 AND 4:00 O'CLOCK POSITIONS.
8 IF THE SCISSORS OR THE TROCAR, BEING USED AT
9 12:00 O'CLOCK, WERE TO SLIP OFF THE BACK OF THE FETAL HEAD, IT
10 COULD WELL BE PUSHED INTO THAT UTERINE ARTERY AT 4:00 O'CLOCK
11 OR 8:00 O'CLOCK WITH, OF COURSE, CATASTROPHIC CONSEQUENCES FOR
12 THE WOMAN.
13 NEXT, THE INTERNAL PODALIC VERSION. DR. COOK AND
14 DR. SPRANG TESTIFIED THAT REACHING INTO THE UTERUS WITH AN
15 INSTRUMENT TO GRAB THE FEET, AND CONVERTING THE LIE OF THE
16 FETUS RISKS RUPTURING THE UTERUS, SEPARATING THE PLACENTA FROM
17 THE UTERINE WALL, AND OTHERWISE TRAUMATIZING THE UTERUS.
18 AND, FINALLY, THE RISK OF INFECTION FROM THE
19 LAMINARIA, WHICH ARE USED FOR TWO OR THREE DAYS IN INTACT D&X.
20 PLAINTIFFS' WITNESSES HAVE TESTIFIED THAT THE
21 LAMINARIA HAVE TO BE PUSHED ALL THE WAY IN THROUGH THE CERVIX
22 INTO THE INTERNAL OS, AND THAT THEY SOMETIMES BREAK THE
23 AMNIOTIC SAC.
24 DR. BROEKHUIZEN TESTIFIED THAT RUPTURE OF THE
25 AMNIOTIC SAC INCREASES THE RISK OF INFECTION IN THAT THE LONGER

1 THE LAMINARIA STAY IN, THE GREATER IS THE RISK OF INFECTION.
2 AGAIN, WHERE, YOUR HONOR, PERFECTLY SAFE
3 ALTERNATIVES EXIST, WE SHOULD NOT BE SUBJECTING WOMEN TO THESE
4 UNQUANTIFIED, UNSTUDIED RISKS. AT THE VERY LEAST, THE TRIAL
5 RECORD HERE SHOWS THAT CONGRESS' FINDING THAT THIS PROCEDURE
6 POSES UNNECESSARY RISK TO WOMEN IS SUPPORTED BY SUBSTANTIAL
7 EVIDENCE.
8 THE FOURTH PROPOSITION THAT HAS BEEN ESTABLISHED BY
9 THE EVIDENCE AT TRIAL IS THAT INTACT SURGICAL REMOVAL IS NO
10 SAFER THAN THE ALTERNATIVES.
11 PLAINTIFFS' WITNESSES SAY THAT INTACT REMOVAL IS
12 SAFER THAN DISMEMBERMENT. THAT HAS BEEN ALMOST A MANTRA HERE.
13 BUT THAT CHORUS IS CONTRADICTED, WE SUBMIT, BOTH BY THE
14 WITNESSES' OWN STATEMENTS ABOUT THE SAFETY OF D&E BY
15 DISMEMBERMENT, AND BY THEIR ACTUAL CONDUCT IN THEIR MEDICAL
16 PRACTICES.
17 THERE HAS BEEN ABUNDANT TESTIMONY FROM PLAINTIFFS'
18 OWN WITNESSES THAT BOTH INDUCTION AND D&E BY DISMEMBERMENT ARE
19 SAFE OR EXTREMELY SAFE OR VERY SAFE OR EQUALLY SAFE.
20 FOR EXAMPLE, DR. SHEEHAN, WHO HAS DONE ABOUT 30,000
21 SURGICAL ABORTIONS DURING HER CAREER, ABOUT 99 PERCENT OF THEM
22 BY DISMEMBERMENT, INJURES A PATIENT WITH AN INSTRUMENT ONLY
23 ABOUT ONE-TENTH OF 1 PERCENT OF THE TIME.
24 TO USE HER OWN WORDS:
25 "THAT IS A REMARKABLY SMALL PERCENTAGE."

1 DR. BROEKHUIZEN HAS DONE FOUR OR 500 D&E'S. AND AS
2 FAR AS HE KNOWS HAS NEVER LEFT FETAL PARTS INSIDE THE UTERUS
3 AND HAS NEVER PERFORATED AN UTERUS.
4 DR. CREININ, IN FACT, TELLS HIS PATIENTS THAT THE
5 FETUS WILL BE REMOVED IN PIECES IN ORDER TO MAKE THE REMOVAL
6 SAFER.
7 PLAINTIFFS' WITNESSES HAVE TESTIFIED THAT THEIR GOAL
8 IS TO REMOVER THE FETUS AS INTACT AS POSSIBLE, BUT MOST OF THEM
9 SAY THAT THAT ALMOST NEVER HAPPENS IN PRACTICE. AND THE REASON
10 IT ALMOST NEVER HAPPENS IS THAT THEY DON'T DILATE ENOUGH TO
11 CONSISTENTLY REMOVE THE FETUS INTACT.
12 AS I MENTIONED EARLIER, YOUR HONOR, TESTIMONY FROM
13 PLAINTIFFS' WITNESSES INDICATES THAT THEY AIM TO DILATE -- THAT
14 THEY AIM TO DILATE ABOUT 1 MILLIMETER FOR EVERY WEEK OF
15 GESTATIONAL AGE -- AT LEAST TWO OF THE WITNESSES.
16 THAT IS CLEARLY SIGNIFICANTLY LESS THAN THE DIAMETER
17 OF THE FETUS. BUT THEY ACKNOWLEDGE THAT THE PROCEDURE CAN BE
18 DONE SAFELY THAT WAY.
19 DRS. CREININ AND SHEEHAN BOTH TESTIFIED THAT
20 DISMEMBERMENT OF THE FETUS OCCURS IN ABOUT 99 PERCENT OF THEIR
21 D&E'S. THEY BOTH ACKNOWLEDGED THAT THEY WOULD BE ABLE TO
22 REMOVE THE FETUS INTACT MORE OFTEN IF THEY DILATED MORE, BUT
23 THEY DON'T.
24 NOT SURPRISINGLY, NONE OF PLAINTIFFS' WITNESSES HAS
25 BEEN WILLING OR ABLE TO QUANTIFY HOW MUCH SAFER THEY THINK

1 INTACT REMOVAL IS. NOR DO ANY STUDIES ESTABLISH THIS PURPORTED
2 BENEFIT OF INTACT D&X.
3 YOUR HONOR, IT WAS IN 1992 THAT DR. MARTIN HASKELL
4 GAVE HIS PRESENTATION ON INTACT D&X. IN THOSE INTERVENING
5 11-AND-A-HALF YEARS, THE SAFETY OF D&X COULD AND SHOULD HAVE
6 BEEN STUDIED. THE EXISTENCE OF THE CHASEN STUDY, DESPITE ITS
7 FLAWS THAT THE COURT HAS HEARD ABOUT TODAY AND LAST WEEK, THE
8 EXISTENCE OF THAT STUDY WOULD SEEM TO CONTRADICT ANY ASSERTION
9 THAT A PROPER RETROSPECTIVE STUDY WOULD BE INFEASIBLE, AS SOME
10 OF THE PLAINTIFFS' WITNESSES HAVE SAID.
11 A PROPER WELL-CONSTRUCTED STUDY OF INTACT D&X COULD
12 BE DONE, EVEN IF THE ACT WERE IN EFFECT. AMPLE MEDICAL RECORDS
13 FOR A RETROSPECTIVE STUDY EXISTS FROM WHEN BEFORE THE ACT WAS
14 PASSED. A PROSPECTIVE STUDY OF THE DISMEMBERMENT VERSUS INTACT
15 REMOVAL COULD BE DONE IF CAUSING FETAL DEMISE WERE INCLUDED IN
16 BOTH COHORTS.
17 OR THE PROCEDURE COULD BE STUDIED PROSPECTIVELY IN A
18 DIFFERENT COUNTRY.
19 PLAINTIFFS CANNOT HAVE IT BOTH WAYS, YOUR HONOR. IF
20 INTACT D&X CAN BE STUDIED RELIABLY, THEN IT SHOULD HAVE BEEN
21 STUDIED AND PROVEN SAFE BEFORE SUBJECTING WOMEN TO IT, IN
22 GENERAL. IF IT CANNOT BE STUDIED RELIABLY, THEN THE CHASEN
23 STUDY THEY HAVE PRESENTED CANNOT BE RELIABLE, ASIDE FROM THE
24 METHODOLOGICAL LIMITATIONS THAT THE COURT HAS HEARD ABOUT.
25 CLEARLY, YOUR HONOR, CONGRESS WAS REASONABLE IN

1 FINDING THAT, QUOTE:

2 "THERE IS NO CREDIBLE MEDICAL EVIDENCE THAT
3 PARTIAL-BIRTH ABORTIONS ARE SAFE OR ARE SAFER THAN
4 OTHER ABORTION PROCEDURES," CLOSE QUOTE.

5 FIFTH: INTACT D&X SUBJECTS LIVING, PARTIALLY-BORN
6 FETUSES TO UNNECESSARY PAIN.

7 DR. ANAND GAVE UNCONTROVERTED TESTIMONY YESTERDAY
8 THAT THE FETUS CAN FEEL PAIN. HAVING BEEN HERE WITH EVERYONE
9 ELSE, I WOULD SUGGEST THAT REGARDLESS OF ONE'S VIEWS ON THE
10 ACCURACY OF HIS TESTIMONY ON EITHER SIDE OF THE CASE, HIS
11 TESTIMONY WAS FASCINATING.

12 THE ANATOMICAL STRUCTURES NEEDED TO PERCEIVE PAINFUL
13 STIMULI, THE NEUROANATOMICAL PATHWAYS, ARE PRESENT AND
14 FUNCTIONAL BY 22 WEEKS LMP DURING THE PERIOD IN WHICH INTACT
15 D&X IS USED.

16 HORMONAL STRESS RESPONSES TO PAINFUL STIMULI START
17 AT ABOUT 18 WEEKS LMP, AND THEY ARE, QUOTE:

18 "ROBUST AND REPRODUCIBLE," CLOSE QUOTE,
19 STARTING AT 22 WEEKS LMP.

20 AND THOSE RESPONSES DO NOT OCCUR WHEN THE FETUS HAS
21 RECEIVED PAIN MEDICATION.

22 EEG SIGNALS ARE REPORTED STARTING AT 21 OR 22 WEEKS
23 LMP. AND THOSE SIGNALS CAN BE CORRELATED TO FETAL ACTIVITY.

24 DR. CHASEN TESTIFIED THAT EVERY TIME HE INJECTS
25 POTASSIUM CHLORIDE INTO THE FETAL HEART UNDER ULTRASOUND

1 GUIDANCE, HE SEES THE FETUS RECOIL AND WITHDRAW WHEN THE NEEDLE
2 REACHES THE FETAL CHEST.
3 YOUR HONOR, CHILDREN HATE GETTING SHOTS. BUT IT
4 WOULDN'T SURPRISE ANYONE THAT, ACCORDING TO DR. ANAND, BEING
5 STABBED IN THE BACK OF THE HEAD OR HAVING THE HEAD CRUSHED OR
6 CUT OFF WITH A PAIR OF SCISSORS WOULD HURT THE FETUS MORE THAN
7 A SHOT.
8 IN ALL OF OUR MEDICALESE, ALL OF OUR MEDICAL
9 LANGUAGE, YOUR HONOR, THAT WE HAVE HEARD IN THIS CASE, WE
10 SOMETIMES FORGET WHAT IT IS WE ARE REALLY TALKING ABOUT.
11 THE CONGRESSIONAL FINDINGS PUT IT IN TERMS THAT
12 ANYONE CAN UNDERSTAND. QUOTE:
13 "DURING A PARTIAL-BIRTH ABORTION PROCEDURE THE
14 CHILD WILL FULLY EXPERIENCE THE PAIN ASSOCIATED WITH
15 PIERCING HIS OR HER SKULL AND SUCKING OUT HIS OR HER
16 BRAIN," CLOSE QUOTE.
17 AS DR. ANAND SAID YESTERDAY:
18 "AS MEDICAL PROFESSIONALS, WE SHOULD GIVE THE
19 BENEFIT OF THE DOUBT TO THE FETUS IN TERMS OF BEING
20 HUMANE TOWARDS THE FETUS."
21 AND IT IS SO EASY, YOUR HONOR, TO PREVENT THAT PAIN.
22 BECAUSE, NUMBER SIX, CAUSING FETAL DEMISE BEFORE
23 REMOVAL IS SAFE AND EFFECTIVE.
24 SEVERAL OF PLAINTIFFS' WITNESSES HAVE TESTIFIED THAT
25 THE ACT WOULD NOT APPLY WHERE THE PHYSICIAN KILLS THE FETUS

1 BEFORE STARTING THE REMOVAL. SEVERAL OF PLAINTIFFS' WITNESSES
2 USE INJECTIONS OF DIGOXIN OR POTASSIUM CHLORIDE BEFORE
3 ABORTION.
4 FOR EXAMPLE, THE POLICY OF PLANNED PARENTHOOD OF SAN
5 DIEGO AND RIVERSIDE COUNTIES, WHERE DR. SHEEHAN SERVES AS
6 MEDICAL DIRECTOR, THAT AFFILIATE'S POLICY IS TO OFFER DIGOXIN
7 TO ALL PATIENTS STARTING AT 22 WEEKS.
8 YOUR HONOR, WE BROUGHT UP THIS MORNING A LETTER THAT
9 WE WOULD LIKE TO GET INTO EVIDENCE THAT STRENGTHENS THE
10 ASSERTION THAT DIGOXIN IS SAFE, BECAUSE THAT EVIDENCE INDICATES
11 THAT OTHER PLANNED PARENTHOOD AFFILIATES ALSO USE DIGOXIN.
12 AND I SHOULD POINT OUT, BECAUSE PLAINTIFFS BROUGHT
13 IT UP IN THEIR CLOSING, PLAINTIFFS' COUNSEL HAVE KNOWN SINCE
14 WELL BEFORE THE TRIAL THAT WE INTENDED TO USE THAT LETTER AS
15 EVIDENCE.
16 DR. SHEEHAN TESTIFIED THAT THE USE OF DIGOXIN IS
17 VERY SAFE FOR THE MOTHER. THE ABORTION TEXTBOOK EDITED BY DR.
18 PAUL DESCRIBES TWO CASE SERIES IN WHICH A TOTAL OF 15,000 WOMEN
19 RECEIVED DIGOXIN TO CAUSE FETAL DEMISE WITHOUT COMPLICATIONS.
20 DR. BROEKHUIZEN TESTIFIED THAT THERE WOULD BE NO
21 COMPLICATIONS FROM DIGOXIN, EVEN IF THE DOSAGE USED TO KILL THE
22 FETUS WERE ACCIDENTALLY INJECTED INTO THE MATERNAL BLOODSTREAM.
23 THE RISKS OF DIGOXIN INJECTION ARE THE SAME AS
24 AMNIOCENTESIS, WHICH IS A VERY COMMON PROCEDURE. AND THAT IS
25 FROM DR. DOE.

1 ALSO, YOUR HONOR, THE SKILLS NECESSARY TO GIVE A
2 DIGOXIN INJECTION ARE THE SAME AS THE SKILLS NEEDED FOR
3 AMNIOCENTESIS. AND ALL OBSTETRICAL AND GYNECOLOGICAL RESIDENTS
4 ARE TAUGHT HOW TO DO AN AMNIOCENTESIS.
5 THERE HAS BEEN SOME TESTIMONY THAT AMNIOCENTESIS IS
6 MORE DIFFICULT WHEN A WOMAN IS OBESE. BUT DR. SPRANG TESTIFIED
7 THAT HE HAS SUCCESSFULLY DONE AMNIOCENTESIS IN A WOMAN WEIGHING
8 260 POUNDS AND ANOTHER WOMAN WEIGHING 300 POUNDS.
9 DR. SHEEHAN TESTIFIED THAT DIGOXIN IS 100 PERCENT
10 EFFECTIVE IN CAUSING FETAL DEMISE WHEN IT IS INJECTED INTO THE
11 FETAL HEART.
12 THERE IS AMPLE TESTIMONY, YOUR HONOR, FROM
13 PLAINTIFFS' OWN WITNESSES THAT CAUSING FETAL DEMISE FIRST MAKES
14 THE D&E PROCEDURE EASIER. BOTH DR. SHEEHAN AND DR. DREY
15 TESTIFIED TO THAT.
16 THERE IS ALSO EVIDENCE, YOUR HONOR, THAT CAUSING
17 FETAL DEMISE FIRST IS EMOTIONALLY BENEFICIAL TO THE WOMEN.
18 PLAINTIFFS' COUNSEL, I BELIEVE, SAID THAT IT
19 PRESENTS NO BENEFITS. WE WOULD SUGGEST THAT THAT EMOTIONAL
20 BENEFIT IS A BENEFIT TO THE WOMAN.
21 ALL OF THE PATIENTS TO WHOM DR. SHEEHAN OFFERS THE
22 INJECTION ACCEPT IT. ALL OF THEM, SHE SAID. I THINK THAT IS
23 REMARKABLE.
24 AND IN DR. DREY'S EFFECT STUDY INVOLVING 126 WOMEN,
25 91 PERCENT OF THEM SAID THEY PREFERRED THEIR FETUSES WERE DEAD

1 BEFORE REMOVAL BEGAN.
2 AND, FINALLY, YOUR HONOR, THE SIXTH POINT THAT THE
3 EVIDENCE HAS SHOWN: NO SEPARATE ACT TO KILL IS NEEDED TO SERVE
4 THE WOMAN'S MEDICAL NEEDS.
5 SEVERAL OF PLAINTIFFS' WITNESSES HAVE TESTIFIED THAT
6 THERE IS NEVER A NEED TO KILL A FETUS IN THE COURSE OF AN
7 ABORTION TO SERVE THE WOMAN'S HEALTH INTEREST.
8 THERE IS AMPLE TESTIMONY, YOUR HONOR, THAT NO
9 SEPARATE ACT THAT WOULD KILL IS NEEDED TO COMPLETE REMOVAL OF
10 THE FETUS IN AN ABORTION, EVEN WHERE THE HEAD GETS LODGED IN
11 THE CERVIX.
12 WE HAVE HEARD TESTIMONY THAT THE PHYSICIAN CAN WAIT
13 FOR UTERINE ACTIVITY TO EXPEL THE HEAD; THAT PITOCIN CAN BE
14 ADMINISTERED INTRAVENOUSLY TO CAUSE UTERINE CONTRACTIONS.
15 THAT A CERVICAL RELAXING AGENT, SUCH AS
16 NITROGLYCERIN, CAN BE USED. THAT DUHRSSEN'S INCISIONS CAN BE
17 MADE IN THE CERVIX, WHICH DR. COOK TESTIFIED DOES NOT ENDANGER
18 THE WOMAN'S FUTURE CHILDBEARING. AND THAT THE PHYSICIAN CAN
19 USE THE MAURICEAU-SMELLIE-VIET MANEUVER TO DELIVER THE HEAD
20 MANUALLY.
21 NEVERTHELESS, YOUR HONOR, THERE IS EVIDENCE HERE IN
22 THIS CASE SUGGESTING THAT ONE OF THE REASONS WHY SOME
23 PHYSICIANS DELIVER FETUSES UP TO THE NECK, THEN STAB OR CRUSH
24 THE SKULL OR CUT OFF THE HEAD IS SIMPLY TO ENSURE THAT THEY
25 DON'T DELIVER A LIVE BABY.

1 AS I HAVE ALREADY SAID, IF THE ONLY PURPOSE IS TO
2 COMPLETE THE REMOVAL, THERE ARE OTHER OPTIONS.
3 DR. CREININ TESTIFIED:
4 "QUESTION: IN YOUR OPINION, IF YOU WERE
5 PERFORMING A SURGICAL ABORTION AT 23 OR 24 WEEKS AND
6 THE CERVIX WAS SO DILATED THAT THE HEAD COULD PASS
7 WITHOUT COMPRESSION, YOU COULD DO WHATEVER YOU
8 NEEDED TO DO IN ORDER TO MAKE SURE THAT THE LIVE
9 BABY WAS NOT DELIVERED, WOULDN'T YOU?
10 "ANSWER: WHATEVER I NEEDED, MEANING WHATEVER
11 SURGICAL PROCEDURES I NEEDED TO DO AS PART OF THE
12 PROCEDURE?
13 "YES.
14 "THEN, THE ANSWER WOULD BE 'YES,'" HE SAID.
15 "QUESTION: AND ONE STEP YOU WOULD TAKE TO
16 AVOID DELIVERY OF A LIVE BABY WOULD BE TO DELIVER OR
17 HOLD THE FETUS' HEAD ON THE INTERNAL SIDE OF THE
18 CERVICAL OS IN ORDER TO COLLAPSE THE SKULL; IS THAT
19 RIGHT?
20 "ANSWER: YES, BECAUSE THE OBJECTIVE OF MY
21 PROCEDURE IS TO PERFORM AN ABORTION."
22 THE TESTIMONY HERE, YOUR HONOR, DOES NOT SIMPLY
23 REFLECT HEADS GETTING STUCK. IT REFLECTS HEADS BEING HELD IN
24 PLACE.
25 AND DR. BROEKHUIZEN TOLD ABOUT PASSING A TROCAR INTO

1 THE BACK OF THE HEAD OF A FETUS WITH HYDROCEPHALY IN A
2 CHROMOSOMAL ANOMALY.
3 ON TWO OR THREE OTHER OCCASIONS, DR. BROEKHUIZEN HAS
4 DELIVERED LIVE HYDROCEPHALICS BY TRAINING THE EXCESS FLUID FROM
5 THE TOP OF THE HEAD.
6 HE TESTIFIED THAT A DOCTOR WOULD AVOID THE BACK OF
7 THE HEAD IN PERFORMING THAT PROCEDURE TO PREPARE FOR A LIVE
8 DELIVERY IN ORDER TO DO THE, QUOTE, "LEAST DAMAGE," CLOSE
9 QUOTE, TO THE BABY.
10 BUT DR. BROEKHUIZEN DID NOT DO THAT IN THE CONTEXT
11 OF THAT ABORTION. HE PUSHED THE TROCAR INTO THE BACK OF THE
12 HEAD.
13 I HAVE REACHED A POINT IN MY CLOSING, YOUR HONOR,
14 WHERE I WOULD LIKE TO STOP FOR A MOMENT AND ADDRESS SOMETHING
15 THAT PLAINTIFFS' COUNSEL ADDRESSED. THAT IS THE QUALITY OF THE
16 WITNESSES.
17 IF I CAN JUST MAKE A COUPLE OF COMMENTS ALONG THOSE
18 LINES. TO POINT OUT, FIRST OF ALL, FOUR OF THE EIGHT WITNESSES
19 WHO TESTIFIED LIVE FOR PLAINTIFFS WORK EITHER FOR A PLANNED
20 PARENTHOOD AFFILIATE OR FOR THE OTHER PARTY, THE CITY AND
21 COUNTY OF SAN FRANCISCO.
22 ADDITIONALLY, DR. WESTHOFF, A FIFTH WITNESS FOR THE
23 PLAINTIFF, TESTIFIED -- FIRST OF ALL, DR. WESTHOFF SERVES ON
24 THE BOARD OF DIRECTORS OF PLANNED PARENTHOOD NEW YORK CITY.
25 AND, IN ADDITION, PLAINTIFFS' COUNSEL POINTED OUT

1 THAT DEFENDANT'S WITNESSES HAVE TESTIFIED IN OTHER ABORTION
2 CASES. DR. WESTHOFF HERSELF, ONE OF PLAINTIFFS' WITNESSES, HAS
3 TESTIFIED BEFORE IN MICHIGAN AND NEW JERSEY.
4 IF I COULD SWITCH GEARS AGAIN, YOUR HONOR, AND MAKE
5 JUST A FEW COMMENTS ABOUT THE JUDICIAL PRECEDENT ON ABORTION
6 LAWS.
7 FIRST OF ALL, WE SUBMIT THAT THE STRENGTH OF THE
8 GOVERNMENT'S INTERESTS HERE ARE WELL-ESTABLISHED IN THE CASE
9 LAW. AS FAR AS BACK AS ROE VERSUS WADE, THE SUPREME COURT HAS
10 RECOGNIZED THE GOVERNMENT'S, QUOTE:
11 "IMPORTANT AND LEGITIMATE INTEREST IN
12 PRESERVING AND PROTECTING THE HEALTH OF THE PREGNANT
13 WOMAN AND IN PROTECTING THE POTENTIALITY OF HUMAN
14 LIFE," CLOSE QUOTE.
15 IN CASEY, THE COURT ACKNOWLEDGED THAT, QUOTE:
16 "THERE IS A SUBSTANTIAL STATE INTEREST IN
17 POTENTIAL LIFE THROUGHOUT PREGNANCY," CLOSE QUOTE.
18 AND THE SIXTH CIRCUIT RECENTLY UPHELD JUST
19 RECENTLY -- DECEMBER OF LAST YEAR -- UPHELD AN OHIO STATUTE
20 AGAINST PARTIAL-BIRTH ABORTION REFERRING TO THE STATE'S
21 INTEREST IN, QUOTE:
22 "PREVENTING THE UNNECESSARY DEATH OF FETUSES
23 WHEN THEY ARE SUBSTANTIALLY OUTSIDE THE MOTHER'S
24 BODY, MAINTAINING A STRONG PUBLIC POLICY AGAINST
25 INFANTICIDE AND PREVENTING UNNECESSARY CRUELTY,"

1 CLOSE QUOTE.
2 YOUR HONOR, STENBERG VERSUS CARHART HOLDS THAT THE
3 GOVERNMENT CANNOT PROHIBIT THE USE OF A PROCEDURE WHICH IS
4 NECESSARY AND APPROPRIATE MEDICAL JUDGMENT.
5 UNDER STENBERG CONSIDERATION MUST BE GIVEN TO, ONE:
6 WHETHER THE PROCEDURE IS NECESSARY FOR MATERNAL HEALTH; AND,
7 TWO: WHETHER THE PROCEDURE OFFERS GREATER SAFETY ADVANTAGES
8 THAN THE ALTERNATIVES.
9 WE SUBMIT, YOUR HONOR, THAT THE EVIDENCE AT TRIAL
10 HAS CONFIRMED THE REASONABLENESS OF CONGRESS' FACTUAL FINDING
11 THAT PARTIAL-BIRTH ABORTION IS, IN FACT, NEVER NECESSARY FOR
12 MATERNAL HEALTH, AND DOES NOT OFFER PROVEN SAFETY ADVANTAGES,
13 LET ALONE THE GREATER ADVANTAGES OF THE WELL-STUDIED, TESTED,
14 PROVEN METHODS ROUTINELY USED.
15 THE ACT, YOUR HONOR, IS CONSISTENT WITH THE SUPREME
16 COURT'S DECISION IN STENBERG.
17 BEFORE CLOSING, YOUR HONOR, IF I COULD JUST ADDRESS
18 PLAINTIFFS' COUNSEL'S BRINGING UP OF THE SCOPE OF THE TRO IN
19 THIS CASE. WE ARE NOT PREPARED TO ADDRESS THAT, FRANKLY, YOUR
20 HONOR. WE WOULD SUGGEST THAT IF PLAINTIFFS WOULD LIKE TO
21 MODIFY THE SCOPE OF THE TRO THAT THEY SHOULD FILE A MOTION TO
22 THAT EFFECT, AND WE WOULD BE GLAD TO RESPOND TO THAT.
23 IN CONCLUSION, YOUR HONOR, IF I MAY, CONGRESS FOUND
24 THAT PARTIAL-BIRTH ABORTION, QUOTE:
25 "APPROPRIATES THE TERMINOLOGY AND TECHNIQUES

1 USED BY OBSTETRICIANS IN THE DELIVERY OF LIVING
2 CHILDREN. OBSTETRICIANS WHO PRESERVE AND PROTECT
3 THE LIFE OF THE MOTHER AND THE CHILD, AND INSTEAD
4 USES THOSE TECHNIQUES TO END THE LIFE OF THE
5 PARTIALLY-BORN CHILD," CLOSE QUOTE.
6 NOWHERE, YOUR HONOR, IS THAT MISAPPROPRIATION MORE
7 APPARENT THAN IN THE TESTIMONY REGARDING HOW THE FETUS IS
8 DELIVERED INTACT IN AN INTACT D&X, USING GENTLE TRACTION.
9 TO QUOTE PLAINTIFFS' WITNESS, DR. WESTHOFF TESTIFIED
10 ABOUT HOW SHE SWEEPS THE FETUS' ARMS ACROSS THE CHEST TO
11 EXTRACT THE UPPER BODY INTACT. THAT TESTIMONY IS EERILY
12 SIMILAR TO DR. SHADIGIAN'S TESTIMONY ABOUT HOW SHE PERFORMS A
13 BREECH DELIVERY. QUOTE:
14 "WE DELIVER UP TO ABOUT THE NAVEL, AND THEN
15 WE PULL THE BODY GENTLY DOWN IN A TOWEL. AND THEN,
16 WE REACH UP AND PUT OUR FINGERS DOWN THE HUMERUS,
17 OR UPPER ARM, AND BASICALLY HOOK NEAR THE ELBOW OF
18 THE BABY'S ARM AND HAVE IT COME OUT," CLOSE QUOTE.
19 THIS IS ALSO ECHOED, IN FACT, IN DR. DOE'S TESTIMONY
20 FOR THE PLAINTIFFS.
21 "WE DO THE SIMILAR MANEUVERS THAT WE WOULD DO
22 TO DO A BREECH DELIVERY."
23 THIS ALSO BEARS OUT CONGRESS' FINDING THAT
24 PARTIAL-BIRTH ABORTION, QUOTE:
25 "BLURS THE LINE BETWEEN ABORTION AND

1 INFANTICIDE IN THE KILLING OF A PARTIALLY-BORN CHILD
2 JUST INCHES FROM BIRTH," CLOSE QUOTE.
3 YOUR HONOR, MS. GARTNER TWICE SAID IN HER CLOSING
4 THAT THE ACT IS LIKE AN ELEPHANT IN THE ROOM DURING AN
5 ABORTION.
6 THERE IS OBVIOUSLY NO LITERAL ELEPHANT IN THE ROOM.
7 BUT I WILL TELL YOU WHAT THERE IS IN THE ROOM, YOUR HONOR.
8 THERE IS A BABY. AND CONGRESS CAN PROHIBIT PARTIALLY
9 DELIVERING THAT BABY ONLY TO KILL IT AT THE LAST MINUTE.
10 THANK YOU, YOUR HONOR.
11 THE COURT: ALL RIGHT.
12 ALL RIGHT. I GUESS THAT CONCLUDES OUR CASE. I AM
13 CERTAINLY GOING TO MISS YOU ALL. IT SEEMS LIKE IT HAS BEEN
14 FOREVER.
15 NEXT WEEK, AS WE TALKED ABOUT EARLIER, YOU CAN
16 ADDRESS THE QUESTION OF THE DISCOVERY NEGOTIATIONS THAT WERE
17 GOING ON. AND THEN, THE FOLLOWING MONDAY I WILL EXPECT THE
18 SUPPLEMENTAL, PROPOSED FINDINGS.
19 AND I TEND TO AGREE WITH COUNSEL, IF YOU ALL WISH TO
20 ADDRESS THE QUESTION OF THE SCOPE OF THE INJUNCTION, YOU
21 PROBABLY SHOULD SUBMIT FURTHER BRIEFING ON THAT ISSUE.
22 WE TALKED ABOUT IT EARLIER, AND I, IN GRANTING THE
23 TEMPORARY RESTRAINING ORDER, WENT ABOUT AS FAR AS I FELT
24 COMFORTABLE GOING AT THAT TIME.
25 IF YOU WANT TO BRIEF IT FURTHER, I WILL GIVE IT

1 FURTHER CONSIDERATION.
2 MS. PARKER: WE HAD ONE QUESTION, IF I MIGHT, YOUR
3 HONOR, ABOUT THE SUPPLEMENTAL FINDINGS, WHICH IT IS NOT CLEAR
4 TO US WHETHER YOU JUST WANT US TO PUT IN THE TRANSCRIPT
5 CITATIONS OR WHETHER WE CAN DO FURTHER SUPPLEMENTATION OF THE
6 FINDINGS GIVEN THE TESTIMONY THAT HAS COME IN.
7 THE COURT: I INDICATED TO YOU THE OTHER DAY WHAT I
8 PRIMARILY WANT IS THE CITATIONS TO THE TRANSCRIPT AND TO THE
9 EXHIBITS, BUT IF YOU ALL WISH TO SUPPLEMENT IT WITH ADDITIONAL
10 TESTIMONY, YOU CAN DO SO. IT'S JUST THAT I AM ONLY GOING TO
11 GIVE YOU A WEEK TO GET IT ALL DONE.
12 SO IF YOU FEEL YOU HAVE THE TIME TO DO THAT, THAT IS
13 FINE WITH ME. WE WILL READ THEM AND CONSIDER THEM.
14 MR. SIMPSON: THAT SUPPLEMENTATION ALSO APPLIES TO
15 THE LAW, FOR EXAMPLE, THE DEFERENCE ISSUES?
16 THE COURT: NO, I DON'T WANT ANY MORE ON THAT. YOU
17 ALL GAVE ME SEPARATE BRIEFS ON IT. YOU MENTIONED A REPLY BRIEF
18 TO THE DEFERENCE ISSUE THAT I DON'T RECALL GETTING.
19 MS. PARKER: THERE WAS ONE FROM THE GOVERNMENT.
20 THE COURT: I DON'T KNOW THAT I HAVE SEEN. I KNOW I
21 HAVEN'T SEEN IT. I DIDN'T REALIZE I GAVE YOU LEAVE TO FILE A
22 REPLY BRIEF.
23 MR. QUINLIVAN: I WILL PROVIDE A COPY TO CHAMBERS.
24 THE COURT: NO, WE CAN DOWNLOAD IT. I HAVE NOT READ
25 THAT YET.

1 MS. GARTNER: ON THE ISSUE OF THE SCOPE OF THE
2 INJUNCTION, I JUST WANTED TO CLARIFY. I DON'T THINK I WAS
3 SUGGESTING THAT WE WANTED YOUR HONOR TO EXPAND THE SCOPE OF THE
4 TRO PENDING A RULING. IF YOUR HONOR GRANTS OUR REQUEST FOR A
5 PERMANENT INJUNCTION, WE WOULD ASK THAT IT BE BROADER. IN THAT
6 CONTEXT, WOULD YOU STILL LIKE TO US FILE A FURTHER BRIEF?
7 THE COURT: ONE OF MY CONCERNS WOULD BE IS IF I WERE
8 TO GRANT THE REQUEST FOR PERMANENT INJUNCTION, IT SEEMS TO ME
9 THAT THIS CASE AS BEING -- A VERY SIMILAR CASE IS BEING
10 LITIGATED IN TWO OTHER JURISDICTIONS. AND I WONDER WHAT THE
11 REACTION WOULD BE TO THE OTHER JUDGES WHO HAVE BEEN SPENDING A
12 LOT OF THEIR TIME WORKING ON THIS ISSUE. AND I WOULD HAVE SOME
13 HESITANCE TO DO THAT, EVEN IF I WERE INCLINED TO GRANT THE --
14 MS. GARTNER: IS THERE A TIME FRAME THAT YOUR HONOR
15 HAD IN MIND FOR OUR SUBMITTING THAT? IT WAS ACTUALLY -- THERE
16 IS A PART OF THE FINDINGS WHERE WE DO INCLUDE CASE LAW ON THAT,
17 ONE OR TWO PARAGRAPHS OF FINDINGS.
18 THE COURT: DO YOU FIND ANYTHING BEYOND THAT LABOR
19 CASE THAT WE DECIDED --
20 MS. GARTNER: WE DID FIND ONE OR TWO ADDITIONAL
21 CASES. ONE, I THINK, WAS FROM THE CENTRAL DISTRICT OF
22 CALIFORNIA, A NEW DISTRICT COURT CASE THAT WE CITED TO YOUR
23 HONOR.
24 THE COURT: ALL RIGHT. IF YOU THINK THAT YOU HAVE
25 ADEQUATELY BRIEFED IT, THEN I WILL JUST CONSIDER IT IN

1 CONJUNCTION WITH THE FINDINGS.
2 MS. GARTNER: WE WILL TAKE ONE MORE LOOK AT THAT.
3 THE COURT: IF YOU WOULD BOTH LIKE TO FURTHER
4 SUPPLEMENT YOUR FINDINGS WITH SOME FURTHER ARGUMENT ON THAT
5 ISSUE, YOU ARE CERTAINLY FREE TO DO SO.
6 ALL RIGHT? ANYTHING ELSE. ALL RIGHT, WE HAVE SOME
7 DEPOSITIONS WE DON'T -- WE NO LONGER NEED. THE IMPEACHMENT
8 DEPOSITIONS. WE HAVE ALL THE ONES THAT WERE SUBMITTED IN LIEU
9 OF TRIAL TESTIMONY IN CHAMBERS. AND SO YOU ALL SHOULD TAKE
10 THAT.
11 IN TERMS OF CLEARING OUT YOUR PAPERS, YOU CAN DO IT
12 NEXT MONDAY, IF YOU WISH. I IMAGINE YOU ALL WISH TO GET BACK
13 HOME. YOU ALL, TOO. SO, IF YOU NEED TO STAY A LITTLE LATER TO
14 GET IT ALL TAKEN CARE OF, THAT IS FINE.
15 WE WILL BE AROUND FOR A LITTLE WHILE.
16 MS. GARTNER: THANK YOU, YOUR HONOR.
17 MR. QUINLIVAN: THANK YOU.
18 THE COURT: WE ARE ADJOURNED.
19
20 (PROCEEDINGS ADJOURNED AT 4:00 P.M.)
21
22
23
24
25

1 I N D E X

2

3 PLAINTIFFS' WITNESS: PAGE

4 CHASEN, STEPHEN T.

5 DIRECT EXAMINATION BY MS. PARKER 1708

6 CROSS-EXAMINATION BY MR. QUINLIVAN 1790

7 REDIRECT EXAMINATION BY MS. PARKER 1825

8 RECROSS-EXAMINATION BY MR. QUINLIVAN 1830

9

10 CLOSING ARGUMENTS:

11 MS. GARTNER 1833

12 MS. VAN RUNKLE 1880

13 MR. QUINLIVAN 1894

14 MR. SIMPSON 1899

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