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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.	)	NO. C 03-4872 PJH
JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY,	)	TUESDAY, MARCH 30, 2004
	)	SAN FRANCISCO, CALIFORNIA
DEFENDANT.	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

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

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

(APPEARANCES CONTINUED ON NEXT PAGE)

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

		PLANNED PARENTHOOD FEDERATIONF AMERICA 1780 MASSACHUSETTS AVENUE, N.W.
		WASHINGTON, D.C. 200036
	BY:	HELENE T. KRASNOFF, ESQUIRE
FOR INTERVENOR PLAINTIFFS CITY AND COUNTY OF SAN FRANCISCO:		OFFICE OF THE CITY ATTORNEY 1390 MARKET STREET, SUITE 1008 SAN FRANCSICO, CALIFORNIA 94102
	BY:	KATHLEEN SUZANNE MORRIS, ALEETA MARIE VAN RUNKLE, DEPUTY CITY ATTORNEYS
FOR DEFENDANT:		U.S. DEPARTMENT OF JUSTICE 20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
		WASHINGTON, D.C. 20530
	BY:	MARK THOMAS QUINLIVAN W. SCOTT SIMPSON, KAIJA MARIE CLARK, ASSISTANT U.S. ATTORNEYS

TUESDAY, MARCH 30, 2004 8:30 A.M.

THE COURT: ALL RIGHT. GOOD MORNING. DO YOU WISH TO RESUME YOUR EXAMINATION OF DR. SHEEHAN?

MS. PARKER: I DO, YOUR HONOR.

BEFORE WE BEGIN WE HAD ONE ISSUE WE WANTED TO RAISE WITH THE COURT. THERE WAS A COURT ARTIST HERE YESTERDAY.

WE REQUEST SHE NOT, IF SHE COMES AGAIN, DO DRAWINGS OF OUR EXPERT WITNESSES BECAUSE OF THE SENSITIVITIES OVER HARASSMENT AND THE CONCERN THAT THE PICTURES ARE BEING WIDELY DISSEMINATED.

I KNOW IT IS AN UNUSUAL REQUEST, BUT IT WAS ONE THAT OUR WITNESSES FELT -- WERE CONCERNED ABOUT.

THE COURT: LET ME THINK ABOUT IT.

MS. GARTNER: OKAY.

THE COURT: ALL RIGHT.

WOULD YOU THEN CALL UP YOUR WITNESS?

MS. PARKER: DR. SHEEHAN.

THE COURT: DR. SHEEHAN.

ALL RIGHT.

MS. MORIYAMA GAVE YOU ALL THE TIMES THAT WERE UTILIZED YESTERDAY?

MS. GARTNER: YES.

THE COURT: GOOD MORNING, DR. SHEEHAN.

YOU ARE STILL UNDER OATH.

THE WITNESS: THANK YOU.

THE COURT: PLEASE CONTINUE.

DR. KATHARINE SHEEHAN,

RESUMED THE STAND AND TESTIFIED FURTHER ON DIRECT EXAMINATION AS FOLLOWS:

DIRECT EXAMINATION (RESUMED)

BY MS. PARKER:

Q. BEFORE WE RESUME WITH OUR DISCUSSION OF HOW YOU PERFORM A DILATION AND EVACUATION PROCEDURE, I JUST WANTED TO ASK YOU A FEW MORE BRIEF BACKGROUND QUESTIONS, IF THAT'S OKAY.

A. YES.

Q. IN ADDITION TO YOUR CLINIC PRACTICE AT PLANNED PARENTHOOD SAN DIEGO AND YOUR PRIVATE GYNECOLOGICAL PRACTICE, DO YOU HAVE ANY HOSPITAL PRIVILEGES OR DO YOU EVER DO ANYTHING AT ANY HOSPITALS?

A. I DO HAVE, BUT I CONSIDER IT A FAIRLY UNIQUE SITUATION WITHIN PLANNED PARENTHOOD IN THAT I AM A FULLY FLEDGED ATTENDING DOCTOR AT THE WOMEN'S HOSPITAL IN SAN DIEGO. AND SO THE PATIENTS AT PLANNED PARENTHOOD HAVE THE ADVANTAGE OF BEING ABLE TO HAVE THEIR PROCEDURES DONE AT THE HOSPITAL, IF THERE ARE INDICATIONS FOR THEM TO NEED TO BE HOSPITALIZED AND NEED THAT HIGHER LEVEL OF ACUITY.

Q. AND WHAT TYPE OF PROCEDURES WOULD YOU DO AT THE WOMEN'S HOSPITAL IN SAN DIEGO?

A. I HAVE EVERY FRIDAY MORNING RESERVED FOR SURGERIES.

USUALLY THEY ARE TUBAL LIGATIONS, REMOVAL OF OVARIAN CYSTS, GENERAL GYNECOLOGIC CARE. BUT WE CAN CERTAINLY RESERVE TIME TO DO D&E'S, AS WELL.

Q. AND HAVE YOU EVER TESTIFIED PREVIOUSLY IN ANY CASE INVOLVING AN ISSUE ABOUT ABORTION?

A. NO.

Q. HAVE YOU EVER TESTIFIED PREVIOUSLY IN A CASE?

A. NO.

Q. SO LET'S NOW RETURN TO OUR DISCUSSION OF D&E. YESTERDAY, YOU INDICATED THAT YOU PERFORMED D&E PROCEDURES IN THE LATE SECOND-TRIMESTER; IS THAT RIGHT?

A. CORRECT.

Q. AND WHAT IS THE GESTATIONAL AGE UP TO WHICH YOU PERFORM THOSE PROCEDURES?

A. UP TO 24 WEEKS GESTATION.

Q. DO YOU DO THE SAME D&E PROCEDURE THROUGHOUT THE SECOND-TRIMESTER OF ABORTION?

A. UNDER 16 WEEKS I GENERALLY USE MISOPROSTOL TO ALLOW A ONE-DAY PROCEDURE. I ALSO USE MAINLY SUCTION TO EXTRACT THE FETAL PARTS AND PLACENTA.

AFTER 16 WEEKS, UNIFORMLY WHEN YOU HAVE LAMINARIA INSERTED OVERNIGHT AND HAVE MORE OF AN EXTRACTION SORT OF PROCEDURE.

Q. LET'S FOCUS OUR DISCUSSION ON AFTER 16 WEEKS UP TO ABOUT 24 WEEKS. IS THAT OKAY WITH YOU?

A. YES.
Q. AND I WOULD LIKE TO START WITH HOW DO YOU START THE PROCEDURE? WHAT HAPPENS WHEN A WOMAN FIRST COMES INTO THE CLINIC WHO NEEDS A LATER SECOND-TRIMESTER ABORTION?
A. SHE GOES THROUGH THE GENERAL INTAKE PROCESS, FILLS OUT HER HISTORY FORMS AND THINGS LIKE THAT. SHE MEETS WITH A COUNSELOR. SHE HAS ALL THE INFORMATION GIVEN TO HER ABOUT THE POTENTIAL PROCEDURE.

SHE HAS A THOROUGH HISTORY REVIEWED WITH A CLINICAL PERSON, USUALLY A NURSE PRACTITIONER, A PHYSICAL EXAMINATION, AN ULTRASOUND TO CONFIRM THE GESTATIONAL AGE.
Q. DO YOU GIVE EVERY PATIENT AN ULTRASOUND?
A. YES, EVERY SINGLE PATIENT GETS AN ULTRASOUND.
Q. WHAT HAPPENS AFTER THE ULTRASOUND?
A. WE MAKE A DECISION ABOUT WHETHER WE ARE ABLE TO PROCEED THERE IN THE CLINIC OR IF SHE NEEDS TO GO TO THE HOSPITAL. SHE HAS ANESTHESIA RISKS EVALUATED. AS LONG AS SHE QUALIFIES FOR AN OUTPATIENT SURGERY IN OUR CLINIC, THEN WE GO AHEAD AND START THE PROCEDURE, BEING SURE THAT SHE HAS HAD HER INFORMED CONSENT OBTAINED.

AND THE FIRST STEP OF THE PROCEDURE IS THE INSERTION OF THE FIRST SET OF LAMINARIA.
Q. HOW MANY LAMINARIA DO YOU INSERT ON THE FIRST DAY?
A. THE FIRST DAY THERE ARE TWO LAMINARIA INSERTED.
Q. WHAT IS THE PURPOSE FOR INSERTING THEM ON THAT DAY?

A. THE PROCESS IS STARTED IN TERMS OF SOFTENING THE CERVIX AND STARTING THE DILATION SO THAT A LARGER NUMBER OF LAMINARIA MAY BE INSERTED AT THE NEXT OPPORTUNITY.

Q. HOW MUCH DO THE LAMINARIA SWELL UP? WE SAW ONE YESTERDAY. I THINK THIS ONE WAS USED (INDICATING). CAN YOU DESCRIBE FOR US HOW MUCH THEY SWELL UP?

A. THE LAMINARIA START USUALLY AT ABOUT THREE OR FOUR MILLIMETERS OF DIAMETER, AND THEY CAN SWELL THREE OR FOUR TIMES UP TO OVER A CENTIMETER.

Q. THAT IS THE FIRST DAY. WHAT HAPPENS AFTER THAT?

A. THE PATIENT IS DISCHARGED. SHE GOES HOME. IF SHE FEELS COMFORTABLE ENOUGH, SHE CAN GO ABOUT HER NORMAL ACTIVITIES. SOME OF THE WOMEN HAVE A LOT OF CRAMPING AND HAVE TO STAY AT REST.

SHE COMES BACK THE NEXT DAY. SHE IS EVALUATED AGAIN. THOSE FIRST LAMINARIA ARE REMOVED, AND THEN A NEW SET IS INSERTED.

Q. DO YOU ALWAYS USE A SECOND SET IN THE LATER OR AFTER 16 OR 18 WEEKS?

A. OUR GENERAL RULE IS AT 18 WEEKS THERE WILL BE A SECOND SET OF LAMINARIA PLACED. IT ISN'T ALWAYS FOLLOWED, PARTICULARLY IF A WOMAN HAS A FETAL DEMISE. IF THE FETUS HAS ALREADY DIED INSIDE THE UTERUS, THE UTERUS IS MUCH MORE IRRITABLE, AND WE USUALLY WILL USE JUST ONE SET OF LAMINARIA THEN.

Q. SO YOU DO THE SECOND SET ON THE SECOND DAY; IS THAT RIGHT?

A. CORRECT.
Q. HOW MANY DO YOU INSERT AT THAT TIME?
A. IT'S NOT AN ABSOLUTE NUMBER. GENERALLY, WE TRY TO PUT IN AS MANY AS WOULD FIT COMFORTABLY. THIS IS GENERALLY IN THE RANGE OF FIVE TO EIGHT.
Q. ARE YOU AIMING FOR A PARTICULAR AMOUNT OF DILATION?
A. THERE IS A GOAL THAT WE HAVE IN THE CLINIC TO TRY TO OBTAIN AT LEAST A MINIMUM AMOUNT OF DILATION TO MAKE THE PROCEDURE SAFE. AND THE RULE THAT WE USE IS THAT THE DILATION OF THE CERVIX IN MILLIMETERS SHOULD BE RELATIVELY EQUAL TO THE GESTATIONAL AGE IN WEEKS.

SO IF THE WOMAN IS AT 20 WEEKS, THEN WE WOULD LIKE TO HAVE 20 MILLIMETERS OF DILATION, OR TWO CENTIMETERS.
Q. AND CAN YOU PREDICT THE AMOUNT OF DILATION YOU WILL GET?
A. IT IS HIGHLY UNPREDICTABLE.
Q. IS THERE A MINIMUM AMOUNT YOU NEED?
A. YES. WITHOUT HAVING ADEQUATE DILATION, ONE ISN'T ABLE TO INTRODUCE THE INSTRUMENTS INTO THE UTERUS. AND SO ABSOLUTELY THE CERVIX HAS TO BE DILATED AN ADEQUATE AMOUNT.
Q. CAN YOU CONTROL THE AMOUNT OF THE DILATION?
A. NO. WE TRY TO GET AN ADEQUATE AMOUNT OF LAMINARIA IN, BUT THE LAMINARIA DILATE VARIABLY BASED ON MANY FACTORS, PRIMARILY WHAT THE NATURE OF THE PATIENT'S CERVIX IS LIKE.

YOUNG TEENAGERS WITH LITTLE, FIRM CERVIXES TEND TO NOT DILATE AS EASILY. A WOMEN WHO HAS HAD A DELIVERY OR TWO,

THE CERVIX WILL DILATE MUCH MORE EASILY.

Q. IN YOUR OPINION, IS IT EVER POSSIBLE TO GET TOO MUCH DILATION?

A. THAT IS A DESIRABLE CONDITION TO HAVE, PLENTY OF DILATION. SO, NO, I DON'T THINK YOU CAN HAVE TOO MUCH.

Q. HOW LONG DO YOU LEAVE THE SECOND SET OF LAMINARIA IN?

A. AGAIN, OVERNIGHT.

Q. SO, SHE'S HAD NOW TWO SETS OF LAMINARIA TWO DIFFERENT DAYS. SHE COMES BACK, I TAKE IT, ON THE THIRD DAY?

A. YES.

Q. AND THEN, IS THAT THE DAY THAT YOU START THE ACTUAL PROCEDURE?

A. CORRECT.

Q. COULD YOU DESCRIBE FOR ME WHAT HAPPENS ON THE THIRD DAY?

A. SHE IS TAKEN TO THE PROCEDURE ROOM. AN IV IS STARTED. SHE CHANGES OUT OF HER CLOTHES. SHE GETS UP ON THE TABLE. IT IS A NORMAL, LIKE A PELVIC EXAM TABLE THAT YOU WOULD GO AND HAVE YOUR PAP SMEAR ON.

THERE IS AN ANESTHESIA PROVIDER THERE, AND ANESTHESIA IS BEGUN SO THE PATIENT CAN BE CALM AND RELAXED AND COMFORTABLE DURING THE PROCEDURE.

A PELVIC EXAM IS CARRIED OUT TO, ONE, REMOVE THE GAUZE AND LAMINARIA THAT HAVE BEEN PUT IN THE CERVIX; AND THEN, ALSO TO ASSESS THE NATURE OF THE CERVIX, HOW DILATED IT IS, HOW SOFT IT IS, HOW EFFACED IT IS. "EFFACEMENT" IS THE PROCESS OF

SHORTENING OF THE CERVIX. THE CERVIX STARTS OUT FAIRLY LONG, AND IT OPENS UP ALONG WITH DILATING.

WE EVALUATE THE PRESENTATION OF THE FETUS, WHAT PART OF THE FETUS IS PRESENTING AT THE CERVIX. I CAN FEEL IF THE CERVIX IS ADEQUATELY DILATED UP INTO THE UTERUS AND FEEL PREVIOUS CESAREAN SCAR, THINGS LIKE THAT.

AND THEN, WE BRING IN THE ULTRASOUND MACHINE AND EVALUATE, AGAIN, FOR THE PRESENTATION OF THE FETUS.

Q. AND, AGAIN, DO YOU USE THE ULTRASOUND WITH EVERY PATIENT AT THAT TIME?

A. YES.

Q. AND AFTER -- AND THE ULTRASOUND, YOU INDICATE YOU ARE DOING THAT TO FIGURE OUT WHAT THE FETUS PRESENTATION IS?

A. CORRECT.

Q. AND DO YOU EVER ATTEMPT TO CHANGE THE FETAL PRESENTATION?

A. NO, I DON'T. BUT CERTAIN PRESENTATIONS ARE MORE DIFFICULT TO DEAL WITH, AND I JUST WANT TO KNOW WHAT I AM DEALING WITH.

Q. OKAY. SO AFTER YOU HAVE ASSESSED THE FETAL PRESENTATION, WHAT DO YOU DO NEXT?

A. THEN, A CERVICAL BLOCK OF LOCAL ANESTHETIC IS PLACED AROUND THE CERVIX, AND THE AMNIOTIC SAC IS RUPTURED, ALLOWING THE AMNIOTIC FLUID TO FLOW OUT.

AND, THEN, USING THE FORCEPS, I BEGIN THE PROCEDURE OF EXTRACTING THE FETAL PART.

Q. AND HOW DO YOU GO ABOUT DOING THAT?

A. I GENERALLY TRY USING THE ULTRASOUND TO FIND THE SMALL PARTS OF THE FETUS, "SMALL PARTS" BEING CONSIDERED THE EXTREMITIES. I REALLY PREFER IT IF THE LOWER EXTREMITIES ARE PRESENTED FIRST. I CAN GRASP THE LOWER EXTREMITIES OF THE FETUS, AND USING GENTLE TRACTION, EXTRACT THE TISSUE.

Q. AND AFTER YOU HAVE DONE THAT, WHAT DO YOU HAVE? WHAT HAPPENS NEXT?

A. I CONTINUE TO PUT TRACTION ON THE FETUS TISSUE. IF THE CERVIX IS ADEQUATELY DILATED, THEN THE FETUS WILL GENERALLY SLIDE DOWN THROUGH THE CERVIX, AND I CONTINUE TO EXTRACT THE TISSUE UNTIL IT IS COMPLETELY EXTRACTED.

IF THE CERVIX IS NOT SO WELL DILATED, THEN DISARTICULATION AND DISMEMBERMENT HAPPENS.

Q. AND HOW LONG -- WELL, AFTER THE FETUS IS REMOVED OR EXTRACTED, WHAT DO YOU DO?

A. I AM SORRY, HOW LONG AFTER?

Q. WELL, AFTER YOU HAVE EXTRACTED THE FETUS --

A. YES.

Q. -- ARE THERE ANY ADDITIONAL PROCEDURES THAT YOU DO?

A. ABSOLUTELY. THE PLACENTA IS USUALLY STILL IN THE UTERUS, ALTHOUGH OCCASIONALLY IT COMES OUT FIRST OR DURING THE PROCEDURE. I MAKE A CERTAIN MANEUVER WITH THE FORCEPS TO BE ABLE TO REMOVE THE PLACENTA AS INTACT AS POSSIBLE.

THEN, I USE AN INSTRUMENT CALL A "CURETTE." IT IS AN INSTRUMENT SHAPED LIKE A LONG SPOON THAT IS INTRODUCED INTO

THE UTERUS. IT GENTLY SCRAPES THE WALLS OF THE UTERUS TO BE SURE THAT THERE AREN'T ANY LITTLE FETAL PARTS OR ANY PARTS OF THE PLACENTA LEFT BEHIND.

AND THEN, TO COMPLETE THE PROCEDURE, I USE A SUCTION CANNULA. IT IS LIKE A LARGE STRAW. IT IS ATTACHED TO A SUCTION MACHINE, AND IT IS USED TO JUST GENTLY ASPIRATE THE UTERINE CAVITY.

Q. AND HOW LONG DOES THE ENTIRE SURGICAL PROCEDURE TAKE?

A. IT REALLY DEPENDS ON HOW DILATED THE CERVIX IS AND HOW INTACT THE FETUS IS AS I EXTRACT THE TISSUE. IF THE CERVIX IS VERY WELL-DILATED AND THE FETUS COMES DOWN EASILY, THEN IT CAN TAKE JUST A MATTER OF A FEW MINUTES. IT CAN TAKE AS LONG AS 10 TO 15 MINUTES.

Q. ARE THERE ANY ADVANTAGES TO DOING THE PROCEDURE MORE QUICKLY?

A. ABSOLUTELY.

Q. WHAT ARE THEY?

A. WELL, ASSUMING THAT THE QUICK ONE IS WHERE THE FETUS IS INTACT, THEN YOU DON'T HAVE THE SHARP BROKEN BONES OF THE FETAL BODY THAT ARE POTENTIALLY ABLE TO LACERATE THE CERVIX AS THEY ARE EXTRACTED, SO THERE IS A DEFINITE DECREASED RISK TO THE MOTHER THEN.

ALSO, THE QUICKER THE PROCEDURE, THE SMALLER AMOUNT OF BLEEDING THAT WILL OCCUR. AND THEN, THIRDLY, THE ANESTHESIA, THE ENTIRE TIME THAT SHE'S ASLEEP UNDER THE

ANESTHESIA SHE IS AT SIGNIFICANT RISKS OF ASPIRATING. THAT IS A CONDITION WHERE THE STOMACH CONTENTS COME BACK UP INTO THE THROAT, AND THEN THEY ARE INHALED INTO THE LUNGS. IT IS A LIFE THREATENING CONDITION. AND OUR ANESTHESIA PEOPLE ARE CONSTANTLY VIGILANT FOR SUCH A SITUATION. AND BEING ABLE TO WAKE THE PATIENT UP VERY QUICKLY IS DEFINITELY IN HER INTEREST.

Q. DO YOU KNOW WHEN IN THE COURSE OF THE D&E PROCEDURE THAT FETAL DEMISE OCCURS?

A. I DON'T KNOW THAT.

Q. DO YOU PAY ATTENTION TO THAT?

A. I DON'T.

Q. WHY NOT?

A. MY GOAL IS TO COMPLETE THE PROCEDURE AS SAFELY AND QUICKLY AS POSSIBLE, SO I AM NOT PAYING ATTENTION TO IT.

Q. HOW LONG HAVE YOU BEEN DOING THE D&E PROCEDURE IN THE MANNER THAT YOU JUST DESCRIBED?

A. I WAS TAUGHT DURING MY RESIDENCY IN THE '70'S. AND I HAVE BASICALLY BEEN PERFORMING IT THE SAME WAY IN ALL THOSE YEARS, WITH SOME MODIFICATION.

WHEN I WENT TO PLANNED PARENTHOOD WE FOCUSED A LITTLE BIT MORE ON THE UNIFORM PREPARATION OF THE CERVIX AND SO THAT WE WOULD BE SURE WE HAD ADEQUATE DILATION AT THE TIME OF THE PROCEDURE.

Q. SO THE MOST SIGNIFICANT CHANGE YOU HAVE MADE TO THAT PROCEDURE OVER THE LAST 20 YEARS IS TO THE DILATION ASPECTS?

A. CORRECT.
Q. AND HOW HAVE YOU DONE THAT?
A. BY CONSISTENTLY USING THE TWO DAYS OF PREPARATION FOR THE OVER 18 WEEKS.
Q. DR. SHEEHAN, HAVE YOU EVER HAD A SITUATION WHERE THE FETUS COMES OUT INTACT OR PARTIALLY INTACT?
A. YES, I HAVE.
Q. AND HOW OFTEN DOES THAT OCCUR?
A. IT COMES OUT PARTIALLY INTACT VERY FREQUENTLY; COMPLETELY INTACT, LESS SO. JUST LAST WEEK I WAS WORKING WITH A RESIDENT FROM UCSD, AND WE HAD THREE OF OUR 12 CASES PROCEED SO THAT THE BODY OF THE FETUS CAME OUT COMPLETELY INTACT.
Q. DO YOU HAVE A PREFERENCE AS TO WHETHER THE FETUS COMES OUT INTACT OR PARTIALLY INTACT?
A. I DEFINITELY DO. I PREFER IT COME OUT INTACT.
Q. AND WHEN -- WHAT ARE THE FACTORS THAT INFLUENCES THAT THE FETUS WILL COME OUT INTACT OR PARTIALLY INTACT?
A. IT IS THE RELATIVE SIDES OF THE FETUS VERSUS THE RELATIVE APERTURE OF THE CERVIX THAT IT HAS TO COME THROUGH.
Q. WHEN A D&E RESULTS IN AN INTACT DELIVERY, WOULD YOU CHARACTERIZE THAT AS A VARIANT OF A D&E, OR A DIFFERENT KIND OF PROCEDURE ALTOGETHER?
A. ALL THE PROCEDURES THAT I AM PROVIDING TO GET THIS REQUEST OF THE PATIENT ACCOMPLISHED ARE, IN MY MIND, THE SAME PROCEDURE. I DON'T DIFFERENTIATE I AM DOING X, Y OR Z

PROCEDURE. IT IS BASICALLY ALL UNDER THE TERMINATION TO ME OF D&E.

Q. AND ARE THERE ANY SITUATIONS WHERE YOU WOULD EXPRESSLY WANT TO GET AN INTACT FETUS?

A. THERE ARE.

Q. WHAT ARE THOSE?

A. I JUST HAD AN EXAMPLE OF THIS ABOUT TWO WEEKS AGO. THERE WAS A YOUNG WOMAN WHO CAME UP FROM MEXICO. HER FETAL CARE HAD BEGUN FAIRLY LATE, AND ON AN ULTRASOUND IT WAS IDENTIFIED THAT THERE WERE NUMEROUS FETAL ANOMALIES.

SHE DECIDED NOT TO TAKE THE TIME TO HAVE AN AMNIOCENTESIS, BUT TO COME DIRECTLY TO HAVE A TERMINATION.

THE DOCTOR TAKING CARE OF HER HAD TOLD HER THAT THESE ANOMALIES WERE NOT COMPATIBLE WITH LIFE, AND SO SHE WAS ADVISED TO COME AND HAVE A TERMINATION.

IN THE SAME REQUEST, THEY WANTED TO HAVE AS MUCH INTACT TISSUE AS POSSIBLE SO THAT THEY COULD ANALYZE THE FETUS AFTER THE TERMINATION PROCEDURE SO THAT THEY WOULD LEARN MORE ABOUT THE CONDITION OF THE FETUS SO THAT THEY COULD GIVE ADVICE TO THIS YOUNG WOMAN ABOUT HER FUTURE PREGNANCIES.

Q. DO YOU RECALL WHAT TYPE OF FETUS ANOMALIES THAT FETUS HAD?

A. I HAD MULTICYSTIC KIDNEYS, ABNORMALITIES OF THE FACIAL BONES, AND A CARDIAC MALFORMATION.

Q. COULD YOU HAVE DONE AN INDUCTION UNDER THOSE CIRCUMSTANCES?

A. AN INDUCTION WAS OFFERED TO HER. WHEN WE DISCUSS OPTIONS

WITH OUR PATIENTS, THIS IS ALWAYS AN OPTION OFFERED TO THEM. WE DON'T ACTUALLY PROVIDE INDUCTION, SO IF SHE HAD ELECTED TO DO THAT, WE WOULD HAVE REFERRED HER FOR THAT.

Q. SHE DIDN'T PURSUE IT. AND WHY WAS THAT?

A. SHE WAS HAPPY ENOUGH FOR US TO TELL HER THAT WE WOULD DO THE BEST JOB WE COULD TO PROVIDE HER WITH INTACT TISSUE, BUT WE COULDN'T GUARANTEE IT.

Q. ARE THERE ANY SITUATIONS WHERE AN INDUCTION IS CONTRAINDICATED? BEFORE WE DO THAT, CAN YOU EXPLAIN FOR US WHAT "CONTRAINDICATION" MEANS?

A. "CONTRAINDICATION" MEANS WHEN A PROCEDURE OR A MEDICINE IS -- CARRIES MORE RISK THAN BENEFIT TO THE PATIENT, SO IT IS ILL-ADVISED.

Q. DO YOU HAVE SITUATIONS WHERE AND INDUCTION WOULD BE CONTRAINDICATED?

A. YES. INDUCTION IS USUALLY CARRIED OUT WITH PROSTAGLANDINS. AND IF THE WOMAN HAS HAD ONE OR MORE PREVIOUS C-SECTIONS, THE SCAR IN THE UTERUS IS CONSIDERED AN AREA OF WEAKNESS IN THE UTERUS AND POTENTIAL RUPTURE, SO WOMEN WITH PREVIOUS C-SECTIONS ARE GENERALLY ADVISED NOT TO HAVE INDUCTION.

Q. AND ARE THERE ANY OTHER SITUATIONS YOU'VE HAD WHERE A PATIENT WOULD WANT AN INTACT FETUS THAT YOU CAN THINK OF?

A. IT IS GENERALLY FOR FETAL ANOMALY DIAGNOSIS.

MR. SIMPSON: YOUR HONOR, I AM GOING TO HAVE TO OBJECT TO THIS LINE OF QUESTIONING. THE EXPERT'S REPORT IN

THIS CASE DOES NOT STATE THAT SHE DETERMINES TO DO PARTICULAR ABORTION IN A PARTICULAR WAY IN A PARTICULAR METHOD IN THE PRESENCE OF ANY PARTICULAR FETAL ANOMALIES. AND THAT THE WITNESS TESTIFIED IN HER DEPOSITION THAT SHE WOULD NOT BE TESTIFYING REGARDING THE NEED TO PERFORM ABORTION BY ANY PARTICULAR METHOD IN THE FACE OF FETAL ANOMALIES.

THE COURT: ALL RIGHT. ANY RESPONSE?

MS. GARTNER: I BELIEVE WE HAD A LOT OF QUESTIONS IN THE DEPOSITION ABOUT THIS AND THE FACT THAT DR. SHEEHAN DOES FETAL ANOMALIES, THAT SHE IS A REFERRAL SOURCE FOR FETAL ANOMALIES IN SAN DIEGO COUNTY, AND THE PROCEDURES SHE PERFORMS WHEN SHE IS PRESENTED WITH THOSE. AND AS SHE HAS INDICATED, SHE DOESN'T DO THE PROCEDURE ANY DIFFERENTLY FOR FETAL ANOMALIES THAN SHE DOES FOR ANY OTHER PREGNANCY TERMINATION.

THE COURT: I AM NOT SURE I UNDERSTAND EXACTLY WHAT SUBJECT IT IS YOU BELIEVE THAT SHE SHOULD NOT BE PERMITTED TO TESTIFY ON.

MR. SIMPSON: IF I COULD READ THE PORTION FROM THE DEPOSITION THAT I HAVE IN MIND. WOULD THE COURT LIKE TO SEE THE DEPOSITION, YOUR HONOR?

THE COURT: NO. JUST READ ME THE SECTION YOU ARE TALKING ABOUT.

MR. SIMPSON: IT IS ON PAGE 33, STARTING ON LINE 25.

"QUESTION: HAVE YOU PERFORMED ABORTIONS -- YOU MAY HAVE SAID THIS ALREADY. HAVE YOU PERFORMED

ABORTIONS IN CASES OF FETAL ANOMALIES?

"ANSWER: YES.

"QUESTION: IN ANY OF THOSE CASES HAVE YOU MADE A JUDGMENT AS TO WHETHER THE ABORTION WAS NEEDED BECAUSE OF A FETAL ANOMALY?

"ANSWER. NO."

THEN, ON PAGE 132, LINE 11:

"QUESTION: WILL YOU BE OFFERING ANY TESTIMONY AS TO THE NEED TO USE ANY PARTICULAR METHOD OF ABORTION IN THE PRESENCE OF ANY FETAL ANOMALIES?

"ANSWER: I BELIEVE I ANSWERED 'NO' BEFORE. IT IS THE SAME PROCEDURE AS FOR ANY OTHER."

THE COURT: ALL RIGHT. RESPONSE?

MS. PARKER: YES. MY RECOLLECTION FROM ATTENDING THE DEPOSITIONS -- I DON'T HAVE THE EXACT CITE -- IS THAT SHE SPECIFICALLY TESTIFIED ABOUT HAVING THE NEED TO HAVE AN INTACT FETUS FOR PURPOSES OF DOING A PATHOLOGICAL DIAGNOSIS. AND I BELIEVE SHE EVEN GAVE A SIMILAR TYPE OF EXAMPLE AT THE DEPOSITION.

THE COURT: IS THAT WHERE YOU ARE GOING WITH THIS LINE OF QUESTIONING?

MS. PARKER: ACTUALLY, I WAS MOVING ON TO THE NEXT AREA, SO --

THE COURT: ALL RIGHT. GO AHEAD.

BY MS. PARKER:

Q. DR. SHEEHAN, DO YOU AS A PHYSICIAN HAVE A PREFERENCE AS TO WHETHER THE FETUS EMERGES INTACT?
A. I DO. I BELIEVE THE PROCEDURE GOES MORE QUICKLY AND MORE SAFELY WHEN THE FETUS COMES OUT AS INTACT AS POSSIBLE.
Q. ARE THERE SITUATIONS WHERE YOU WERE DOING A D&E AND THERE WAS SUFFICIENT DILATION TO REMOVE THE FETUS, EXCEPT FOR THE HEAD?
A. YES.
Q. AND DOES IT HAPPEN -- HOW OFTEN DOES THAT HAPPEN?
A. THAT HAPPENS FAIRLY FREQUENTLY. IN FACT, I HAVE BEEN WORKING WITH A RESIDENT FROM UCSD, AS I ALLUDED EARLIER, AND JUST LAST WEEK THREE OF OUR 12 PROCEDURES PROCEEDED IN THIS WAY.
Q. AND WHY IS IT FREQUENT THAT THE FETUS EMERGES EXCEPT FOR THE HEAD?
A. THE HEAD IS THE LARGEST PART OF THE FETAL BODY.
Q. AND WHAT DO YOU DO WHEN THAT HAPPENS? WHAT IS YOUR PROCEDURE?
A. TYPICALLY, I CONTINUE TO PUT TRACTION ON THE FETAL BODY. IF IT IS ABLE TO SLIDE THROUGH THE CERVICAL APERTURE, THEN IT WILL. THAT IS RARE.
USUALLY WHAT HAPPENS IS WE NEED TO DISARTICULATE THE FETAL BODY AT THE NECK, AND THEN DO A COMPRESSION OF THE FETAL HEAD WITH A FORCEPS TO REMOVE THE HEAD.
Q. AND CAN YOU WAIT FOR THE FETAL HEAD TO DELIVER ON ITS OWN?

A. THAT IS NOT ADVISABLE.
Q. WHY IS THAT?
A. THE PATIENT IS UNDER ANESTHESIA, AND IT WOULD TAKE QUITE AWHILE FOR THE UTERUS TO LABOR ENOUGH TO OPEN THE CERVIX FURTHER TO ALLOW THE FETAL HEAD TO DELIVER.
Q. ARE THERE ANY SPECIAL RISKS IF THE FETUS EMERGES MORE INTACT THAN NOT?
A. I CAN'T THINK OF ANY.
Q. WHAT IS YOUR OVERALL EXPERIENCE WITH THE SAFETY OF D&E?
DO YOU HAVE AN OPINION ABOUT THE SAFETY OF D&E?
A. I THINK D&E'S ARE VERY SAFE PROCEDURE. WHEN DISCUSSING IT WITH MY PATIENTS, I ALWAYS UNDERLINE IT IS A VERY SAFE PROCEDURE. IT IS AT LEAST AS SAFE AS GOING TO TERM AND DELIVERING A BABY. IT IS PROBABLY SAFER THAN APPENDECTOMY OR TONSILLECTOMY.
WE ACTUALLY HAVE BEEN TRACKING STATISTICS AT OUR PLANNED PARENTHOOD AFFILIATE FOR A NUMBER OF YEARS AND HAVE FOUND THAT THE NUMBER OF COMPLICATIONS IN SECOND-TRIMESTER ABORTIONS IS ACTUALLY LESS THAN THE NUMBER IN THE FIRST-TRIMESTER. SO IT IS A VERY SMALL PERCENTAGE, LESS THAN 1 PERCENT.
Q. AND HAVE YOU EVER HAD A SITUATION WHERE YOU HAVE HAD SOME COMPLICATIONS AS A RESULT OF THE D&E?
A. YES.
Q. WHAT TYPE OF COMPLICATIONS HAVE YOU EXPERIENCED?

A. WE HAVE HAD PERFORATIONS AND INSTANCES OF HEMORRHAGE AND INFECTION.
Q. AND HOW OFTEN HAVE YOU HAD A PERFORATION DURING A D&E PROCEDURE?
A. THE NUMBERS IN OUR AFFILIATE ARE USUALLY ONE OR TWO PERFORATIONS A YEAR, AND WE ARE DOING ABOUT 2,000 D&E'S PER YEAR.
Q. SO .1 PERCENT, I THINK, IF I DO THE MATH?
A. CORRECT.
Q. AND WERE ANY OF THOSE SITUATIONS WHERE YOU WERE SUCCESSFUL IN REMOVING THE FETUS INTACT?
A. NO.
Q. HAVE YOU EVER HAVE HAD A RETAINED PLACENTA IN PERFORMING A SECOND-TRIMESTER D&E?
A. NEVER.
Q. SO DO YOU EVER USE A CHEMICAL AGENT TO CAUSE FETAL DEMISE?
A. YES.
Q. WHAT IS THAT AGENT?
A. THE AGENT IS DIGOXIN.
Q. WHAT IS DIGOXIN?
A. DIGOXIN IS THE NAME FOR DIGITALIS, WHICH IS A CARDIAC MEDICINE THAT IS TYPICALLY USED FOR SPECIFIC CARDIAC CONDITIONS, MOST TYPICALLY HEART FAILURE.
Q. AND AT WHAT GESTATIONAL AGE DO YOU USE DIGOXIN?
A. WE START USING IT AT 22 WEEKS.

Q. WHY DO YOU CHOOSE 22 WEEKS?
A. WE LIKE TO PREVENT AN EVENTUALITY OF A LIVE BIRTH, AND BECAUSE IT SEEMS TO MAKE THE PROCEDURE MOVE ALONG A LITTLE BIT EASIER ON THE DAY OF THE PROCEDURE.
Q. ARE PATIENTS REQUIRED TO USE DIGOXIN AT 22 WEEKS?
A. NO. THEY ARE DEFINITELY GIVEN THE CHOICE.
Q. AND ARE THERE ANY PATIENTS FOR WHOM YOU WOULD NOT RECOMMEND DIGOXIN STARTING AT 22 WEEKS?
A. THERE IS A GROUP OF HEART CONDITIONS THAT ARE CONSIDERED CONDUCTION DEFECTS, WHERE THE ELECTRICAL CONDUCTION THAT PULSES THROUGH THE HEART IS ABNORMAL.

A PARTICULAR INSTANCE OF THAT WOULD BE WOLFF-PARKINSON-WHITE SYNDROME WHERE DIGOXIN WOULD BE CONTRAINDICATED, BECAUSE IT COULD POTENTIALLY INCREASE THE DYSFUNCTION OF THE ELECTRICAL CONDUCTION IN THE HEART.

Q. HAVE YOU EVER USED DIGOXIN BEFORE 22 WEEKS?
A. I HAVE.
Q. AND WHAT ARE THOSE CIRCUMSTANCES?
A. IT HAS BEEN IN A SITUATION WHERE THE PATIENT ACTUALLY REQUESTED IT.
Q. BUT YOU DON'T GENERALLY USE IT BEFORE 22 WEEKS; IS THAT RIGHT?
A. NO, I DON'T.
Q. AND WHY IS THAT?
A. IT WOULD BE AN ADDITIONAL UNNECESSARY PROCEDURE THAT WOULD

POTENTIALLY ADD RISK TO THE PROCEDURE.
Q. AND WHAT KIND OF RISKS ARE THERE?
A. RISK OF INFECTION OR RISK OF GOING INTO LABOR EARLY.
Q. HAVE YOU EVER SEEN A WOMAN WHO BECAME INFECTED AS A RESULT OF A DIGOXIN INJECTION?
A. I HAVE.
Q. CAN YOU DESCRIBE THAT FOR US?
A. I HAVE SEEN ONE PATIENT THAT I AM FAIRLY CERTAIN HAD INFECTION. SHE HAD WHAT IS DESCRIBED AS CHORIOAMNIONITIS, WHICH IS GENERALIZED INFECTION OF THE MEMBRANES INSIDE THE UTERUS AROUND THE FETUS.

IN ANOTHER CASE WHERE I WAS SUSPICIOUS THAT SHE WAS INFECTED BECAUSE OF THE ADMINISTRATION OF DIGOXIN, MAINLY BECAUSE SHE HAD A FEVER.
Q. AND YOU INDICATED DIGOXIN CAUSES FETAL DEMISE; IS THAT RIGHT?
A. CORRECT.
Q. DOES IT CAUSE IT IN EVERY SINGLE TIME IT IS ADMINISTERED?
A. NO, IT IS NOT 100 PERCENT UNIFORMLY SUCCESSFUL.
Q. AND WHY IS THAT? DO YOU HAVE ANY SENSE OF WHY IT IS NOT UNIFORMILY SUCCESSFUL?
A. WE ADMINISTER THE DIGOXIN WITH A NEEDLE THROUGH THE ABDOMINAL WALL OF THE WOMAN INTO THE UTERUS. WE ARE AIMING TO GET IT INTO THE FETAL HEART, OR AT LEAST INTO THE FETAL THORAX. HOWEVER, WE ARE NOT ABLE TO DO THAT EVERY TIME. IF WE ARE NOT

ABLE TO DO THAT, THEN WE ATTEMPT TO PUT THE DIGOXIN INTO THE AMNIOTIC FLUID.

AND IT SEEMS TO WORK LESS OFTEN WHEN IT IS JUST PUT INTO THE AMNIOTIC FLUID.

Q. WHAT PERCENTAGE OF TIME ARE YOU SUCCESSFUL IN GETTING THE DIGOXIN INTO THE FETAL HEART?

A. I WOULD SAY APPROXIMATELY 50 PERCENT.

Q. AND WHEN DO YOU ADMINISTER -- WHEN DO YOU ADMINISTER THE DIGOXIN WHEN YOU USE IT?

A. THE DAY BEFORE THE PROCEDURE.

Q. AND WHY DO YOU DO IT THEN?

A. WE STARTED DOING IT ON THE FIRST DAY OF LAMINARIA, AND WE FOUND TOO MANY WOMEN WERE GOING INTO LABOR EARLY.

Q. SO YOU NOW DO IT 24 HOURS IN ADVANCE OF THE ACTUAL PROCEDURE?

A. CORRECT.

Q. DO YOU KNOW WHEN IT TAKES EFFECT?

A. I HAVE NOT LOOKED AT THAT.

Q. HAVE YOU EVER USED A CHEMICAL AGENT CALLED "KCL," OR "POTASSIUM CHLORIDE" IN THE CONTEXT OF THE D&E PROCEDURE?

A. NO.

Q. SO, LET'S SEE.

MS. PARKER: MAY I APPROACH JUST FOR COLLECTION OF THE --

BY MS. PARKER:

Q. DR. SHEEHAN, AT THE BEGINNING OF OUR TESTIMONY YESTERDAY YOU INDICATED YOU WERE GOING TO TESTIFY ALSO ABOUT THE PARTIAL-BIRTH ABORTION BAN ACT AND THE IMPACT IN YOUR PRACTICE. DO YOU REMEMBER THAT?

A. YES.

Q. AND I'VE PUT UP HERE A SECTION OF THAT ACT. DO YOU SEE THAT?

A. I DO.

Q. AND HAVE YOU SEEN THAT BEFORE?

A. YES.

Q. WHEN DID YOU SEE IT?

A. WHEN THE ACT WAS PASSED.

Q. ARE YOU CONCERNED ABOUT THE POTENTIAL IMPACT OF THIS LAW ON YOUR PRACTICE AS YOU'VE DESCRIBED IT THIS MORNING?

A. I AM VERY CONCERNED.

Q. WHY ARE YOU VERY CONCERNED?

A. BECAUSE AS I'VE DISCUSSED, IT IS FREQUENT AND PREFERRED THAT I DO SOMETHING THAT IS DESCRIBED IN THIS ACT, WHICH IS THAT THE FETUS IS DELIVERED, IN THE CASE OF A BREECH PRESENTATION, TO THE -- ANY PART OF THE FETAL TRUNK IS PAST THE NAVEL. SO I AM AFRAID THAT WHAT I DO MEETS THE DESCRIPTION HERE IN THE ACT.

Q. AND IN ADDITION TO THE IMPACT ON YOUR OWN PRACTICE, DO YOU HAVE OTHER CONCERNS ABOUT THE IMPACT OF THE ACT?

A. I AM VERY CONCERNED. I HAVE HEARD A NUMBER OF PROVIDERS

DISCUSSING THAT THEY WOULD FIND IT DIFFICULT TO CONTINUE PROVIDING SECOND-TRIMESTER ABORTION CARE IF THIS ACT ACTUALLY WENT INTO EFFECT.

Q. AND WOULD THAT CREATE ANY PROBLEMS IF PEOPLE CEASE DOING SECOND-TRIMESTER ABORTION CARE?

A. ABSOLUTELY. IT WOULD MAKE IT MORE DIFFICULT FOR WOMEN WHO ARE SEEKING THESE PROCEDURES TO ACTUALLY GET THEM. THERE PROBABLY WOULD BE A DELAY IN ACCESSING THE CARE.

AND WE KNOW THAT EVERY WEEK THAT A WOMAN WAITS FURTHER INTO GESTATION, HER RISK OF COMPLICATION GOES UP BY 50 PERCENT. SO IT IS ESSENTIAL THAT WOMEN SEEK THE CARE AS SOON AS POSSIBLE.

Q. AND WHY EXACTLY WOULD THIS ACT IMPACT ON YOUR PRACTICE, ON HOW YOU PERFORM YOUR PROCEDURES?

A. WELL, I WOULD BE CONCERNED ABOUT THE ATTENTION THAT I HAVE BEEN PLACING ON OBTAINING EXCELLENT CERVICAL DILATION, BECAUSE THAT PART OF THE PROCESS WHICH I BELIEVE CREATES THE SAFETY OF THE PROCEDURE WOULD BE ALSO PUTTING ME IN THE POSITION OF VIOLATING THE ACT.

SO I WOULD FEEL LIKE I WOULD HAVE TO CONSIDER NOT DILATING AS FAR, WHICH WOULD NOT BE PREFERABLE, BECAUSE THAT IS THE SAFETY -- THE SAFETY FEATURE OF MY PROCEDURE.

Q. AND DO YOU KNOW WHAT THE TERM "DELIBERATELY AND INTENTIONALLY" MEANS?

A. I DON'T UNDERSTAND IT. I KNOW A LITTLE BIT OF GRAMMAR, AND

I KNOW THOSE ARE ADVERBS, AND THEY SHOULD BE MODIFYING THE VERB, WHICH IS "DELIVERS." SO "DELIBERATELY AND INTENTIONALLY DELIVERING," THAT IS WHAT I DO. THAT IS WHAT I AM TRYING TO DO IN MY PROCEDURE.

Q. AND WHAT ABOUT THE TERM "LIVING FETUS," WHAT DOES THAT MEAN TO YOU?

A. IT WOULD BE A FETUS THAT STILL HAS A HEARTBEAT, AND THAT WOULD STILL APPLY TO MANY OF MY CASES.

Q. AND IN YOUR PRACTICE DO YOU BRING THE FETUS TO THE POINT WHERE THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE WOMAN?

A. YES, I DO. THAT'S WHAT I MAINLY DO.

Q. AND THAT HAPPENS OFTEN?

A. YES.

Q. AND YOU HAVE A PREFERENCE FOR THAT?

A. I DO.

Q. IN YOUR OPINION, COULD THIS LAW BE UNDERSTOOD AS VIOLATING D&E'S FOR DISARTICULATION OCCURS?

A. YES, THAT IS POSSIBLE.

Q. AND HOW WOULD THAT HAPPEN?

A. IF A DISARTICULATION PROCEDURE HAD STARTED, BUT THE FETUS THEN WAS DELIVERED TO THE LEVEL OF THE NAVEL, IT COULD STILL BE LIVING. THE HEARTBEAT COULD STILL BE GOING, AND THE FETUS WOULD HAVE ALREADY HAD A DISARTICULATION PROCEDURE STARTED.

Q. AND HAVE YOU ENCOUNTERED THOSE SITUATIONS IN YOUR PRACTICE?

A. YES.
Q. DO YOU KNOW WHAT THE TERM "OVERT ACT" MEANS?
A. NOT REALLY.
Q. NOW, YOU UNDERSTAND THAT THERE HAS BEEN AN INJUNCTION ENTERED IN THIS CASE, AND RIGHT NOW THE ACT IS NOT BEING ENFORCED; IS THAT RIGHT?
A. YES.
Q. IF THE INJUNCTION WERE LIFTED, DO YOU KNOW WHAT YOU WOULD DO WITH YOUR PRACTICE?
A. I WOULD HAVE TO CONSIDER LONG AND HARD HOW WE ARE PROVIDING D&E'S. THE EVOLUTION OF THE PROCESS THAT WE ARE DOING NOW HAS BEEN BASED ON TRYING TO ACHIEVE THE HIGHEST SAFETY FOR OUR PATIENTS, SO WE WOULD HAVE TO CONSIDER EACH PART OF THE PREPARATION AND THE PROCEDURE TO TRY TO AVOID VIOLATING THE BAN.
MS. PARKER: MAY I ALSO GET ANOTHER?
THE COURT: YES.
BY MS. PARKER:
Q. SO, DR. SHEEHAN, I WOULD LIKE TO SHOW YOU ANOTHER PORTION OF THE PARTIAL-BIRTH ABORTION BAN ACT, WHICH IS KNOWN AS THE "CIVIL ACTION PROVISIONS." DO YOU SEE THAT WHICH IS BEFORE YOU?
A. I DO.
Q. HAVE YOU SEEN THAT BEFORE?
A. I HAVE.

Q. AND THAT PROVISION STATES THAT IF THE FATHER IS MARRIED TO THE MOTHER AT THE TIME SHE RECEIVES A PARTIAL-BIRTH ABORTION PROCEDURE, AND IF THE MOTHER HAS NOT ATTAINED THE AGE OF 18 YEARS AT THE TIME OF THE ABORTION, THE MATERNAL GRANDPARENTS OF THE FETUS MAY, IN A CIVIL ACTION, OBTAIN APPROPRIATE RELIEF, UNLESS THE PREGNANCY RESULTED FROM THE PLAINTIFF'S CRIMINAL CONDUCT OR THE PLAINTIFF CONSENTED TO THE ABORTION.

DO YOU SEE THAT?

A. YES.

Q. AND THAT INDICATES ESSENTIALLY THAT IF THE FATHER OR MATERNAL GRANDPARENTS OF THE FETUS COULD SUE, RIGHT, IF THEY DON'T GIVE CONSENT TO THE PROCEDURE?

A. YES.

Q. DO YOU CURRENTLY OBTAIN CONSENT FOR THE ABORTION FROM THE FATHER?

MR. SIMPSON: YOUR HONOR, I AM AFRAID WE HAVE TO OBJECT TO THIS LINE OF QUESTIONING. I DON'T BELIEVE THAT THERE IS ANY ALLEGATION IN THE COMPLAINT REGARDING THIS PROVISION.

THE COURT: AND SO YOUR OBJECTION IS IRRELEVANT?

MR. SIMPSON: EXACTLY.

THE COURT: OKAY.

MS. PARKER: BUT THIS GOES TO THE IMPACT OF THE ACT IF IT IS NOT ENJOINED ON HER PRACTICE.

THE COURT: I ACTUALLY WANT TO HEAR FROM ALL OF THE POSITIONS BY BOTH SIDES ABOUT THEIR OPINION AS TO THE IMPACT.

I WILL PERMIT THIS LINE OF QUESTIONING.

AND YOU MAY ASK YOUR EXPERTS THE SAME QUESTIONS, IF YOU WISH TO DO IT.

BY MS. PARKER:

Q. DR. SHEEHAN, DO YOU CURRENTLY OBTAIN CONSENT FOR THE ABORTION FROM THE FATHER?

A. I DON'T. THE DECISION TO OBTAIN AN ABORTION IS A VERY PRIVATE MATTER BETWEEN THE PATIENT AND ME, HER PHYSICIAN. SO I DON'T ASK THE PERMISSION OF ANYBODY ELSE.

Q. AND DO YOU EVER OBTAIN PERMISSION FROM THE MATERNAL GRANDPARENTS OF THE FETUS IF THE MOTHER IS NOT YET 18?

A. THAT WOULD BE MY PATIENT'S PARENTS, AND, NO, I DON'T ASK THEIR PERMISSION.

Q. AND IF THE ACT WENT INTO EFFECT WOULD YOU HAVE TO CHANGE YOUR PRACTICE IN THAT REGARD IN TERMS OF THE CONSENT YOU OBTAIN FOR THE PROCEDURE?

A. I WOULD.

Q. ARE YOU CONCERNED ABOUT THAT?

A. I AM VERY CONCERNED ABOUT THAT. I SEE PATIENTS IN A NUMBER OF SITUATIONS WHERE THIS WOULD REALLY CAUSE A SIGNIFICANT DISRUPTION IN THE RELATIONSHIP BETWEEN THE PATIENT. AND THE WOMEN WHO COME IN FOR SECOND-TRIMESTER PROCEDURES PARTICULARLY ARE IN SOME SORT OF CHAOTIC SITUATION IN THEIR LIVES.

FREQUENTLY MAYBE THEIR HUSBAND IS JUST LEAVING THEM. THEY ARE NOT IN GOOD RELATIONSHIPS WITH THEIR FAMILIES. AND TO

HAVE TO OBTAIN THE CONSENT OF SOMEBODY WHO IS NOT LOOKING OUT FOR THE PATIENT'S BEST INTEREST WOULD DEFINITELY CAUSE A PROBLEM.

MS. PARKER: THANK YOU, DR. SHEEHAN. I HAVE NO FURTHER QUESTIONS AT THIS TIME.

THE COURT: I JUST HAVE A FEW QUESTIONS BEFORE YOU START QUESTION, COUNSEL.

WITH REGARD TO THE PROCEDURE THAT YOU USE WHEN THE FETUS IS DELIVERED PRETTY MUCH INTACT AND THE HEAD IS LODGED, IS THE PROCEDURE THAT YOU DESCRIBE, THE DISARTICULATION OF THE NECK, THE ONLY PROCEDURE THAT YOU USE IN THAT SCENARIO?

THE WITNESS: IT IS NOT THE ONLY PROCEDURE. IF THE CERVIX IS ADEQUATELY DILATED AND EFFACED SO IT IS THIN, I CAN SOMETIMES GET ONE OF THE FORCEPS AROUND THE FETAL HEAD TO COMPRESS IT WITHOUT ACTUALLY DISARTICULATING.

THE COURT: OKAY. AND IS THE PREPARATION OF THE CERVIX THE SAME REGARDLESS OF WHETHER OR NOT THE PROCEDURE IS A D&E OR INTACT D&E?

THE WITNESS: I DON'T DIFFERENTIATE THOSE TWO PROCEDURES. I SET OUT TO DO A D&E TO OBTAIN THE TERMINATION OF THE PREGNANCY OF THE PATIENT, SO I DON'T REALLY CONSIDER MYSELF DOING INTACT D&E. IF THAT HAPPENS AS PART OF THE PROCESS, THEN I'M ACTUALLY RELIEVED, BECAUSE IT REDUCES THE RISK FOR THE PATIENT.

BUT, IT'S ALL PART OF THE SAME CONTINUUM TO ME.

THE COURT: ALL RIGHT. SO IS IT APPROPRIATE FOR ME TO ASSUME, THEN, FROM YOUR TESTIMONY THAT YOU HAVE NO CONTROL OVER WHETHER OR NOT THE EXTRACTION IS GOING TO BE INTACT OR PARTIAL?

THE WITNESS: YOU'RE EXACTLY RIGHT. THIS IS SOMETHING THAT HAPPENS AS WE EVALUATE THE CERVIX AT THE BEGINNING OF THE PROCEDURE. THE WOMAN HAS ALREADY GONE THROUGH TWO DAYS OF PREPARATION OF THE CERVIX. IT IS NOT UNTIL THAT MOMENT WHEN SHE IS ALREADY LYING ON THE TABLE AND ASLEEP WHEN I AM ABLE TO EVALUATE WHAT THE DILATION OF THE CERVIX IS.

SO IT IS AT THAT MOMENT THAT I AM ABLE TO HAVE MORE INFORMATION AND CAN MAKE A JUDGMENT ABOUT HOW THE PROCEDURE IS GOING TO PROCEED AT THAT POINT.

THE COURT: OKAY. ALL RIGHT. THANK YOU.

ALL RIGHT, MR. SIMPSON?

CROSS-EXAMINATION

BY MR. SIMPSON:

Q. GOOD MORNING, DR. SHEEHAN. HOW ARE YOU TODAY?

A. I AM FINE, MR. SIMPSON. HOW ARE YOU?

Q. GOOD. I BELIEVE YOU FIRST BECAME MEDICAL DIRECTOR OF PLANNED PARENTHOOD SAN DIEGO AND RIVERSIDE COUNTIES IN 1981?

A. THAT'S CORRECT.

Q. THAT WAS IN FEBRUARY OF 1981?

A. CORRECT.

Q. SINCE FEBRUARY OF 1981, DOCTOR, HOW MANY MEDICAL ARTICLES

HAVE YOU PUBLISHED?

A. I'VE BEEN PART OF TWO VERY MAJOR RESEARCH PROJECTS ON MEDICAL ABORTION THAT WERE RUN BY PLANNED PARENTHOOD FEDERATION. I WAS A PRINCIPAL INVESTIGATOR IN THOSE.

BUT THE ONLY ONE THAT ACTUALLY HAS MY NAME ON IT AS AUTHOR IS ONE.

Q. ONE. WHEN WAS THAT PUBLISHED?

A. I BELIEVE 1989.

Q. HAVE YOU EVER PUBLISHED ANYTHING ON ABORTION?

A. AS I SAY, I PARTICIPATED IN THE MEDICAL ABORTION TRIALS OF PLANNED PARENTHOOD FEDERATION OF AMERICA.

Q. BUT THAT ISN'T PUBLISHED IN A PEER-REVIEWED JOURNAL?

A. THEY ACTUALLY ARE PUBLISHED IN A NUMBER OF DIFFERENT JOURNALS AND DIFFERENT PARTS OF IT, BUT MY NAME IS NOT ON AS AN AUTHOR BECAUSE THERE WERE SO MANY PEOPLE INVOLVED WITH THE STUDIES.

Q. YOU TESTIFIED YESTERDAY, I BELIEVE, THAT YOU HAVE PERFORMED APPROXIMATELY 30,000 SURGICAL ABORTIONS THROUGHOUT YOUR CAREER?

A. THAT IS MY BEST GUESS.

Q. AND APPROXIMATELY 300 INDUCTION ABORTIONS?

A. DURING MY RESIDENCY.

Q. NOW, EARLIER TODAY YOU TESTIFIED THAT YOU HAVE PRACTICED SOME IN A HOSPITAL SETTING, CORRECT?

A. CORRECT.

Q. BUT LESS THAN 1 PERCENT OF THE ABORTIONS THAT YOU HAVE

PERFORMED HAVE BEEN IN A HOSPITAL SETTING?
A. CORRECT.
Q. APPROXIMATELY HOW MANY TIMES, DOCTOR, HAVE YOU DELIVERED BABIES DURING YOUR CAREER?
A. I STOPPED AFTER MY RESIDENCY, AND I APPROXIMATELY DELIVERED 200 TO 300 BABIES DURING MY RESIDENCY.
Q. DID YOU TESTIFY DURING YOUR DEPOSITION THAT THAT NUMBER WAS 200?
A. I BELIEVE I DID.
Q. SO THE NUMBER IS 200?
A. YES.
Q. SO YOU HAVE NOT DELIVERED BABIES SINCE YOUR RESIDENCY ENDED IN 1978?
A. CORRECT.
Q. IN PERFORMING ABORTIONS, DOCTOR, DO YOU MAKE ANY JUDGMENT AS TO WHETHER AN ABORTION IS NEEDED BECAUSE OF MATERNAL HEALTH CONDITIONS?
A. I DON'T MAKE THOSE DETERMINATIONS. IF THE PATIENT HAS BEEN WORKING WITH AN OBSTETRICIAN FOR HER CARE, AND THEN IS ADVISED AND SHE DECIDES TO HAVE A TERMINATION, THEN SHE MAY BE REFERRED TO ME.
Q. AND YOU ALSO DON'T MAKE ANY JUDGMENTS AS TO WHETHER AN ABORTION IS NEEDED BECAUSE OF A FETAL ANOMALY, CORRECT?
A. I DON'T MAKE THAT DECISION.
Q. YESTERDAY YOU TESTIFIED THAT PLANNED PARENTHOOD SAN DIEGO

PERFORMS ABORTIONS DUE TO THE PRESENCE OF A FETAL ANOMALY. BUT, IN REALITY, YOU DON'T MAKE THE DETERMINATION WHETHER THE ABORTION IS NEEDED IN THOSE INSTANCES?

A. THAT'S CORRECT.

Q. IN FACT, ISN'T IT TRUE THAT IT IS THE POLICY OF PLANNED PARENTHOOD TO PERFORM ABORTIONS FOR WOMEN WHO COME AND HAVE ADEQUATE INFORMATION TO MAKE A DECISION AND CHOOSE TO HAVE AN ABORTION?

A. THAT'S CORRECT.

MR. SIMPSON: YOUR HONOR, COULD I APPROACH THE WITNESS, PLEASE?

MS. PARKER: COULD YOU LET US KNOW WHAT EXHIBIT YOU ARE USING?

MR. SIMPSON: I HAVE GIVEN THE WITNESS EXHIBIT A-27. DEFENDANT'S A-27.

BY MR. SIMPSON:

Q. DR. SHEEHAN, EXHIBIT A-27, DOES THAT APPEAR TO BE AN E-MAIL FROM KAREN SHEA TO DEENA MAEROWITZ?

I AM REFERRING TO THE PORTION IN THE MIDDLE OF THE PAGE.

A. IT DOES SAY THE ORIGINAL MESSAGE IS FROM KAREN SHEA TO DEENA MAEROWITZ.

Q. HAVE YOU EVER SEEN THIS DOCUMENT BEFORE?

A. YES.

Q. THIS DOCUMENT INDICATES THAT KAREN SHEA IS THE CLINICAL

SERVICES MANAGER FOR PLANNED PARENTHOOD FEDERATION OF AMERICA; IS THAT WHAT IT SAYS?

A. YES, IT DOES SAY THAT.

Q. DO YOU KNOW FOR A FACT THAT KAREN SHEA IS THE CLINICAL SERVICES MANAGER FOR PPFA?

A. I DON'T KNOW IF THAT IS STILL HER TITLE.

Q. DO YOU KNOW WHETHER THAT WAS HER POSITION IN NOVEMBER OF 2002?

A. YES.

Q. IN THAT CAPACITY, DID KAREN SHEA OVERSEE THE MEDICAL PROTOCOLS TO BE FOLLOWED BY PPFA AFFILIATES?

A. I AM NOT SURE HER ROLE IS OVERSIGHT OF THE MEDICAL PROTOCOLS. SHE WAS INVOLVED WITH MAKING THEM.

Q. YOU GAVE A DEPOSITION IN THIS CASE; IS THAT CORRECT, DR. SHEEHAN?

A. YES.

Q. I ASSUME YOU TESTIFIED TRUTHFULLY DURING YOUR DEPOSITION?

A. I AM SURE I DID.

Q. DID YOU GET A CHANCE TO REVIEW A TRANSCRIPT OF YOUR DEPOSITION AFTERWARDS?

A. I DID.

MR. SIMPSON: YOUR HONOR, I AM GOING TO BE READING TO HER SOME FROM HER DEPOSITION. WOULD YOU LIKE ME TO HAND UP A COPY OF THE DEPOSITION?

THE COURT: YOU SHOULD LODGE THE ORIGINAL BEFORE YOU

USE IT. AND PLEASE ALLOW HER TO READ THE SECTION. IF YOU ARE GOING TO USE IT FOR IMPEACHMENT PURPOSES, ALLOW HER TO READ THE SECTION FIRST TO HERSELF.

MR. SIMPSON: CERTAINLY.

BY MR. SIMPSON:

Q. IN FACT, DR. SHEEHAN, LET ME HAND YOU A COPY OF YOUR DEPOSITION. IF YOU CAN REFER TO PAGE 47, PLEASE. I AM GOING TO BE READING STARTING FROM LINE 14 ON PAGE 47.

"QUESTION: HAVE YOU HAD CONTACT WITH KAREN SHEA IN HER CAPACITY AS CLINICAL SERVICES MANAGER FOR PPFA?

"ANSWER: YES.

"QUESTION: WHAT DOES SHE DO IN THAT CAPACITY?

"ANSWER: I BELIEVE SHE OVERSEES THE PROTOCOLS FOR PPFA.

"QUESTION: WHAT DO YOU MEAN BY 'OVERSEES THE PROTOCOLS'?

"ANSWER: SHE MANAGES THE AMENDMENTS AND COMMUNICATES THOSE TO THE AFFILIATES."

YOU TESTIFIED TRUTHFULLY AT THAT TIME, CORRECT?

A. YES.

Q. WOULD KAREN SHEA, THEN, BE RESPONSIBLE FOR INDICATING IN THE PROTOCOLS ANY PPFA-WIDE CHANGES IN THE WAY THAT PPFA AFFILIATES PERFORM ABORTIONS?

A. THE PROCESS OF PROTOCOLS IS ONE THAT PPFA MAKES STANDARDS

THAT ARE VERY GENERAL. AND THEN THE LOCAL AFFILIATES MAKE THEIR OWN PROTOCOLS FROM THOSE. SO, THEY DON'T TELL PLANNED PARENTHOOD HOW TO DO THE ABORTIONS.

Q. WHAT, THEN, IS THE PURPOSE OF THE PROTOCOLS?

A. TO MAKE SURE THAT THE AFFILIATES HAVE CERTAIN STANDARDS THAT THEY MUST MEET.

Q. SO THEN, THE PPFA AFFILIATES NEED TO FOLLOW THE PROTOCOLS THAT PPFA ESTABLISHES?

A. RIGHT. BUT THE AFFILIATE PROTOCOLS ARE MUCH MORE SPECIFIC THAN THE GENERAL STANDARDS OF THE PLANNED PARENTHOOD FEDERATION.

Q. DOCTOR, IF I COULD REFER YOU BACK TO EXHIBIT A-27, THE E-MAIL.

MS. PARKER: I AM GOING TO OBJECT, YOUR HONOR, BECAUSE THIS HAS NOT YET BEEN ENTERED INTO EVIDENCE, SO IT IS NOT A FORMAL EXHIBIT.

THE COURT: WELL, IF YOU REFER TO IT AS 27 FOR PURPOSES OF IDENTIFICATION. IT HAS NOT YET BEEN MOVED INTO EVIDENCE.

MR. SIMPSON: THANK YOU, YOUR HONOR.

BY MR. SIMPSON:

Q. THERE IS A SECTION THERE ENTITLED "INTACT D&X." DO YOU SEE THAT?

A. I DO.

Q. IT SAYS:

"INTACT D&X (D&X INTACT DILATION AND EXTRACTION, PARTIAL-BIRTH ABORTION) CONSISTS OF THE FOLLOWING FOUR ELEMENTS: ONE, DELIBERATE DILATION OF THE CERVIX, USUALLY OVER A SEQUENCE OF DAYS; TWO, INSTRUMENTAL CONVERSION OF THE FETUS TO A FOOTLING BREECH; THREE, BREECH EXTRACTION OF THE BODY EXCEPTING THE HEAD; AND FOUR, PARTIAL EVACUATION OF THE INTRACRANIAL CONTENTS OF THE LIVING FETUS TO EFFECT VAGINAL DELIVERY OF A DEAD, BUT OTHERWISE INTACT FETUS."

DID I READ THAT CORRECTLY, DOCTOR?

A. YOU DID READ THAT.

Q. HAVE YOU EVER PERFORMED THE INTACT D&X PROCEDURE DESCRIBED THERE?

A. NO.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO MOVE EXHIBIT A-27 INTO EVIDENCE.

THE COURT: ON WHAT BASIS?

MR. SIMPSON: YOUR HONOR, IT IS -- IT IS NOT HEARSAY. WE ARE OFFERING IT -- WE ARE NOT OFFERING IT FOR ITS TRUTH. WE ARE OFFERING IT FOR THE FACT THAT THE CLINICAL SERVICES MANAGER AT PPFA STATED THAT INTACT D&X CONSISTS OF THESE ELEMENTS.

THE COURT: I DON'T UNDERSTAND WHAT THE RELEVANCE IS IF IT IS NOT OFFERED FOR THE TRUTH. OF WHAT IMPORT IS THE FACT

THAT THIS MANAGER BELIEVED THAT THIS WAS THE DEFINITION? WHAT DOES THAT MEAN?

MR. SIMPSON: YOUR HONOR, PART OF THE PLAINTIFFS' ARGUMENT HERE HAS BEEN AND IS AND WE THINK WILL BE THAT BASICALLY THERE IS NO SUCH PROCEDURE AS INTACT D&X AS A SEPARATE PROCEDURE. THE FACT THAT THE PERSON AT PPFA RESPONSIBLE FOR ESTABLISHING MEDICAL PROTOCOLS FOR PPFA AFFILIATES HAS STATED THAT THERE IS A PROCEDURE CALLED "INTACT D&X," AND IT HAS THOSE PARTICULAR ELEMENTS, WE BELIEVE IS VERY RELEVANT TO OUR ASSERTION THAT THE PLAINTIFFS' ARGUMENT IN THAT REGARD IS INCORRECT.

THE COURT: BUT NEITHER OF THE -- NEITHER AUTHOR NOR THE RECIPIENT WHO REQUESTED THE INFORMATION IS GOING TO BE A WITNESS; IS THAT CORRECT?

MR. SIMPSON: THAT'S CORRECT, YOUR HONOR.

THE COURT: HOW DO WE KNOW THAT THE INFORMATION PROVIDED IS THE OFFICIAL POSITION OF PLANNED PARENTHOOD?

MR. SIMPSON: YOUR HONOR, ALL WE ARE SAYING IS THAT -- I SUPPOSE THAT QUESTION CONSISTS OF TWO DIFFERENT ELEMENTS: AUTHENTICITY, ONE; AND MORE IMMEDIATELY, WHETHER THIS IS A POSITION OF PLANNED PARENTHOOD.

ON THE AUTHENTICITY ELEMENT OF IT, PPFA HAS PRODUCED THIS DOCUMENT TO US. IT BEARS PPFA'S BATES STAMP IN THE LOWER RIGHT CORNER. AND ONE WOULD THINK THAT PPFA WOULD NOT PRODUCE TO US AN E-MAIL BEARING INDICATIONS THAT IT WAS WRITTEN BY A

PPFA OFFICER UNLESS IT WERE, IN FACT, AN E-MAIL WRITTEN BY A PPFA OFFICER.

MS. PARKER: IF I MIGHT, YOUR HONOR.

THE COURT: WAIT. WAIT. AND THE SECOND ISSUE?

MR. SIMPSON: THE SECOND ONE, YOUR HONOR, WE HAVE ESTABLISHED THAT THIS PERSON IS RESPONSIBLE FOR SETTING THE PROTOCOLS THAT PPFA AFFILIATES ARE TO FOLLOW.

THE COURT: ARE YOU OFFERING THIS AS ONE OF THOSE PROTOCOLS?

MR. SIMPSON: NO. NO, YOUR HONOR. BUT THE PROTOCOLS INDICATE THE MANNER IN WHICH PPFA AFFILIATES SHOULD PERFORM THEIR SERVICES. OBVIOUSLY, ONE OF THE SERVICES THEY PERFORM IS ABORTION. AND THIS SETS OUT HOW THIS PERSON VIEWS --

THE COURT: THE DIFFICULTY THAT I AM HAVING -- I ALWAYS HAVE A LOT OF DIFFICULTY. IN ALL MY TRIALS EVERYBODY WANTS TO SUBMIT E-MAILS. AND THERE IS A REAL DIFFICULTY IN MY VIEW OF ME ACCEPTING THIS E-MAIL AS AN OFFICIAL POSITION OF THE EMPLOYER OF EITHER THE RECIPIENT OR THE AUTHOR WITHOUT HEARING FROM THEM EXACTLY WHAT WAS MEANT BY THIS.

I MEAN, I WOULD AGREE WITH YOU THAT IF THE INFORMATION CONTAINED IN THIS, IN THE RESPONSE TO THE E-MAIL WAS, INDEED, REFLECTIVE OF THE PROTOCOL, THAT THAT WOULD BE PERTINENT INFORMATION.

BUT I AM NOT SURE THAT IT IS. I HAVE READ THIS. I

AM NOT EXACTLY SURE HOW OFFICIAL THIS IS. IF IT IS NOT THE OFFICIAL POSITION, IF IT IS ONLY THE BELIEF OF THE MANAGER INVOLVED, I AM NOT SURE THAT IS ENOUGH.

MR. SIMPSON: YOUR HONOR, IF I COULD ASK THE WITNESS ONE MORE QUESTION BEFORE THE COURT MAKES A DECISION ON THAT.

BY MR. SIMPSON:

Q. DR. SHEEHAN, DO THE PROTOCOLS THAT PPFA ESTABLISHES THROUGH KAREN SHEA, DO THOSE PROTOCOLS TO SOME EXTENT DESCRIBE HOW PPFA AFFILIATES SHOULD PERFORM VARIOUS METHODS OF ABORTION?

A. NO. THIS IS NOT PART OF THE PROTOCOL.

Q. I UNDERSTAND, DOCTOR, THIS IS NOT PART OF THE PROTOCOL. BUT DO THE PROTOCOLS SET FORTH HOW ABORTIONS ARE PERFORMED?

A. NOT IN THIS DEGREE OF SPECIFICITY.

MR. SIMPSON: COULD I APPROACH THE WITNESS, PLEASE, YOUR HONOR?

THE COURT: YES.

MS. PARKER: COULD WE HAVE A COPY OF WHAT YOU ARE PROVIDING?

MR. SIMPSON: SURE. IT IS A-31.

IF I COULD HAVE THE COURT'S INDULGENCE FOR A MOMENT TO GET A DIFFERENT EXHIBIT.

BY MR. SIMPSON:

Q. DOCTOR, I HAVE JUST GIVEN YOU EXHIBIT A-31. I WOULD ALSO LIKE TO GIVE YOU A-11.

DO YOU RECOGNIZE EXHIBIT A-11, DOCTOR?

A. YES.
Q. WHAT IS THAT?
A. THIS IS A SECTION FROM THE MANUAL OF MEDICAL STANDARDS AND GUIDELINES OF PLANNED PARENTHOOD FEDERATION OF AMERICA.
Q. DOES THAT CONSIST OF -- DOES THAT CONSTITUTE TO SOME EXTENT THE PROTOCOLS THAT PPFA PROVIDES TO ITS AFFILIATES?
A. THIS IS NOT PART OF THE PROTOCOL. THIS IS PART OF INFORMATION THAT IS GIVEN TO THE PATIENTS. THIS IS CALLED A "CLIENT INFORMATION FOR INFORMED CONSENT."
Q. DOES PPFA -- I'M SORRY. DOES PLANNED PARENTHOOD SAN DIEGO USE THE INFORMATION FROM THE MANUAL TO ANY EXTENT IN ESTABLISHING ITS PROTOCOLS?
A. WE DEFINITELY USE THE INFORMATION FROM THE PROTOCOL -- FROM THE STANDARDS AND GUIDELINES TO MAKE OUR PROTOCOLS. THERE IS A STRONG DISTINCTION BETWEEN WHAT IS EXPECTED AS STANDARDS OF BEHAVIOR AND CARE, MEDICAL CARE, AND THE INFORMATION THAT IS GIVEN TO THE PATIENTS AS INFORMED CONSENT.
Q. WOULD YOU AGREE, DOCTOR, THAT EXHIBIT A-31 TO SOME EXTENT SETS FORTH THE WAY -- I AM SORRY, EXHIBIT -- WOULD YOU AGREE, DOCTOR, THAT EXHIBIT A-27 TO SOME EXTENT INDICATES THE WAY THAT ABORTIONS SHOULD BE PERFORMED?
A. NO. THIS HAS NOTHING AT ALL WITH DIRECTION TO THE AFFILIATES ABOUT HOW ABORTIONS SHOULD BE PERFORMED.
Q. I APOLOGIZE IF I ASKED THIS ALREADY, DOCTOR. DO THE PROTOCOLS THAT COME FROM PPFA SET FORTH STEPS FOR ABORTIONS?

A. COULD YOU BE MORE SPECIFIC? THEY SET FORTH STANDARDS THAT ARE EXPECTED TO BE MET, BUT THERE IS NO COOKBOOK:

"FIRST YOU DO THIS, FIRST. THEN YOU DO THIS."

IT IS NOT A HOW-TO-DO-AN-ABORTION PROTOCOL. IT IS: WHAT STANDARDS MUST BE MET FOR THE PATIENT'S SAFETY?

Q. WHAT DOES THE WORD "PROTOCOL" MEAN TO YOU, DOCTOR, IN A MEDICAL CONTEXT?

A. THE PROTOCOLS ARE WHAT IS GENERATED AT THE LOCAL AFFILIATE LEVEL, AND THAT IS WHERE THE INFORMATION IS THAT SAYS:

"YOU WILL DO THIS, AND YOU WILL DO THAT."

BUT THE STANDARDS AND GUIDELINES THAT COME FROM PLANNED PARENTHOOD FEDERATION ARE JUST THAT: THEY ARE STANDARDS AND GUIDELINES.

Q. DOCTOR, YOU TESTIFIED IN YOUR DEPOSITION THAT DOCTOR -- I AM SORRY -- THAT KAREN SHEA ESTABLISHES PROTOCOLS THAT PPFA SENDS OUT TO ITS AFFILIATES.

A. I THINK WE ARE HAVING A SEMANTIC ARGUMENT, BECAUSE WHAT SHE IS IN CHARGE OF IS THE STANDARDS AND GUIDELINES.

Q. AND THE STANDARDS AND GUIDELINES WOULD SET FORTH WHAT?

A. WHAT THE STANDARDS ARE THAT PLANNED PARENTHOOD AFFILIATES HAVE TO DO TO BE ABLE TO CONTINUE TO BE CONSIDERED PLANNED PARENTHOOD.

MR. SIMPSON: IF I COULD HAVE ONE MORE MOMENT.

(PAUSE IN THE PROCEEDINGS.)

MR. SIMPSON: YOUR HONOR, I BELIEVE THAT WE HAVE

ESTABLISHED AT LEAST PPFA PROVIDES TO ITS AFFILIATES AT LEAST THE STANDARDS AND GUIDELINES THAT THE AFFILIATES NEED TO FOLLOW IN PROVIDING ABORTION SERVICES.

THE WITNESS DID TESTIFY AT HER DEPOSITION THAT KAREN SHEA, THE PERSON WHO WROTE THIS E-MAIL, DOES PROVIDE OR PARTICIPATE IN PROVIDING PROTOCOLS TO PLANNED PARENTHOOD AFFILIATES. AND WE BELIEVE THAT -- AND THIS WITNESS ALSO HAS TESTIFIED -- THAT KAREN SHEA IS THE CLINICAL SERVICES MANAGER, IN FACT, FOR PPFA.

SO WE WOULD SUBMIT, YOUR HONOR, THAT THIS E-MAIL CAN BE ADMITTED, NOT FOR ITS TRUTH, BUT TO SHOW THAT THE PERSON RESPONSIBLE FOR SETTING FORTH PPFA PROTOCOLS TO THE AFFILIATES DEFINES "INTACT D&X" IN THIS WAY.

THE COURT: I UNDERSTAND. RESPONSE?

MS. PARKER: I AM GOING TO OBJECT, LACK OF FOUNDATION. WE DON'T HAVE MS. SHEA WITH US, NOR DO WE HAVE THE RECIPIENT, DEENA MAEROWITZ, OR THE COPIED -- PERSON WHO WAS COPIED, ELIZABETH TALMONT. THERE IS A COMPLETE LACK OF FOUNDATION.

PLUS, IT WAS CLASSIC HEARSAY, BECAUSE THEY ARE CLEARLY TRYING TO INTRODUCE IT FOR THE TRUTH OF WHAT IS IN IT, THAT, IN FACT, THIS IS WHAT PPFA BELIEVES "D&X, INTACT D&X" TO BE.

AND I DON'T BELIEVE THAT DR. SHEEHAN HAS DONE ANYTHING TO SATISFY EITHER THE FOUNDATIONAL OR THE HEARSAY

EXCEPTION REQUIREMENTS THAT MR. SIMPSON SEEMS TO BE ATTEMPTING.

MR. SIMPSON: IF I CAN JUST READ ONE MORE. I DON'T THINK I READ THIS BEFORE, YOUR HONOR, FROM DR. SHEEHAN'S DEPOSITION.

"QUESTION: WHAT DO YOU MEAN BY 'OVERSEES THE PROTOCOLS'?

"ANSWER: SHE MANAGES THE AMENDMENTS AND COMMUNICATES THEM TO THE AFFILIATES.

"QUESTION: MANAGES AMENDMENTS OF THE PROTOCOLS?

"ANSWER: I BELIEVE SO."

AND I BELIEVE I HAVE READ THIS LAST ONE BEFORE.

"QUESTION: SO YOU ARE TALKING ABOUT PROTOCOLS AFFILIATES ARE TO FOLLOW IN PROVIDING MEDICAL PROCEDURES?

"ANSWER: CORRECT."

THE COURT: I AM GOING TO SUSTAIN THE OBJECTION ON FOUNDATION GROUNDS AND HEARSAY GROUNDS. CERTAINLY IT SEEMS TO ME THAT IF THIS DOCUMENT IS AS IMPORTANT AS YOU SEEM TO BELIEVE IT IS, YOU COULD HAVE SIMPLY NAMED THE AUTHOR AS A WITNESS. IN THIS CASE YOU HAVE NOT DONE SO. IT IS NOT APPROPRIATE TO BRING IT IN THROUGH THIS WITNESS' TESTIMONY OR THE LAST WITNESS' TESTIMONY.

MR. SIMPSON: THANK YOU, YOUR HONOR.

BY MR. SIMPSON:

Q. DOCTOR, I THINK YOU'VE TESTIFIED THAT TO PREPARE THE CERVIX

FOR D&E YOU SOMETIMES USE LAMINARIA?
A. CORRECT.
Q. AND LAMINARIA IS A CLASS OF OSMOTIC DILATORS?
A. THAT'S CORRECT.
Q. WHEN YOU INSERT LAMINARIA, YOU HAVE TO INSERT THEM ALL THE WAY THROUGH INTO THE INTERNAL OS, CORRECT?
A. CORRECT.
Q. DO THE LAMINARIA THEN SOMETIMES BREAK THE AMNIOTIC SAC?
A. YES, THAT HAPPENS.
Q. A D&E ROUTINELY INVOLVES DISARTICULATION OF THE FETUS.
A. IT CERTAINLY DOES HAPPEN. I DON'T THINK I WOULD USE THE WORD "ROUTINELY," BUT PART OF THE CONTINUUM OF THE PRACTICE OF D&E.
Q. IF I COULD REFER YOU, DOCTOR, TO YOUR DEPOSITION. PAGE 59. START READING ON LINE 20.
"QUESTION: IF I COULD REFER YOU BACK TO THE E-MAIL, EXHIBIT 6."
THE COURT: COUNSEL, THE PROCEDURE FOR A WITNESS NOT A PARTY IS TO ALLOW THEM TO READ. IDENTIFY THE PAGE AND LINE NUMBER AND READ IT TO THEMSELVES FIRST.
MR. SIMPSON: SILENTLY, CERTAINLY.
THE COURT: SILENTLY AFTER SHE AFFIRMS THAT IS THE TESTIMONY SHE GAVE.
MR. SIMPSON: OKAY. CERTAINLY. THAT IS FINE.
///

BY MR. SIMPSON:

Q. DOCTOR, IF I COULD HAVE YOU READ SILENTLY PAGE 59, FROM LINE 20, TO PAGE 60, LINE 13.

ARE YOU DONE WITH THAT?

A. I AM.

Q. IS IT CORRECT THERE, DOCTOR, THAT I WAS ASKING YOU ABOUT INTACT D&X AS IT IS DESCRIBED IN EXHIBIT A-27, THE E-MAIL?

A. THAT'S RIGHT.

Q. AND DID I NOT ASK YOU AT WHAT POINT IN GESTATION YOU THOUGHT THAT PROCEDURE COULD BE USED?

A. THAT'S CORRECT.

Q. IF I COULD START ON PAGE 60, LINE 4:

"QUESTION: WHY DO YOU THINK IT IS NOT USUALLY USED AT ANY POINT IN THE SECOND-TRIMESTER?

"ANSWER: BECAUSE ROUTINE D&E IS USUALLY AN ADEQUATE PROCEDURE."

YOU SAID "ROUTINE D&E," THERE, CORRECT?

A. YES.

Q. "QUESTION: WHAT DO YOU MEAN BY 'ROUTINE D&E'?

"ANSWER: THE D&E AS DESCRIBED HERE ON THIS EXHIBIT 6.

"QUESTION: AND BY 'ROUTINE D&E,' DO YOU MEAN D&E CHARACTERIZED BY A DISARTICULATION?

"ANSWER: OR BY SUCTION AND CURETTAGE."

IS THAT WHAT YOU SAID?

A. CORRECT.
Q. SO "'ROUTINE D&E" INVOLVES DISARTICULATION OF THE FETUS?
A. USUALLY.
Q. AND DOCTOR, IN YOUR EXPERIENCE IN DOING A D&E, THE DISARTICULATION OF THE FETUS USUALLY OCCURS AT THE JOINTS, CORRECT?
A. YES.
Q. AND IN RELATION TO THE MOTHER, IN RELATION TO THE MOTHER'S BODY, THE DISARTICULATION USUALLY OCCURS INSIDE THE UTERUS?
A. IT OCCURS RIGHT AT THE POINT OF THE CERVIX WHERE THE CERVIX IS THE SMALLEST APERTURE THAT IT HAS TO PASS THROUGH, AND THAT IS WHAT CAUSES THE TRACTION.
Q. INSIDE THE CERVICAL OS?
A. YES.
Q. ARE YOU AWARE OF ANY STUDIES, DOCTOR, REGARDING MATERNAL INJURY FROM THE FRAGMENTS OF THE FETUS IN A D&E?
A. YES.
Q. YOU ARE? IF I COULD REFER YOU TO 123 OF YOUR DEPOSITION. PAGE 123, FROM LINE 8 THROUGH LINE 17. IF YOU COULD READ THAT TO YOURSELF, PLEASE.
A. UH-HUH.
Q. AND THE TRANSCRIPT SAYS, STARTING ON LINE 8:

"ARE YOU AWARE OF ANY STUDIES REGARDING MATERNAL INJURY FROM FRAGMENTS OF THE FETUS?

ANSWER: YES.

"QUESTION: CAN YOU TELL ME ANY AUTHORS OR TITLES OF THOSE STUDIES?

"ANSWER: I'M SORRY. I MISUNDERSTOOD YOUR QUESTION. I THOUGHT YOU WERE ASKING ME IF I KNEW OF CASES.

"QUESTION: ANY PUBLISHED STUDIES REGARDING INJURY TO THE MOTHER FROM FETAL FRAGMENTS?

"ANSWER: SPECIFICALLY, NO."

IS THAT YOUR TESTIMONY NOW?

A. YES.

Q. NOW, DOCTOR, CAN YOU TELL US, PLEASE, WHAT INSTRUMENTS YOU USE IN PERFORMING A D&E?

A. I USE A SPECULUM TO VIEW THE CERVIX. I USE A TENACULUM TO STABILIZE THE CERVIX. I USE A RING FORCEPS TO MANIPULATE WITH. I USE ANY ONE OF A NUMBER OF DIFFERENT TYPES OF FORCEPS TO EXTRACT THE FETAL PARTS. AND I USE A CANNULA, SUCTION CANNULA.

Q. YOU SAID "RING FORCEPS." CAN YOU DESCRIBE RING FORCEPS TO US?

A. RING FORCEPS ARE -- THEY ARE AN INSTRUMENT THAT IS KIND OF LIKE A SCISSORS, AND THEN IT HAS TWO CIRCLES FOR YOUR FINGERS. THERE IS CROSSED BLADES, AND AT THE END OF THE BLADE IS A ROUND APERTURE, LIKE A RING. AND THAT IS WHY THEY ARE CALLED "RINGS." AND THOSE TWO RINGS MEET EACH OTHER AT THE END SO YOU CAN GRASP THINGS WITH THEM.

Q. IS THAT THE SAME THING AS AN OVUM FORCEPS?

A. YES.

Q. YOU SAID "OTHER FORCEPS." CAN YOU IDENTIFY THOSE FOR US, PLEASE?

A. BY NAME?

Q. YES.

A. IT WOULD BE SOPHER, BIERER AND BLUMENTHAL FORCEPS.

Q. DO THOSE FORCEPS HAVE TEETH?

A. YES, THEY ARE SERRATED.

Q. WHERE THEY COME TOGETHER?

A. CORRECT.

Q. ARE THE TEETH ON THE INSIDE WHERE THEY COME TOGETHER?

A. YES.

Q. DOCTOR, IN PERFORMING A D&E, YOU GENERALLY REACH FOR WHATEVER PART, FETAL PART PRESENTS AT THE CERVIX, CORRECT?

A. USING THE ULTRASOUND, I ASCERTAIN WHAT THE FETAL PRESENTATION IS, AND I TRY VERY HARD TO GET THE SMALL PARTS FIRST.

Q. YOU GENERALLY REACH FOR WHATEVER PART PRESENTS AT THE CERVIX?

A. I USE THE ULTRASOUND TO SHOW THAT I -- HELP ME GET TO THE SMALL PARTS OF THE FETUS THAT ARE CLOSEST TO THE CERVIX.

Q. DOCTOR, IF A PHYSICIAN IS PERFORMING A D&E AND IS ATTEMPTING TO DISARTICULATE THE FETUS, AN OBSERVER WHO IS WATCHING THAT WOULD BE ABLE TO PERCEIVE, BASED ON THE PHYSICIAN'S MOVEMENTS WITH THE FORCEPS, THAT THE PHYSICIAN IS ATTEMPTING TO DISARTICULATE; IS THAT CORRECT?

A. NO, BECAUSE IT GENERALLY JUST LOOKS LIKE DOWNWARD TRACTION.
Q. YOU ARE TELLING ME THAT THE PHYSICIAN DOES NOT MAKE CERTAIN DISTINCTIVE MANEUVERS WITH THE FORCEPS WHEN THE INTENT IS TO DISARTICULATE?
A. CORRECT.
Q. DOCTOR, I WOULD LIKE TO SHOW YOU ANOTHER PART OF YOUR DEPOSITION. THIS PART WAS TRANSCRIBED SEPARATELY BECAUSE THIS PART WAS DESIGNATED AS "CONFIDENTIAL" BY YOUR ATTORNEY.

MR. SIMPSON: IF I COULD HAND THIS UP TO THE COURT, AS WELL.

YOUR HONOR, IF I COULD HAVE JUST HAVE A MOMENT.

YOUR HONOR, AT THIS POINT I NEED TO READ ABOUT A HALF PAGE OF MATERIAL FROM THAT CONFIDENTIAL PORTION. I HAVE THAT PARTICULAR PAGE --

THE COURT: ARE YOU USING THIS FOR IMPEACHMENT PURPOSES?

MR. SIMPSON: YES, I AM, YOUR HONOR. ABSOLUTELY. I HAVE THIS PARTICULAR PAGE HIGHLIGHTED, SO I CAN SHOW THE COURT AND PLAINTIFF'S COUNSEL EXACTLY WHAT LINES I WANT TO READ WITHOUT HAVING TO IDENTIFY THEM YET TO THE WITNESS UNTIL I ACTUALLY SHOW HER.

AND I AM READY TO ASK QUESTIONS ON IT. IF I COULD HAND THIS UP, AS WELL.

NOW, YOUR HONOR, WE DON'T PARTICULARLY AGREE WITH THE DESIGNATION OF THIS PORTION OF THE TRANSCRIPT AS

"CONFIDENTIAL" BY PLAINTIFF'S COUNSEL, BUT ONE COULD READ THE PROTECTIVE ORDER IN THIS CASE AS REQUIRING ME TO SEEK THE COURT'S CONSIDERATION BEFORE I READ THIS.

SO, AGAIN, IT IS THAT PART HIGHLIGHTED IN YELLOW.

MS. PARKER: YOUR HONOR, WE ARE NOT CONCERNED WITH THE CONFIDENTIALITY OF THIS PARTICULAR PORTION OF THE TRANSCRIPT. THE PORTION OF THE TRANSCRIPT WAS DESIGNATED "CONFIDENTIAL" BECAUSE OF A MEDICAL RECORD THAT WAS BEING USED WITH THE QUESTIONING, BUT IT DOESN'T APPEAR HE IS ATTEMPTING TO PUT THAT INTO THE RECORD AT THIS TIME.

MR. SIMPSON: THANK YOU.

THE COURT: WOULD YOU IDENTIFY THE PORTION TO THE WITNESS?

BY MR. SIMPSON:

Q. DOCTOR, COULD YOU TURN TO PAGE 15 IN THAT CONFIDENTIAL TRANSCRIPT, PLEASE? AND READ SILENTLY, PLEASE, VERSES -- I AM SORRY -- LINES 3 THROUGH 14.

ARE YOU DONE WITH THAT? THANK YOU.

MS. PARKER: ACTUALLY, I APOLOGIZE. WE HAVE AN ISSUE THAT IS RAISED WITH THIS PORTION OF THE TRANSCRIPT. WE ARE NOT SURE IF WE WERE EVER GIVEN A PORTION OF THE CONFIDENTIALITY SECTION FOR DR. SHEEHAN TO REVIEW AND SIGN.

AND SO BEFORE YOU BEGIN ASKING HER QUESTIONS ABOUT THIS SECTION, I THINK YOU NEED TO ESTABLISH THAT FOUNDATION. WHEN YOU ASKED HER PREVIOUSLY IF SHE HAD REVIEWED AND SIGNED

HER TRANSCRIPT, SHE WAS REFERRING TO THE NONCONFIDENTIAL PORTION OF IT.

BY MR. SIMPSON:

Q. DOCTOR, IS IT YOUR RECOLLECTION THAT DURING YOUR DEPOSITION THERE WAS A PORTION OF THE -- ACTUALLY, TWO PORTIONS OF THE DEPOSITION THAT WERE DESIGNATED AS "CONFIDENTIAL" BY YOUR ATTORNEY?

A. I DO RECALL THAT.

Q. DID YOU RECEIVE A COPY OF THOSE PORTIONS OF THE DEPOSITION TO REVIEW?

A. I DID NOT.

Q. BUT YOU RECEIVED A COPY OF THE REST OF THE DEPOSITION TO REVIEW?

A. CORRECT.

Q. DID YOU TESTIFY TRUTHFULLY DURING THE PORTIONS OF THE DEPOSITION THAT WERE DESIGNATED AS "CONFIDENTIAL"?

A. YES.

Q. I AM GOING TO READ TO YOU, DOCTOR, THE PORTION -- THOSE LINES THAT I HAVE DESIGNATED. THEN, I WILL ASK YOU WHETHER YOU GAVE THAT TESTIMONY.

THE COURT: JUST A MOMENT. BEFORE YOU DO IT, YOU HAVE READ THAT PORTION TO YOURSELF?

THE WITNESS: JUST NOW.

THE COURT: YES. DOES THAT ACCURATELY REFLECT YOUR TESTIMONY?

THE WITNESS: YES.

MR. SIMPSON: THANK YOU, YOUR HONOR.

BY MR. SIMPSON:

Q. DOCTOR, DURING YOUR DEPOSITION DID I ASK YOU ABOUT THE RECORDS OF A PARTICULAR ABORTION?

A. YES.

Q. AND THAT WAS AN ABORTION THAT YOU HAD OBSERVED?

A. CORRECT.

Q. YOU DID NOT PERFORM IT, BUT YOU OBSERVED IT?

A. CORRECT.

Q. I WOULD LIKE TO READ NOW THOSE LINES THREE THROUGH 14 ON PAGE 15:

"QUESTION YOU MAY HAVE TOLD ME THIS ALREADY. IF SO, I APOLOGIZE. YOU TOLD ME THAT YOU KNOW THE PHYSICIAN WAS NOT ATTEMPTING TO TURN THE LIE OF THE FETUS. HOW DO YOU KNOW THAT THEY WERE NOT TRYING TO DO THIS?

"ANSWER: BECAUSE THE PHYSICIAN WAS DISARTICULATING AND ATTEMPTING DISARTICULATION.

"QUESTION: BUT SHE DID NOT SUCCEED IN DOING THAT?

"ANSWER: CORRECT.

"QUESTION: HOW DO YOU KNOW SHE WAS ATTEMPTING DISARTICULATION?

"ANSWER: BECAUSE I COULD OBSERVE HER MANEUVERS WITH THE FORCEPS."

COULD I ASK YOU AGAIN IS THAT WHAT YOU TESTIFIED?

A. YES.

Q. COULD I ASK YOU AGAIN, DOCTOR, ISN'T IT TRUE THAT IN PERFORMING AN ABORTION IN ATTEMPTING TO DISARTICULATE, THE PHYSICIAN MAKES CERTAIN MANEUVERS WHEN THE INTENT IS TO DISARTICULATE?

A. THE MANEUVERS THAT A PHYSICIAN MAKES ARE TO ATTEMPT TO GRASP THE SMALL PARTS OF THE FETUS AND BRING THEM DOWN TO THE LEVEL OF THE CERVIX WHERE THE TRACTION MADE BY THAT SMALLER APERTURE CAUSES FRICTION OR PRESSURE AGAINST THE FETAL BODY, AND THEN THE PARTS DISARTICULATE.

Q. YOU TESTIFIED IN YOUR DEPOSITION, DOCTOR, THAT YOU KNEW THAT THIS OTHER PHYSICIAN WAS ATTEMPTING DISARTICULATION, QUOTE:

"BECAUSE I COULD OBSERVE HER MANEUVERS WITH THE FORCEPS," CLOSE QUOTE.

WHY DID YOU SAY THAT?

A. SHE WAS ATTEMPTING TO REACH THE SMALL PARTS OF THE FETUS. SHE WAS ATTEMPTING TO MAKE CONTACT WITH THE FETUS.

Q. LET ME ASK YOU THIS WAY, DOCTOR: WHEN THE INTENT IS TO REMOVE THE FETUS INTACT, ARE THERE DIFFERENT TYPES OF MANEUVERS THAT THE PHYSICIAN USES?

A. THOUGH MY INTENT WHEN I DO A D&E IS TO TRY TO PRESERVE THE MOST INTACT, THE FETUS, I NEVER MAKE AN ATTEMPT TO COMPLETELY REVERSE THE LIE OF THE FETUS. IS THAT WHAT YOU ARE ASKING?

Q. THAT WAS NOT MY QUESTION. IS IT TRUE, DOCTOR, WE HAVE TALKED ABOUT WHEN THE PHYSICIAN IS ATTEMPTING DISARTICULATION, I HAVE ASKED YOU WHETHER THERE ARE CERTAIN MANEUVERS THAT THE PHYSICIAN USES WITH THE FORCEPS TO DO THAT.

NOW, I AM ASKING ABOUT THE OTHER SIDE OF IT. WHEN THE PHYSICIAN IS ATTEMPTING TO REMOVE THE FETUS INTACT, ARE THERE CERTAIN DISTINCT MANEUVERS THAT THE PHYSICIAN USES?

A. THEY ARE BASICALLY THE SAME MANEUVERS, AS LONG AS THE FETAL PARTS ARE LOW AND YOU ARE ATTEMPTING TO REACH THOSE.

Q. IF I COULD HAVE YOU TURN TO YOUR DEPOSITION, DOCTOR. THE WHOLE PART, THE MAIN PART, NOT THE CONFIDENTIAL PART. PAGE 101, PLEASE.

IF I COULD ASK YOU TO READ, DOCTOR, TO YOURSELF PAGE 101, LINE 22 THROUGH PAGE 102, LINE 8.

HAVE YOU READ THAT?

A. UH-HUH.

Q. THANK YOU.

IF I COULD READ THAT TO YOU, PAGE 101, STARTING ON LINE 22.

AND I SHOULD SAY FIRST THIS QUESTION REFERS TO YOUR EXPERT REPORT; IS THAT CORRECT?

A. UH-HUH.

Q. "QUESTION: COULD YOU DESCRIBE, DOCTOR, WHAT YOU MEAN IN PARAGRAPH 4 BY YOUR 'BEST EFFORTS TO REMOVE THE FETUS INTACT'?

"ANSWER: I THINK I ALREADY DESCRIBED THAT, BUT WHAT I ATTEMPT TO DO IS TO GRASP THE FETAL FEET WITH THE INSTRUMENT, AND PUTTING GENTLE TRACTION ON THAT FETAL EXTREMITY, I TRY TO TEASE THE TISSUE DOWN SO THAT THE FETUS COMES DOWN FEET FIRST THROUGH THE CERVIX, THE PELVIS AND THE THORAX, AND I ACTUALLY GET THE ARMS OUT AND JUST USE GENTLE TRACTION, RATHER THAN USING THE KIND OF CRUSHING AND COMPRESSING GESTURES THAT ONE WOULD USE TO DO THE DISARTICULATION."

IS THAT WHAT YOU SAID?

A. YES.

Q. ISN'T IT TRUE, DOCTOR, THAT WHEN YOU WERE OBSERVING THE OTHER PHYSICIAN DO THE ABORTION THAT WE DISCUSSED DURING THE CONFIDENTIAL PORTION OF YOUR DEPOSITION, ISN'T IT TRUE THAT YOU COULD OBSERVE THAT SHE WAS ATTEMPTING DISARTICULATION BECAUSE SHE WAS USING THE CRUSHING AND COMPRESSING GESTURES THAT YOU REFERRED TO IN WHAT WE JUST READ?

A. WHAT SHE WAS TRYING TO DO WAS MAKE CONTACT WITH THE FETUS. SHE HAD NOT SUCCESSFULLY DONE THAT. SHE WAS EXPLORING THE UTERUS WITH HER FORCEPS TO ATTEMPT TO MAKE CONTACT WITH THE FETUS, AND TO BRING IT DOWN.

Q. DOCTOR, IT APPEARS THAT YOUR TESTIMONY DURING THE CONFIDENTIAL PORTION OF YOUR DEPOSITION IS INCONSISTENT WITH WHAT YOU ARE SAYING NOW. YOU SAID DURING THAT CONFIDENTIAL

PORTION:

"QUESTION: YOU TOLD ME THAT YOU KNOW THE PHYSICIAN WAS NOT ATTEMPTING TO TURN THE LIE OF THE FETUS. HOW DO YOU KNOW THAT THEY WERE NOT TRYING TO DO THIS?

"ANSWER: BECAUSE THE PHYSICIAN WAS DISARTICULATING AND ATTEMPTING DISARTICULATION.

"QUESTION: BUT SHE DID NOT SUCCEED IN DOING THAT?

"ANSWER: CORRECT.

"QUESTION: HOW DO YOU KNOW THAT SHE WAS ATTEMPTING DISARTICULATION?

"ANSWER: BECAUSE I COULD OBSERVE HER MANEUVERS WITH THE FORCEPS."

YOU ARE TELLING US NOW THAT THERE ARE NO SUCH GESTURES.

A. I THINK THE DISTINCTION IS THAT SHE -- THE DIFFERENCE OF WHAT SHE WAS DOING WAS INTRODUCING THE FORCEPS, OPENING THEM WIDE, COMPRESSING, AND TRYING TO BRING DOWN THE FETAL PART SO SHE COULD START THE PROCEDURE.

THE PROCEDURE THAT WE USE IS GENERALLY DISARTICULATION AND CRUSHING MANEUVERS TO GET THE FETUS SMALL ENOUGH TO FIT THROUGH THE APERTURE.

I WAS TRAINING THIS PERSON. I KNEW EXACTLY WHAT HER MANEUVERS WERE TRYING TO DO. SHE WAS NOT REACHING UP INSIDE THE UTERUS TO TRY TO GET THE FETAL FEET THAT WERE AT THE TOP OF

THE UTERUS AND REVERSE THE LIE OF THE UTERUS.

SHE WAS JUST TRYING TO GET -- GRAB ONTO THE FETUS AND BRING IT DOWN.

Q. BACK TO YOUR TESTIMONY ON PAGE 2 OF YOUR DEPOSITION, YOU WOULD AGREE NOW THAT THERE ARE CRUSHING AND COMPRESSING GESTURES THAT ONE WOULD USE TO DO THE DISARTICULATION OF A FETUS?

A. IT'S BASICALLY THE SAME: YOU CLOSE -- YOU OPEN AND CLOSE THE FORCEPS. AND IF YOU OPEN AND CLOSE IT ON A FETAL PART AND WITH TRACTION, THE WHOLE FETUS COMES DOWN, THAT IS GOOD. IF YOU OPEN AND CLOSE IT AND THERE IS TOO MUCH TRACTION AGAINST THE CERVIX SO THAT IT DISARTICULATES, THEN YOU GET DISARTICULATION.

Q. AND YOU WOULD AGREE WITH YOUR PRIOR TESTIMONY, I ASSUME, THAT WHEN YOU ARE ATTEMPTING TO REMOVE THE FETUS INTACT, YOU USE GENTLE TRACTION TO TRY TO TEASE THE TISSUE DOWN?

A. IT'S STILL THE SAME BASIC MANEUVER: YOU PUT -- YOU OPEN THE FORCEPS. YOU CLOSE IT ON THE FETAL PART, AND YOU BRING IT DOWN.

Q. YOUR TESTIMONY IN THE DEPOSITION WAS TRUTHFUL?

A. YES.

Q. DOCTOR, DO YOU KNOW -- DO YOU RECOLLECT IN THE CASE THAT WE DISCUSSED IN THE CONFIDENTIAL PORTION OF YOUR DEPOSITION, DO YOU RECOLLECT APPROXIMATELY THE GESTATIONAL AGE OF THAT FETUS?

A. I BELIEVE IT WAS 23 WEEKS.

Q. DO YOU KNOW WHY THE PHYSICIAN WAS NOT ATTEMPTING TO REMOVE THE FETUS INTACT?
A. SHE WAS AT THE VERY EARLY STAGES OF THE PROCEDURE RIGHT AFTER THE RUPTURE OF THE AMNIOTIC MEMBRANES. AND SHE WAS JUST INTENDING TO MAKE HER FIRST CONTACT WITH THE FETUS.
Q. YOU SAID IN YOUR DEPOSITION THAT SHE WAS ATTEMPTING TO DISARTICULATE.
A. BECAUSE THAT IS WHAT WE GENERALLY DO.
Q. SO SHE WAS NOT ATTEMPTING TO REMOVE THE FETUS INTACT?
A. I THINK YOU ARE NOT UNDERSTANDING THAT WE ARE TRYING TO DO THE SAME THING: WE ARE TRYING TO BRING THE FETUS DOWN TO THE LEVEL OF THE CERVIX. IF THE FETUS COMES OUT WITHOUT A LOT OF FRICTION AGAINST THE CERVIX, THEN IT COMES OUT INTACT. IF IT DOESN'T, THEN IT DISARTICULATES.
Q. I THINK YOU'VE TESTIFIED, DOCTOR, THAT YOU SOMETIMES HAVE TO COMPRESS THE FETAL SKULL TO COMPLETE THE REMOVAL OF THE FETUS?
A. CORRECT.
Q. YOUR PURPOSE IN COMPRESSING THE SKULL IS NOT NECESSARILY TO CAUSE FETAL DEMISE?
A. NO.
Q. YOU MAY HAVE TESTIFIED ABOUT THIS ALREADY, DOCTOR. IN PERFORMING A SECOND-TRIMESTER ABORTION, A SURGICAL ABORTION, YOU USE ULTRASOUND?
A. CORRECT.

Q. USING ULTRASOUND REDUCES THE RISK OF LEAVING FETAL PARTS INSIDE THE UTERUS?
A. YES.
Q. THE USE OF ULTRASOUND ALSO REDUCES THE RISK OF UNINTENTIONALLY INJURING THE PATIENT WITH YOUR INSTRUMENTS?
A. YES.
Q. IN APPROXIMATELY WHAT PERCENTAGE OF YOUR SECOND-TRIMESTER SURGICAL ABORTIONS HAVE YOU UNINTENTIONALLY INJURED THE PATIENT WITH AN INSTRUMENT?
A. I CAN TELL YOU THAT PERSONALLY LESS THAN 0.1 PERCENT OF THE TIME.
Q. THIS IS A REMARKABLY SMALL PERCENTAGE, CORRECT?
A. YES, IT IS.
Q. YOU ALSO BELIEVE THAT THE USE OF ULTRASOUND DECREASES THE NUMBER OF TIMES THAT YOU HAVE TO REACH IN INTO THE CERVIX TO GET A FETAL PART?
A. IT DOES HELP YOU DIRECT THE FORCEPS.
Q. IT REDUCES THE NUMBER OF TIMES THAT YOU HAVE TO REACH IN WITH THE FORCEPS?
A. IT PROBABLY DOES. IT IS NOT CERTAIN THAT IT DOES.
Q. DOCTOR, I THINK YOU'VE TESTIFIED THAT IN YOUR OPINION THE INTACT REMOVAL OF THE FETUS IN A SECOND-TRIMESTER ABORTION IS SAFER FOR THE WOMAN THAN REMOVAL BY DISARTICULATION?
A. YES.
Q. CAN YOU IDENTIFY, DOCTOR, FOR US WHICH RISKS OF D&E THAT

YOU BELIEVE ARE REDUCED BY REMOVING THE FETUS INTACT?
A. SPECIFICALLY, INJURY TO THE UTERUS WITH THE FORCEPS, LACERATION OF THE CERVIX WITH THE SHARP FETAL PARTS, REDUCTION OF BLOOD LOSS BY A QUICKER PROCEDURE, REDUCTION OF ANESTHETIC RISK BY A SHORTER PROCEDURE.
Q. IS THAT WHAT YOU CAN THINK OF?
A. YES.
Q. CAN YOU TELL US, DOCTOR, FOR EACH OF THOSE, PLEASE, CAN YOU QUANTIFY FOR US TO WHAT DEGREE AN INTACT REMOVAL REDUCES EACH OF THOSE RISKS?
FIRST OF ALL, INJURY WITH FORCEPS. CAN YOU QUANTIFY FOR US SOME PERCENTAGE OF THE REDUCTION OF THE RISK THAT YOU SEE IN INTACT REMOVAL?
A. I CAN'T ABSOLUTELY QUANTIFY IT. IF YOU ARE SUCCESSFUL WITH MAKING CONTACT WITH THE FETUS ON YOUR FIRST PASS WITH THE FORCEPS, AND THEN BRING IT DOWN INTACT, IT WOULD BE DRAMATICALLY REDUCED. BUT I CAN'T GIVE YOU A NUMBER.
Q. CAN YOU QUANTIFY THE REDUCTION OF THAT RISK FOR US IN, AS YOU SAID, THE RISK OF LACERATION FROM FETAL PARTS?
A. IF THE FETUS IS BROUGHT OUT INTACT, THEN THE LACERATION, THE RISK OF LACERATION BY FETAL PARTS WOULD BE REDUCED TO ZERO.
Q. NOW, WHEN YOU HAVE TO COMPRESS THE SKULL TO COMPLETE THE DELIVERY, THAT IS NOT AN INTACT REMOVAL, CORRECT?
A. CORRECT.
Q. THE RISK OF BLOOD LOSS YOU ALSO CITED. CAN YOU QUANTIFY

FOR US THE REDUCTION IN THE RISK OF BLOOD LOSS WHERE THERE IS AN INTACT REMOVAL?

A. I DON'T MEASURE THE BLOOD LOSS. I JUST NOTE IT. AND IT IS LESS WHEN THE PROCEDURE IS LESS TIME.

Q. AND, LASTLY, CAN YOU QUANTIFY FOR US THE REDUCTION IN THE RISK FROM ANESTHETIC WHERE THERE IS AN INTACT REMOVAL?

A. AGAIN, IT IS REDUCING THE NUMBER OF TIME OF EXPOSURE TO RISK.

Q. DOCTOR, HAVE YOU EVER LOOKED BACK TO YOUR PRACTICE RETROSPECTIVELY AND MADE THOSE COMPARISONS? IN OTHER WORDS, HAVE YOU IN YOUR RECORDS EVER COMPARED THE COMPLICATION RATES FOR YOUR PATIENTS FOR WHOM YOU HAVE PERFORMED DISMEMBERMENT D&E'S VERSUS COMPLICATION RATES FOR PATIENTS WHOM YOU HAVE DONE INTACT D&E'S?

A. I HAVE NOT DONE THAT.

Q. DO YOU NOTE ON YOUR PATIENTS' CHARTS WHEN YOU ARE ABLE TO EFFECT AN INTACT REMOVAL?

A. NO.

Q. SO EVEN IF YOU WANT TO MAKE THAT COMPARISON YOU WOULDN'T BE ABLE TO?

A. CORRECT.

THE COURT: MR. SIMPSON, I THINK IT IS TIME FOR OUR MORNING BREAK.

MR. SIMPSON: CERTAINLY.

THE COURT: WE WILL BREAK FOR 15 MINUTES.

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

(PROCEEDINGS RESUMED AT 10:18 A.M.)

THE COURT: ALL RIGHT. PLEASE CONTINUE.

MR. SIMPSON: YOUR HONOR, WITH SOME APOLOGIES TO THE COURT, I WOULD LIKE TO REVISIT JUST VERY BRIEFLY THE ISSUE OF THIS E-MAIL, EXHIBIT A-27.

EARLIER WHEN WE WERE DISCUSSING THAT, WE WERE PRESENTING IT PRIMARILY SAYING THAT WE WERE NOT PRESENTING IT FOR ITS TRUTH.

BUT JUST FOR THE RECORD, YOUR HONOR, IF I COULD SUGGEST ANOTHER AVENUE FOR THAT. OBVIOUSLY, SOMETHING IS NOT HEARSAY IF IT IS AN ADMISSION. IF I COULD JUST POINT OUT THAT IN RULE 801(D)(2)(D), IT SPEAKS OF A STATEMENT BY THE PARTIES' AGENT OR SERVANT CONCERNING A MATTER WITHIN THE SCOPE OF THE AGENCY OR EMPLOYMENT MADE DURING THE EXISTENCE OF A RELATIONSHIP.

AND WE WOULD JUST SUBMIT THAT EXHIBIT A-27 APPEARS TO FALL WITHIN THAT LANGUAGE.

THE COURT: OKAY. DOES THE PLAINTIFFS' COUNSEL WISH TO MAKE A RESPONSE?

MS. PARKER: WELL, WE STILL HAVE FOUNDATION PROBLEMS THAT WE DON'T HAVE EITHER THE AUTHOR OR THE RECIPIENT PRESENT AT TRIAL OR ANYBODY WHO CAN TESTIFY ABOUT IT.

SO THE FACT THAT IT IS HEARSAY, THERE MAY BE AN EXCEPTION TO IT, IS DOWN ONE LEVEL. AND WE ALSO DON'T HAVE

TESTIMONY THAT IT'S BEEN MADE WITHIN THE SCOPE OF THE AGENCY OR EMPLOYMENT.

THE COURT: THAT ACTUALLY GOES TO A FOUNDATIONAL ISSUE, AS WELL. I STILL HAVE THE SAME DIFFICULTY THAT I INDICATED BEFORE. EVEN IF I CONSIDERED IT AN ADMISSION, I AM NOT SURE THAT I CAN WITHOUT A LITTLE MORE INFORMATION ABOUT THE AUTHOR. AND NOT JUST THE TITLE. IT STILL CAN'T BE INTRODUCED THROUGH THIS WITNESS' TESTIMONY.

YOU DON'T HAVE A PROPER FOUNDATION.

MR. SIMPSON: THANK YOU, YOUR HONOR.

BY MR. SIMPSON:

Q. DR. SHEEHAN, IN YOUR PRACTICE I THINK YOU TESTIFIED ON DIRECT WHEN YOU ARE PREPARING TO PERFORM A SURGICAL ABORTION IN THE SECOND-TRIMESTER, YOU ARE AIMING FOR A CERTAIN DEGREE OF CERVICAL DILATION; IS THAT CORRECT?

A. CORRECT.

Q. AND YOUR RULE OF THUMB IS TO AIM FOR 1 MILLIMETER DILATION FOR EACH WEEK OF GESTATIONAL AGE?

A. THAT'S CORRECT.

Q. SO AN ABORTION AT 18 WEEKS YOU WOULD BE AIMING FOR 1.8 CENTIMETERS OF DILATION?

A. CORRECT.

Q. ONCE YOU HAVE ACHIEVED THAT DEGREE OF DILATION, YOU THEN PROCEED WITH THE REMOVAL OF THE FETUS?

A. YES.

Q. DOES THAT DEGREE OF DILATION CONSTITUTE SIGNIFICANTLY LESS THAN THE WIDTH OF THE WIDEST PART OF THE FETUS?
A. YES.
Q. DO YOU BELIEVE THAT THE PROCEDURE CAN BE DONE SAFELY WITH THAT DEGREE OF DILATION?
A. YES.
Q. IN DOING A D&E AT, LET'S SAY, 16 WEEKS, IN WHAT PERCENTAGE OF THOSE CASES ARE YOU ABLE TO REMOVE THE FETUS INTACT?
A. IT HAPPENS VERY RARELY.
Q. CAN YOU GIVE ME A PERCENTAGE?
A. ONE PERCENT OF THE TIME.
Q. DOES THAT PERCENTAGE GO UP SOMEWHAT WITH INCREASING GESTATIONAL AGE?
A. I BELIEVE IT STAYS IN THE SAME RANGE.
Q. SO, YOU'RE TESTIFYING THAT AT 17 WEEKS, 18 WEEKS, 19 WEEKS, 20 WEEKS, 21 WEEKS, 22 WEEKS, YOU ARE ABLE TO REMOVE THE FETUS INTACT APPROXIMATELY ONE PERCENTAGE OF THE TIME?
A. CORRECT.
Q. WOULD THAT BE TRUE ALSO OF 23 AND 24 WEEKS?
A. YES.
Q. IF YOU DILATED MORE, WOULD YOU BE ABLE TO GET THE FETUS OUT INTACT MORE OFTEN?
A. IT WOULD OFTEN REQUIRE A SIGNIFICANT DEGREE OF MORE DILATION.
Q. HOW MUCH?

A. IF I HAVE ONLY 18 MILLIMETERS, 1.8 CENTIMETERS FOR AN 18 WEEK FETUS, I WOULD HAVE TO DILATE AT LEAST ANOTHER CENTIMETER OR TWO TO GET COMPLETE INTACT EXTRACTION OF THE FETUS.

Q. WHAT WOULD BE REQUIRED TO GET YOU THAT ADDITIONAL DILATION?

A. I WOULD HAVE TO USE MECHANICAL DILATION OR ANOTHER SET OF LAMINARIA.

Q. ANOTHER SET OF LAMINARIA AND WAIT ANOTHER NIGHT FOR THEM TO DILATE?

A. CORRECT. ALTHOUGH THERE IS NO GUARANTEE THAT WOULD ACTUALLY BE SUCCESSFUL. SOME WOMEN'S CERVIXES DON'T DILATE THAT EASILY.

Q. DOCTOR, DO YOU SOMETIMES GIVE AN INJECTION -- I THINK YOU TESTIFIED TO THIS. DO YOU SOMETIMES GIVE AN INJECTION TO CAUSE FETAL DEMISE BEFORE STARTING TO REMOVE THE FETUS IN A D&E?

A. YES.

Q. DO YOU ALWAYS OFFER THAT INJECTION BEYOND 21 WEEKS?

A. NO.

Q. IS THERE SOME POINT IN GESTATION AT WHICH YOU ALWAYS OFFER THAT INJECTION TO THE PATIENT?

A. WE ALWAYS OFFER IT STARTING AT 22 WEEKS.

Q. STARTING AT 22 WEEKS?

A. CORRECT.

Q. YOU WOULDN'T MAKE THAT OFFER IF YOU THOUGHT THE INJECTION WERE UNSAFE?

A. I DON'T THINK IT IS UNSAFE.

Q. WHAT PERCENTAGE OF PATIENTS ACCEPT THAT OFFER?
A. ALL OF THEM.
Q. DO YOU KNOW WHETHER OTHER PLANNED PARENTHOOD AFFILIATES OFFER DIGOXIN BEFORE D&E?
A. THEY DO.
Q. HOW MANY?
A. I KNOW OF ONE.
Q. WHICH ONE IS THAT?
A. LOS ANGELES.
Q. DO YOU KNOW OF ANY OTHERS?
A. NO.
Q. DO YOU KNOW AT WHAT POINT PLANNED PARENTHOOD LOS ANGELES OFFERS AN INJECTION OF DIGOXIN? AT WHAT POINT OF GESTATIONAL AGE THEY OFFER THAT?
A. I BELIEVE THEY START AT 21 WEEKS.
Q. IN YOUR EXPERIENCE, DOCTOR, DOES CAUSING FETAL DEMISE BEFORE STARTING THE REMOVAL IN A D&E MAKE THE REMOVAL EASIER?
A. IN MY EXPERIENCE IT DOES MAKE IT EASIER.
Q. THAT IS BECAUSE THE FETUS IS EASIER TO DISARTICULATION?
A. THE FETAL TISSUE IS SOFTER.
Q. AND IT IS EASIER TO DISARTICULATE?
A. YES.
Q. AND DOES IT ALSO MAKE THE HEAD EASIER TO COMPRESS?
A. YES.
Q. IN YOUR EXPERIENCE, DOCTOR, DIGOXIN INJECTION IS

100 PERCENT EFFECTIVE IN CAUSING FETAL DEMISE WHEN YOU INJECT THE DIGOXIN INTO THE HEART, CORRECT?

A. CORRECT.

Q. YOU SAID EARLIER, DOCTOR, DID YOU NOT, ON DIRECT EXAMINATION, THAT YOU ARE ABLE TO GET THE DIGOXIN INTO THE FETAL HEART 50 PERCENT OF THE TIME?

A. APPROXIMATELY.

Q. IF I COULD REFER YOU TO YOUR DEPOSITION, PLEASE. PAGE 142. IF YOU COULD READ, PLEASE, DOCTOR, PAGE 142, LINES THREE THROUGH SIX.

IF YOU COULD READ THAT SILENTLY.

A. YES.

Q. AND THAT SAYS, LINE 3:

"QUESTION: DO YOU HAVE A VIEW AS TO WHAT PERCENTAGE OF CASES YOU SUCCEED IN GETTING IT INTO THE HEART?

"ANSWER: I WOULD BE APPROXIMATING: 50 TO 75 PERCENT OF THE TIME."

WE WERE TALKING IN THAT INSTANCE ABOUT INJECTING DIGOXIN FOR FETAL DEMISE, CORRECT?

A. CORRECT.

Q. SO IS IT TRUE THAT YOU ARE ABLE TO GET THE DIGOXIN INTO THE FETAL HEART 50 TO 75 PERCENT OF THE TIME?

A. THAT IS AN APPROXIMATE NUMBER, YES.

Q. ON DIRECT EXAMINATION YOU GAVE THE NUMBER 50, BUT THE ACTUAL NUMBER WOULD BE SOMEWHERE BETWEEN 50 AND 75, CORRECT?

A. I THINK THAT IS WHAT THE WORD "APPROXIMATE" MEANS, YES.

MR. SIMPSON: COULD I APPROACH THE WITNESS, PLEASE, YOUR HONOR?

MS. PARKER: COULD --

THE COURT: YES.

MS. PARKER: COULD YOU LET US KNOW WHAT EXHIBIT?

MR. SIMPSON: EXHIBIT A-48.

THE WITNESS: THANK YOU.

BY MR. SIMPSON:

Q. DOCTOR, I HAVE SHOWN YOU EXHIBIT A-48 IN THIS CASE. ARE YOU FAMILIAR WITH THAT DOCUMENT?

A. YES.

Q. WHAT IS IT, PLEASE?

A. IT IS THE PLANNED PARENTHOOD OF SAN DIEGO AND RIVERSIDE COUNTIES CONSENT FOR LANOXIN.

Q. IT SAYS "LANOXIN". IS LANOXIN THE SAME THING AS DIGOXIN?

A. YES.

Q. LANOXIN IS THE BRAND NAME?

A. CORRECT.

Q. SO IS THIS THE FORM USED BY PLANNED PARENTHOOD SAN DIEGO TO ADVISE PATIENTS REGARDING THE USE OF DIGOXIN?

A. IT IS.

Q. AND THAT IS THE AFFILIATE AT WHICH YOU ARE THE MEDICAL DIRECTOR?

A. IT IS.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO OFFER EXHIBIT A-48 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. PARKER: NO, YOUR HONOR.

THE COURT: ADMITTED.

THE CLERK: A-48 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-48 WAS RECEIVED IN EVIDENCE.)

BY MR. SIMPSON:

Q. IF I COULD READ PART OF THAT DOCUMENT TO YOU, DOCTOR. THE FIRST PARAGRAPH. I AM GOING TO START IN THE MIDDLE OF THE PARAGRAPH. IT SAYS:

"THE PURPOSE OF THE MEDICATION," DO YOU SEE THAT?

A. YES.

Q. IT SAYS:

"THE PURPOSE OF THE MEDICATION" -- AND IT'S REFERRING TO DIGOXIN, CORRECT?

A. YES.

Q. "THE PURPOSE OF THE MEDICATION IS TO CAUSE FETAL DEMISE TO PREVENT THE POSSIBILITY OF A LIVE BIRTH SHOULD I MISCARRY BEFORE HAVING MY D&E PROCEDURE AND TO HELP PREPARE MY BODY FOR THE TERMINATION PROCESS. THE USE OF THE LANOXIN FOR THIS PURPOSE IS VERY SAFE."

DO YOU AGREE WITH THE STATEMENT HERE, DOCTOR, THAT THE USE OF DIGOXIN IS VERY SAFE?

A. YES.
Q. ARE YOU FAMILIAR, DOCTOR, WITH THE PROCEDURE KNOWN AS AMNIOCENTESIS?
A. YES.
Q. NOW, IS IT TRUE, DOCTOR, THAT A PHYSICIAN WHO HAS THE SKILL TO PERFORM AN AMNIOCENTESIS WOULD ALSO HAVE THE SKILL TO PERFORM AN INJECTION OF DIGOXIN FOR FETAL DEMISE?
A. YES.
Q. EVERY OB/GYN LEARNS HOW TO DO AN AMNIOCENTESIS?
A. CORRECT.
Q. CONTINUING THERE IN EXHIBIT A-48, SECOND PARAGRAPH, SECOND SENTENCE:

"HOWEVER, POSSIBLE COMPLICATIONS INCLUDE, BUT ARE NOT LIMITED TO, INFECTION, SHOCK, ALLERGIC REACTION AND EVEN DEATH."

YOU'VE SEEN TWO CASES OF INFECTION AFTER A DIGOXIN INJECTION; IS THAT CORRECT?
A. THESE CASES THAT I ASSUME ARE RELATED TO DIGOXIN INJECTION, YES.
Q. YOU JUST ASSUMED THAT, BUT IT WAS NEVER SHOWN DEFINITIVELY THAT THE INFECTIONS WERE CAUSED BY THE INJECTION?
A. CORRECT.
Q. YOU STARTED USING DIGOXIN TO CAUSE FETAL DEMISE IN THE YEAR 2000?
A. CORRECT.

Q. AND YOU DO ABOUT 100 PER YEAR?
A. THAT'S CORRECT.
Q. AND IN THOSE TWO CASES THAT YOU REFERRED TO, NO LONGER TERM EFFECTS OCCURRED IN EITHER OF THOSE TWO CASES BECAUSE OF THE INFECTION?
A. THAT'S CORRECT.
Q. AND YOU DON'T KNOW OF ANY CASES OF INFECTION THAT WERE ACTUALLY SHOWN TO HAVE BEEN CAUSED BY A DIGOXIN INJECTION?
A. CORRECT.
Q. IF ANY SUCH INFECTION OCCURRED, DOCTOR, EMPTYING THE UTERUS IN THE COURSE OF THE ABORTION WOULD REDUCE THE RISK OF ANY LONG-TERM EFFECTS OF AN INFECTION?
A. YES.
Q. THE SENTENCE THAT I JUST READ FROM EXHIBIT A-48 LISTS SOME OTHER POTENTIAL COMPLICATIONS:
"SHOCK, ALLERGIC REACTION AND EVEN DEATH."
NOW, YOU HAVE NEVER HEARD OF ANY OCCURRENCE OF ANY OF THOSE COMPLICATIONS?
A. CORRECT.
Q. YOU'VE NEVER EXPERIENCED ANY OF THEM IN YOUR PRACTICE?
A. CORRECT.
Q. DOCTOR, I WOULD LIKE TO SHOW YOU PLAINTIFF'S EXHIBIT 31 IN THIS CASE. ARE YOU FAMILIAR WITH THAT BOOK?
A. I AM.
MR. SIMPSON: DOES THE COURT HAVE A COPY OF THAT?

THE COURT: NO.

(EXHIBIT HANDED TO COURT.)

BY MR. SIMPSON:

Q. DOCTOR, YOU SAID YOU ARE FAMILIAR WITH THAT BOOK?

A. I DID SAY THAT.

Q. DO YOU USE IT?

A. I DO.

Q. DO YOU CONSIDER IT TO BE RELIABLE?

A. I DO.

Q. PLEASE TURN TO PAGE 123. CHAPTER 10 STARTS ON THAT PAGE?

A. YES.

Q. HAVE YOU READ THAT CHAPTER BEFORE?

A. YES.

Q. IF YOU CAN TURN TO PAGE 131 WITHIN THAT CHAPTER, PLEASE.

THIS IS A PARAGRAPH THAT GOES FROM THE LEFT COLUMN TO THE RIGHT COLUMN UNDER THE HEADING:

"FETICIDAL TECHNIQUES."

IF I COULD READ THAT ONE PARAGRAPH, PLEASE.

"WRIGHT AND JACKSON REPORTED SUCCESSFUL USE OF 1 MILLIGRAM DIGOXIN AS A FETICIDAL AGENT FOR 5,000 D&E ABORTIONS AT 19 WEEKS GESTATION OR MORE. THEY INJECTED 1 MILLIGRAM TRANSABDOMINALLY INTO THE FETUS, OR AMNIOTIC FLUID, WITHOUT ULTRASONOGRAPHIC GUIDANCE. APART FROM THE FEW TRANSIENT EPISODES OF MATERNAL BRADYCARDIA THAT RESULTS

SPONTANEOUSLY" -- IF I COULD STOP FOR A MOMENT THERE.

DOCTOR, BRADYCARDIA IS A SLOWING OF THE HEART RATE?

A. CORRECT.

Q. CONTINUING WITH THE QUOTATION:

"NO ADVERSE EFFECTS OCCURRED DESPITE INSTANCES OF INADVERTENT INTRAMYOMETRIAL AND SYSTEMIC INJECTION."

STOPPING AGAIN FOR A MOMENT. IS IT TRUE, DOCTOR, THAT "INTRAMYOMETRIAL INJECTION" WOULD BE INJECTION INTO THE MUSCLE OF THE UTERUS?

A. CORRECT.

Q. CONTINUING WITH THE QUOTATION:

"FETAL DEATH WAS CONFIRMED IN ALL CASES BY ULTRASONOGRAPHY WITHIN 30 MINUTES. ANOTHER PROVIDER OF LATE ABORTIONS REPORTED SUCCESS IN INDUCING DEMISE WITHOUT SERIOUS COMPLICATIONS USING THE SAME DOSE OF DIGOXIN AND A SIMILAR INJECTION PROTOCOL IN MORE THAN 10,000 INDUCTION/D&E PROCEDURES AT OR BEYOND 18 WEEKS GESTATION. IN BOTH SERIES DIGOXIN WAS WITHHELD UNTIL OSMOTIC DILATORS WERE SUCCESSFULLY INSERTED INTO THE CERVIX."

DID I READ THAT CORRECTLY?

A. YES.

Q. DOES THIS INFORMATION, DOCTOR, SUPPORT YOUR OPINION THAT

DIGOXIN INJECTION IS SAFE FOR THE MOTHER?
A. YES, IT DOES.
Q. DO YOU HAVE ANY REASON TO DOUBT THE FINDINGS DESCRIBED HERE?
A. NO.
Q. DOCTOR, WOULD YOU CONCEDE THAT THE PARTIAL BIRTH ABORTION BAN ACT DOES NOT APPLY WHERE THE PHYSICIAN HAS CAUSED FETAL DEMISE BEFORE ENTERING THE UTERUS?
A. YES.
Q. DOCTOR, ARE YOU AWARE OF ANY PUBLISHED STUDIES REGARDING INTACT D&X?
MS. PARKER: OBJECTION, LACK OF FOUNDATION WHAT "INTACT D&X" MEANS.
BY MR. SIMPSON:
Q. DOCTOR, IF I CAN REFER YOU TO EXHIBIT A-27. THAT IS THE E-MAIL WE WERE DISCUSSING EARLIER.
MS. PARKER: WHICH IS NOT IN EVIDENCE.
BY MR. SIMPSON:
Q. WHICH WE HAVE -- EARLIER, DOCTOR, DID I NOT READ OUT LOUD THE SECTION OF EXHIBIT A27 ENTITLED "INTACT D&X"?
A. YES.
Q. I DID DO THAT?
A. YOU DID.
THE COURT: HE CAN USE IT EVEN THOUGH IT IS NOT IN EVIDENCE.

BY MR. SIMPSON:

Q. DOCTOR, ARE YOU AWARE OF ANY PUBLISHED STUDIES REGARDING INTACT D&X AS IT'S DESCRIBED THERE?

A. YES.

Q. YOU ARE AWARE OF PUBLISHED STUDIES?

A. I AM AWARE OF THOSE STUDIES THAT YOU SHOWED ME DURING MY DEPOSITION.

Q. AND WHICH ONES ARE THOSE?

A. THE ONES THAT WERE PRESENTED AT NAF, SO I GUESS THEY ARE NOT ACTUALLY PUBLISHED. THEY ARE PRESENTED.

Q. YOU ARE NOT SPEAKING, THEN, OF PEER-REVIEWED PUBLICATIONS?

A. CORRECT.

Q. YOU DON'T KNOW OF ANY PEER-REVIEWED STUDIES ON INTACT D&X?

A. I DO NOT KNOW OF ANY.

Q. THERE IS NO REASON WHY INTACT D&X COULD NOT BE THE SUBJECT OF A PROSPECTIVE STUDY, CORRECT?

A. THE ONLY REASON I CAN THINK OF IT WOULD TAKE A HUGE, HUGE NUMBER OF PATIENTS TO BE ABLE TO DO SUCH A STUDY TO PROVE ANY DIFFERENCE FROM ANOTHER PROCEDURE.

Q. IS THAT PARTLY BECAUSE DISMEMBERMENT D&E IS SO SAFE?

A. YES. THE RISKS OF D&E, AS WE HAVE BEEN DISCUSSING, DISARTICULATION, ARE VERY, VERY LOW.

Q. IS THERE ANY REASON, DOCTOR, WHY INTACT D&X COULD NOT BE THE SUBJECT OF A RETROSPECTIVE STUDY?

A. AS FAR AS I KNOW THE PEOPLE THAT PERFORM PROCEDURES THAT

WOULD QUALIFY FOR INTACT D&X DO NOT KEEP THE STATISTICS ADEQUATELY TO BE ABLE TO EVALUATE THEM.

Q. DOCTOR, I AM NOT SURE THE COURT HAS HEARD YET IN THIS TRIAL THE DIFFERENCE BETWEEN A PROSPECTIVE AND RETROSPECTIVE STUDY. CAN YOU EXPLAIN THAT TO US?

A. PROSPECTIVE STUDY IS ONE THAT IS -- GOES FORWARD. IT ASKS A QUESTION. SEPARATES GROUPS BASED ON A QUESTION, AND THEN STUDIES THE OUTCOME IN THOSE PATIENTS GOING FORWARD.

A RETROSPECTIVE STUDY IS ONE THAT LOOKS BACKWARD AT INCIDENCES THAT HAVE ALREADY HAPPENED AND ARE DOCUMENTED.

Q. A RETROSPECTIVE STUDY IS A MATTER OF REVIEWING MEDICAL RECORDS?

A. USUALLY, YES.

Q. NOW, IN THE HIERARCHY OF MEDICAL RESEARCH AND PUBLICATION, IS THERE A PECKING ORDER BETWEEN RETROSPECTIVE STUDIES AND PROSPECTIVE STUDIES?

A. YES.

Q. AND CAN YOU EXPLAIN THAT TO US?

A. PROSPECTIVE STUDIES ARE CONSIDERED MORE AUTHORITATIVE.

Q. WOULD YOU SAY, DOCTOR, THAT IF THERE WERE A RETROSPECTIVE STUDY OF INTACT D&X, THAT IS A RETROSPECTIVE STUDY OF COLLECTED DATA, YOU WOULD NOT CONSIDER THAT METHODOLOGY TO BE OF THE HIGHEST CALIBER?

A. TRUE.

Q. YOU CONSIDER RETROSPECTIVE ANALYSIS OF DATA TO BE THE

CATEGORY RESEARCH?
A. CORRECT.
Q. DOCTOR, I THINK YOU'VE TESTIFIED A BIT ON DIRECT, HAVE YOU, REGARDING THE USE OF INTACT REMOVAL TO HAVE AN INTACT FETUS FOR PURPOSES OF PATHOLOGY?
A. I THINK THE POINT OF THE POINT OF THE TESTIMONY WAS TO SAY THAT A WOMAN HAS A KNOWN FETAL ANOMALY AND SHE WANTS TO HAVE THAT CONFIRMED OR STUDIED FURTHER AFTER THE TERMINATION PROCEDURE, THEN SHE AND HER DOCTOR WHO HAD REFERRED -- WHO HAS REFERRED THE PATIENT TO US REQUEST THAT WE TRY TO OBTAIN AS INTACT TISSUE AS POSSIBLE.
Q. NOW, AN INDUCTION ABORTION WOULD PROVIDE AN INTACT FETUS, WOULD IT NOT?
A. YES.
Q. AND DO YOU DO INDUCTIONS?
A. NO.
Q. INTACT D&X, AS IT IS DESCRIBED IN EXHIBIT A-27, THE E-MAIL, THAT PROCEDURE DESTROYS THE CENTRAL NERVOUS SYSTEM, CORRECT?
A. CORRECT.
Q. THE CENTRAL NERVOUS SYSTEM OF THE FETUS?
A. YES.
Q. SO IT WOULD BE -- THAT PROCEDURE WOULD BE WORTHLESS IN DIAGNOSING ANY FETAL ANOMALIES INVOLVING THE CENTRAL NERVOUS SYSTEM?
A. BRAIN, YES.

Q. DOCTOR, THE PHYSICIAN NEVER ACTUALLY NEEDS TO DIAGNOSE A FETAL ANOMALY IN ORDER TO TREAT THE MOTHER'S CONDITION; IS THAT RIGHT?
A. RIGHT.
Q. DOCTOR, DOES PLANNED PARENTHOOD SAN DIEGO GIVE ITS PATIENTS A WRITTEN INFORMATION ABOUT D&E?
A. YES.
Q. IN FACT, I BELIEVE I ALREADY GAVE YOU EARLIER, DOCTOR, A COPY OF EXHIBIT A-31?
A. YES.
Q. IS THAT A COPY OF THE WRITTEN MATERIAL THAT YOU GIVE TO PATIENTS ABOUT D&E?
A. IT IS.
MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO OFFER EXHIBIT A-31 INTO EVIDENCE.
THE COURT: ANY OBJECTION?
MS. PARKER: NO, YOUR HONOR.
THE COURT: ADMITTED.
THE CLERK: A-31 INTO EVIDENCE.
(DEFENDANT'S EXHIBIT A-31 WAS RECEIVED IN EVIDENCE.)
BY MR. SIMPSON:
Q. AND, DOCTOR, DOES PPSD GIVE ITS PATIENTS WRITTEN INFORMATION ABOUT THE USE OF OSMOTIC DILATORS?
A. YES, IT DOES.

MR. SIMPSON: CAN I APPROACH THE WITNESS, YOUR HONOR?

THE COURT: YES.

BY MR. SIMPSON:

Q. DOCTOR, I HAVE GIVEN YOU A COPY OF EXHIBIT A-32. IS THIS A COPY OF THE WRITTEN MATERIAL THAT YOU GIVE TO PATIENTS ABOUT THE USE OF OSMOTIC DILATORS?

A. YES, IT IS.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO MOVE TO OFFER EXHIBIT A-32 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. PARKER: NO OBJECTION, YOUR HONOR.

THE COURT: ADMITTED.

THE CLERK: A-32 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-32 WAS RECEIVED IN EVIDENCE.)

BY MR. SIMPSON:

Q. DOCTOR, DOES PPSD GIVE PATIENTS INFORMATION ABOUT THE USE OF MISOPROSTOL?

A. YES.

Q. DOCTOR, I HAVE GIVEN YOU A COPY OF WHAT IS EXHIBIT A-33. IS THIS A COPY OF THE WRITTEN MATERIAL THAT YOU GIVE TO PATIENTS ABOUT THE USE OF MISOPROSTOL?

A. YES.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO OFFER

EXHIBIT A-33 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. PARKER: NO OBJECTION.

THE COURT: ADMITTED.

THE CLERK: A-33 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-33
WAS RECEIVED IN EVIDENCE.)

BY MR. SIMPSON:

Q. AND, FINALLY, DOES PPSD HAVE A DOCUMENT SHOWING THE NUMBERS OF ABORTIONS THAT IT HAS RECENTLY PROVIDED AT DIFFERENT GESTATIONAL AGES?

A. I BELIEVE YOU ARE ASKING ABOUT THE PAPER YOU HAVE IN YOUR HAND. YES.

Q. I HAVE GIVEN YOU, DOCTOR, A COPY OF EXHIBIT A-28 IN THIS CASE. IS THIS A DOCUMENT CREATED BY PPSD SHOWING THE NUMBERS OF ABORTIONS PROVIDED IN 2002?

A. YES, IT IS.

Q. PROVIDED BY PPSD?

A. YES.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO OFFER EXHIBIT A-28 INTO EVIDENCE, PLEASE.

MS. PARKER: NO OBJECTION.

THE COURT: ALL RIGHT, ADMITTED.

THE CLERK: A-28 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-28
WAS RECEIVED IN EVIDENCE.)

BY MR. SIMPSON:

Q. DOCTOR, IS THERE A TYPOGRAPHICAL ERROR IN THIS DOCUMENT?

A. THERE IS.

Q. IS IT ON THE LINE THAT SAYS:

"ABORTION GREATER THAN 12 WEEKS"?

A. YES, THAT SHOULD SAY "LESS THAN."

Q. THANK YOU.

NOW, DOCTOR, AS MEDICAL DIRECTOR OF PPSD, YOU ARE FAMILIAR WITH THE AFFILIATES' PRACTICES REGARDING THE CREATION AND MAINTENANCE OF MEDICAL RECORDS; ARE YOU NOT?

A. YES.

Q. IN THE REGULAR COURSE OF ITS PROVISION OF MEDICAL SERVICES, PPSD CREATES AND MAINTAINS RECORDS OF THE SERVICES PROVIDED TO INDIVIDUAL PATIENTS?

A. YES.

Q. I WOULD LIKE TO GIVE YOU, DOCTOR, WHAT HAS BEEN DESIGNATED AS EXHIBIT A-73 IN THIS CASE.

DOCTOR, IS THIS A MEDICAL RECORD CREATED AND MAINTAINED IN THE REGULAR COURSE OF PPSD'S PROVISION OF SERVICES?

A. YES.

MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO MOVE EXHIBIT A-73 INTO EVIDENCE.

MS. PARKER: OBJECTION, YOUR HONOR, LACK OF FOUNDATION AND HEARSAY. AND THIS IS ONE OF THE MEDICAL RECORDS FOR WHOM YOUR HONOR WANTS THE GOVERNMENT FIRST TO ESTABLISH THAT AN INTACT PROCEDURE WAS USED. AND HE HAS NOT YET ESTABLISHED THAT.

THE COURT: I ASSUME THAT IS GOING TO BE THE NEXT QUESTION.

MR. SIMPSON: CERTAINLY, YOUR HONOR.

THE COURT: WELL, I AM NOT GOING TO ADMIT IT INTO EVIDENCE UNTIL IT IS ESTABLISHED THAT IT IS INTACT, INVOLVING AN INTACT PROCEDURE.

BY MR. SIMPSON:

Q. DOCTOR, DO YOU RECOGNIZE EXHIBIT A-73?

A. YES.

Q. WHY DO YOU RECOGNIZE THAT?

A. IT IS FROM MY AFFILIATE.

Q. SO, THIS IS A RECORD OF AN ABORTION PROVIDED BY PLANNED PARENTHOOD SAN DIEGO?

A. YES.

Q. DID YOU PERFORM THIS ABORTION?

A. I DID NOT.

Q. DID YOU OBSERVE THIS ABORTION?

A. I DID.

Q. IS THIS THE SAME ABORTION THAT WE DISCUSSED EARLIER THAT YOU HAD OBSERVED?

A. YES.
Q. THAT IS THE ABORTION THAT YOU HAD OBSERVED WHERE WE WERE DISCUSSING WHETHER THE PHYSICIAN PERFORMING THE ABORTION WAS ATTEMPTING DISARTICULATION?
A. CORRECT.
Q. DOCTOR, CAN YOU DESCRIBE TO ME THE CIRCUMSTANCES OF THIS CASE?
WHAT HAPPENED DURING THIS ABORTION?
MS. PARKER: OBJECTION, YOUR HONOR. I THINK THAT'S AN ATTEMPT TO CIRCUMVENT THE COURT'S RULING ON THE MEDICAL RECORDS.
IT SEEMS INAPPROPRIATE TO GO INTO THE DETAILS OF THIS PARTICULAR CASE UNTIL HE HAS ESTABLISHED ITS RELEVANCE BECAUSE IT'S HIGHLY PRIVATE --
THE COURT: I THINK I TOLD YOU AT THE END OF THE PROCEEDINGS YESTERDAY THAT ONLY THOSE RECORDS, AND YOU ADVISED ME YESTERDAY THERE WERE THREE TOTAL, I IMAGINE THERE ARE TWO REMAINING ONES, THAT INVOLVED, THAT CLEARLY REFLECT THAT THEY INVOLVED AN INTACT PROCEDURE WOULD BE PERMITTED FOR YOUR USE AT TRIAL. THAT SHOULD BE THE VERY FIRST QUESTION THAT IS ASKED.
MR. SIMPSON: I WILL ASK MORE FOCUSSED QUESTIONS, YOUR HONOR.
THE COURT: NO. THAT'S THE QUESTION, WHETHER OR NOT THIS INVOLVES AN INTACT PROCEDURE. OTHERWISE, YOU MAY NOT ASK ANY QUESTIONS ABOUT THESE PARTICULAR RECORDS UNLESS IT INVOLVES

AN INTACT PROCEDURE.

BY MR. SIMPSON:

Q. DOCTOR, IN THE CASE INVOLVED IN A-73, DID A COMPLICATION OCCUR IN THAT CASE?

THE COURT: I DON'T QUITE UNDERSTAND WHY YOU ARE NOT UNDERSTANDING WHAT I AM SAYING, MR. SIMPSON.

I WILL DO THE QUESTIONING.

DOCTOR, DOES THE PROCEDURE THAT WAS UTILIZED IN THE ABORTION PROCEDURE THAT IS REFLECTED IN A-73, INVOLVE AN INTACT PROCEDURE?

THE WITNESS: NO.

THE COURT: AN INTACT D&E?

THE WITNESS: NO, IT DOES NOT.

THE COURT: OKAY.

MR. SIMPSON: YOUR HONOR, IF I COULD REFER THE COURT -- DOES THE COURT HAVE A COPY OF EXHIBIT A-73?

THE COURT: YES.

MR. SIMPSON: IF I COULD ASK THE COURT, PLEASE, TO REFER TO BATES NUMBER PPFA001061.

THE COURT: ALL RIGHT. I AM LOOKING AT THAT.

MR. SIMPSON: AND IN THE LAST PARAGRAPH ON THAT PAGE -- OBVIOUSLY, I AM NOT TRYING TO TESTIFY, YOUR HONOR. IF I COULD JUST FROM MY KNOWLEDGE OF THESE RECORDS, IF I COULD TELL THE COURT WHAT THIS INVOLVES.

THIS WAS A CASE WHERE.

MS. PARKER: OBJECTION, YOUR HONOR. WE ARE GETTING INTO A LOT OF DETAILS ABOUT A VERY CONFIDENTIAL PROCEDURE. IF MR. SIMPSON FEELS --

THE COURT: I AM GOING TO ALLOW HIM TO MAKE AN OFFER OF PROOF.

TELL ME WHERE ON THIS PIECE -- ON THIS SHEET --

MR. SIMPSON: THAT'S WHAT I AM DOING, YOUR HONOR.

THE COURT: -- IT REFLECTS THAT IT IS SOMETHING OTHER THAN WHAT THE WITNESS HAS TESTIFIED, THAT IT WAS NOT AN INTACT D&E.

MR. SIMPSON: I WILL DO THAT, YOUR HONOR.

A TEAR IN THE WOMAN'S UTERUS OCCURRED IN THIS CASE. IT WAS A 5-CENTIMETER TEAR. OBVIOUSLY, THAT WAS AN EMERGENCY. THE PATIENT WAS TAKEN TO THE HOSPITAL. HER ABDOMEN WAS OPENED, AND IF I COULD REFER NOW TO THE LAST PARAGRAPH ON THAT PAGE 1061.

ABOUT 60 PERCENT OF THE WAY THROUGH THAT PARAGRAPH IS A SENTENCE THAT BEGINS "THE UTERUS WAS DELIVERED."

IT SAYS: "THE UTERUS WAS DELIVERED FROM THE ABDOMEN ALONG WITH THE POC."

BY MR. SIMPSON:

Q. DR. SHEEHAN, "POC" STANDS FOR PRODUCTS OF CONCEPTION?

A. YES.

MR. SIMPSON: THEN THE DOCUMENT CONTINUES.

"POC WAS INTACT AND SENT TO PATHOLOGY."

IT INDICATES, YOUR HONOR, THAT THE FETUS WAS NOT REMOVED BECAUSE SOMEHOW THE PHYSICIAN PERFORMING THE ABORTION MADE A TEAR IN THE WOMAN'S UTERUS, BUT THE FETUS WAS NOT DISARTICULATED, THE FETUS WAS STILL INTACT.

MS. PARKER: OBJECTION, YOUR HONOR. THIS IS NOT A D&E PROCEDURE IF IT WAS REMOVED FROM THE ABDOMEN.

I WOULD MOVE TO STRIKE ALL OF HIS PRIOR STATEMENTS FROM THE RECORD BECAUSE IT REVEALS VERY CONFIDENTIAL MEDICAL.

THE COURT: I WILL GRANT THE REQUEST, COUNSEL. THIS IS NOT AN INTACT D&E PROCEDURE, AND THAT'S THE ONLY ONES THAT I WAS GOING TO PERMIT YOU TO MOVE INTO EVIDENCE.

SO I AM NOT GOING TO ALLOW ANY QUESTIONS ON THIS RECORD.

MR. SIMPSON: THANK YOU, YOUR HONOR.

THE COURT: DO YOU WANT TO SHOW HER ONE OF THE OTHERS?

MR. SIMPSON: YES, ONE OF THE OTHERS. IF I CAN ASK A FEW PRELIMINARY QUESTIONS TO THAT.

THE COURT: I WOULD LIKE YOU TO ASK THE FIRST QUESTION; ESTABLISH WHAT KIND OF PROCEDURE WAS INVOLVED FIRST.

MR. SIMPSON: YES. THIS ONE WILL BE QUITE CLEAR.

BY MR. SIMPSON:

Q. DR. SHEEHAN, PPFA REQUIRES THAT ITS AFFILIATES BE ACCREDITED AS PPFA AFFILIATES, CORRECT?

A. CORRECT.

Q. EACH AFFILIATE HAS TO BE REACCREDITED PERIODICALLY?
A. YES.
Q. AS PART OF THE REACCREDIATION PROCESS, PPFA SENDS REACCREDITATION REVIEW TEAMS TO THE AFFILIATES TO REVIEW THE AFFILIATE'S OPERATIONS?
A. YES.
Q. IN FACT, YOU SERVE ON THE REACCREDITATION REVIEW TEAMS, DON'T YOU?
A. THAT'S CORRECT.
Q. DO REACCREDITATION REVIEW TEAMS REVIEW THE MEDICAL RECORDS OF THE AFFILIATES?
A. YES, THEY DO.
Q. BASED ON YOUR SERVICE ON THE REACCREDITATION REVIEW TEAMS, ALL AFFILIATES CREATE AND MAINTAIN RECORDS OF SERVICES PROVIDED TO INDIVIDUAL PATIENTS, CORRECT?
A. YES.
Q. I HAVE GIVEN YOU, DOCTOR, EXHIBIT A-73 (SIC) FOR THIS CASE. IF YOU COULD TAKE A MOMENT TO REVIEW THAT PLEASE.
THE COURT: I AM SORRY, COUNSEL, WHAT WAS THE NUMBER OF THE EXHIBIT?
MR. SIMPSON: A-63. I MISSPOKE. A-63.
THE COURT: A-63. ALL RIGHT.
MS. PARKER: YOUR HONOR, IF I MIGHT, THIS DOCUMENT IS, I BELIEVE, ABOUT 50 PAGES LONG AND MR. SIMPSON HAS NOT YET ESTABLISHED WHETHER DR. SHEEHAN HAS EVER SEEN THIS DOCUMENT

BEFORE. IF HE WANTS HER TO STAY ON THE STAND AND READ IT, IT MIGHT TAKE HER CONSIDERABLE TIME.

MR. SIMPSON: I WILL REFER HER TO ONE PAGE, YOUR HONOR, RIGHT NOW.

MS. PARKER: OBJECTION. WE WANT A WITNESS, OBVIOUSLY, TO HAVE REVIEWED A FULL RECORD --

THE COURT: COUNSEL, LET'S LET HER TAKE A LOOK AT IT AND DETERMINE FOR HERSELF WHETHER OR NOT SHE NEEDS MORE TIME TO REVIEW IT.

WE ARE LOOKING AT EXHIBIT A-63.

MR. SIMPSON: YES.

THE COURT: CORRECT?

MR. SIMPSON: YES.

THE COURT: PLEASE ESTABLISH THAT THIS WAS AN INTACT D&E PROCEDURE.

MR. SIMPSON: I WILL DO THAT RIGHT NOW, YOUR HONOR.

BY MR. SIMPSON:

Q. DOCTOR, DO YOU SEE THE BATES STAMPS IN THE LOWER RIGHT CORNER OF THOSE PAGES OF EXHIBIT A-63?

A. YES.

Q. REFER, PLEASE, TO PPFA879, PLEASE.

IF YOU COULD LOOK ABOUT TWO INCHES UP FROM THE BOTTOM OF THE PAGE, THERE'S A SECTION OF BLANK LINES WITH HANDWRITING FILLED IN.

THE PRINTING SAYS, "PATIENT'S STABLE AND DISCHARGED

IN GOOD CONDITION." BELOW THAT IT SAYS, PRINTED "COMPLICATIONS".

CAN YOU READ TO US PLEASE THE -- WHAT'S WRITTEN THERE IN HANDWRITING?

A. "PATIENT DILATED TO", I BELIEVE THAT SAYS "30 TO 40 MILLIMETERS, PASSED THE FETUS AND PLACENTA INTACT."

Q. DOES THIS REFLECT AN INTACT REMOVAL, DOCTOR?

A. IT APPEARS TO ME, AND I HAVEN'T READ THE REST OF THE PAGE, BUT IT APPEARS THE PATIENT DELIVERED SPONTANEOUSLY.

Q. WHY DO YOU SAY THAT?

A. IT SAYS "PASSED THE FETUS."

Q. WHAT IS THE DIFFERENCE BETWEEN AN INTACT REMOVAL AND PASSING THE FETUS SPONTANEOUSLY?

A. TO ME, INTACT REMOVAL MEANS THAT YOU ACTUALLY DO SOMETHING TO REMOVE THE FETUS. IT APPEARS THAT THE PATIENT PASSED THE FETUS HERSELF IN THIS SITUATION.

THE COURT: IS THAT AKIN TO WHAT WE WOULD REFER TO AS A SPONTANEOUS ABORTION?

THE WITNESS: YES.

BY MR. SIMPSON:

Q. NOW, DOCTOR, THE TERM "SPONTANEOUS ABORTION" IS THAT USUALLY USED FOR WHAT A LAYMAN WOULD CALL A MISCARRIAGE?

A. CORRECT.

Q. WOULD YOU NORMALLY USE THE PHRASE "SPONTANEOUS ABORTION" TO REFER TO A PROCEDURE WHERE A PHYSICIAN HAS ADMINISTERED

MISOPROSTOL OR PITOCIN?

A. I THINK IT MAY BE USED IN THAT SITUATION. IT'S BEEN USED ON ONE OF OUR CONSENT FORMS TO DESCRIBE TO THE PATIENT WHAT MIGHT HAPPEN TO HER.

MR. SIMPSON: YOUR HONOR, WE WOULD MOVE TO ADMIT EXHIBIT A-63 INTO EVIDENCE.

THE COURT: ON WHAT ISSUE?

MR. SIMPSON: YOUR HONOR, THE COURT HAS PERMITTED US AMONG THE MANY MEDICAL RECORDS THAT WE SECURED FROM PLAINTIFF'S COUNSEL, FROM THE PLAINTIFFS, THE COURT HAS PERMITTED US TO SUBMIT INTO THE COURT THOSE MEDICAL RECORDS THAT SHOW AN INTACT REMOVAL OF THE FETUS. THIS RECORD CLEARLY FALLS WITHIN THAT CATEGORY.

THE COURT: I BELIEVE MY RULING PERTAINED TO INTACT D&E. THAT'S THE SUBJECT HERE; NOT THIS KIND OF PROCEDURE.

AND I AM NOT EVEN SURE IT'S CORRECT TO CHARACTERIZE IT AS A PROCEDURE IF THE FETUS AND PLACENTA WAS PASSED SPONTANEOUSLY BY THE MOTHER.

DOES THAT MEAN THAT THE PHYSICIAN DID NOT TAKE ANY AFFIRMATIVE STEPS TO REMOVE THE FETUS?

THE WITNESS: WHAT I AM NOT CLEAR ON, YOUR HONOR, IS WHAT PREPARATION WAS DONE TO GET THE PATIENT TO THIS POINT. SHE MAY HAVE HAD MISOPROSTOL OR LAMINARIA OR OTHER INTERVENTION TO INITIATE THE PROCESS, BUT WHAT IT APPEARS TO ME IS THEN SHE WENT AHEAD AND DELIVERED. IF THAT WERE TRUE, IT WOULD BE AN

INDUCTION.

BY MR. SIMPSON:

Q. COULD I ASK YOU A QUESTION ON THAT, PLEASE, DOCTOR?

ON THAT PAGE 879, TOWARD THE MIDDLE OF THE PAGE THERE IS A GRID WITH FIVE COLUMNS, THE DATE, PREOPERATIVE ORDERS, AND SO FORTH.

DO YOU SEE THAT?

A. YES.

Q. HALFWAY DOWN THAT GRID IS A LINE THAT SAYS "CYTOTEC"?

A. YES.

Q. CYTOTEC IS THE BRAND NAME OF MISOPROSTOL, CORRECT?

A. CORRECT.

Q. DO YOU SEE THE FIGURES AND LETTERS FILLED IN ON THAT LINE THAT SAYS "CYTOTEC"?

A. MINE HAVE BEEN BLANKED OUT. I JUST SEE THE TIME AND SOME INITIALS.

Q. DO THOSE THINGS ON THAT LINE INDICATE THAT CYTOTEC WAS ADMINISTERED?

A. I WOULD IMAGINE THAT THAT'S WHAT HAPPENED, YES.

MR. SIMPSON: YOUR HONOR, WE WOULD MOVE THIS EXHIBIT A-63 INTO EVIDENCE.

THE COURT: RESPONSE?

MS. PARKER: WE OBJECT, YOUR HONOR. THIS IS NOT AN INTACT D&E AS THE WITNESS HAS TESTIFIED, IT'S A SPONTANEOUS ABORTION.

AND I CAN DO REDIRECT IF YOUR HONOR WANTS ME TO ESTABLISH THAT FURTHER, BUT I THINK THE WITNESS HAS ALREADY TESTIFIED TO THAT.

THE COURT: I AGREE.

I WON'T PERMIT IT AT THIS TIME, MR. SIMPSON.

BY MR. SIMPSON:

Q. DOCTOR, JUST A FEW MORE QUESTIONS, IF I COULD.

YOU'VE TESTIFIED THAT BEGINNING AT 22 WEEKS GESTATION YOU ALWAYS OFFER DIGOXIN TO CAUSE FETAL DEMISE?

A. YES.

Q. I THINK YOU SAID THAT ALL OF THE PATIENTS TO WHOM YOU OFFER THAT ACCEPT IT?

A. THAT'S CORRECT.

Q. BEFORE 22 WEEKS, SAY WHEN YOU ARE DOING A D&E AT 20 OR 21 WEEKS -- LET ME RESTATE THAT QUESTION.

YOU'VE ALSO TESTIFIED THAT SOMETIMES YOU REMOVE THE FETUS UP TO THE HEAD BEFORE COMPLETING THE DELIVERY, CORRECT?

A. CORRECT.

Q. WHEN YOU ARE DOING THAT AT 20 OR 21 WEEKS WHERE YOU HAVE NOT ADMINISTERED DIGOXIN TO CAUSE FETAL DEMISE, HAVE YOU SEEN ANY SIGNS OF THE LIFE IN THE FETUS WHEN YOU REMOVE THE FETUS UP TO THE HEAD?

A. NO.

Q. IS IT YOUR VIEW THAT IN ALL CASES THE FETUS HAS DIED BEFORE THAT POINT?

A. NO.
Q. ARE YOU TELLING ME THAT THE FETUS SHOWS NO SIGNS OF LIFE?
A. I AM SAYING THAT I AM NOT LOOKING FOR THAT.
Q. I HAVEN'T ASKED YOU, DOCTOR, WHETHER YOU ARE LOOKING FOR THOSE SIGNS OF LIFE.

DO YOU SEE OR OTHERWISE PERCEIVE SIGNS OF LIFE?

A. I HAVE NOT NOTED SIGNS OF LIFE.
Q. WHERE YOU ARE REMOVING THE FETUS AT 20 OR 21 WEEKS WHERE DIGOXIN HAS NOT BEEN ADMINISTERED, DO YOU SEE ANY MOVEMENT IN THE FETUS WHEN YOU EXTRACT IT UP TO THE HEAD?
A. I HAVE NOT NOTICED THAT.
Q. HAVE YOU NOTICED ANY BEATING OF THE HEART WHEN YOU HAVE EXTRACTED THE FETUS UP TO THE HEAD?
A. I HAVE NOT LOOKED FOR THAT. I HAVE NOT NOTED THAT.
Q. YOU TESTIFIED, DOCTOR, THAT YOU SOMETIMES HAVE TO COLLAPSE THE CALVARIUM TO COMPLETE THE DELIVERY.

WHERE YOU HAVE DONE THAT AT 20 OR 21 WEEKS, DO YOU SEE OR FEEL ANY MOVEMENT IN THE FETUS WHEN YOU COLLAPSE THE CALVARIUM?

A. NO.

MR. SIMPSON: I BELIEVE THAT IS ALL I HAVE, YOUR HONOR.

THE COURT: REDIRECT EXAMINATION?

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REDIRECT EXAMINATION

BY MS. PARKER:

Q. IN RESPONSE TO SOME QUESTIONS BY MR. SIMPSON, YOU STATED YOU WERE NOT AWARE OF ANY STUDIES, BUT YOU WERE AWARE OF CASES REGARDING MATERNAL INJURY FROM FRAGMENTS OF THE FETUS.

DO YOU RECALL THAT TESTIMONY?

A. YES.

Q. WHAT WERE THOSE CASES?

A. I HAVE SEEN A FEW TIMES WHEN A BONEY PART IS -- OF THE FETUS IS BEING PULLED DOWN THROUGH THE CERVIX THAT IT LACERATES RIGHT THROUGH THE CERVIX. SO MY PERSONAL EXPERIENCE, I HAVE SEEN THAT.

I HAVE OBSERVED OTHER PEOPLE PERFORMING PROCEDURES WHERE THIS HAS HAPPENED. I HAVE DISCUSSED IT A NUMBER OF TIMES WITH OTHER EXPERTS WHO PROVIDE THESE PROCEDURES, AND IT'S A WELL-KNOWN RISK.

ALSO THERE IS AN AUDIOTAPE THAT'S BEEN PRODUCED ON THE TOPIC OF SECOND-TRIMESTER ABORTION. DR. DAVID GRIMES IS THE AUTHOR OF THAT AND IT IS COMMENTED UPON IN THAT AUDIOTAPE.

Q. AND MR. SIMPSON ALSO ASKED YOU A SERIES OF QUESTIONS ABOUT THE PERCENT OF TIME WHEN YOU WERE ABLE TO REMOVE THE FETUS INTACT.

DO YOU REMEMBER THAT SERIES OF QUESTIONS?

A. YES.

Q. AND I BELIEVE YOU INDICATED IT WAS ONE PERCENT OF THE TIME?

A. YES.
Q. IN THAT LINE OF QUESTIONING, WHAT DID YOU MEAN BY "INTACT"?
A. I MEAN WHEN THE ENTIRE FETUS IS COMPLETELY INTACT.
Q. SO DOES THE ONE PERCENT INCLUDE THE SITUATION WHERE THE FETUS IS REMOVED UP TO THE NECK AND THEN A FURTHER PROCEDURE IS USED TO COMPLETE --
A. NO, I MEAN THE FETUS IS ENTIRELY INTACT WHEN IT'S EXTRACTED.
Q. AND DO YOU KNOW IN WHAT PERCENT OF THE D&E PROCEDURES YOU PERFORM THAT THE PROCEDURE PROCEEDS IN A WAY THAT THE FETUS IS REMOVED UP TO THE NECK AND THEN YOU NEED TO DO A FURTHER MANEUVER PROCEDURE TO COMPLETE THE PROCESS?
A. THAT'S A MUCH MORE COMMON SITUATION. IT PROBABLY HAPPENS ONE IN 15 TIMES OR SO.
Q. DOES THAT NUMBER CHANGE AS THE GESTATIONAL AGE INCREASES?
A. IN GENERAL, OVER 18 WEEKS, I WOULD SAY, IT HAPPENS AT ANY OF THOSE GESTATIONAL AGES VERY UNIFORMLY.
Q. AND IS IT YOUR OPINION THAT THE PROCEDURE WHERE THE FETUS IS REMOVED UP TO THE NECK AND THEN YOU NEED TO DO SOME ADDITIONAL PROCEDURE TO COMPLETE THE PROCESS, DOES THAT VIOLATE, IN YOUR VIEW, THE PARTIAL-BIRTH ABORTION BAN ACT?
A. YES, IT DOES.
MS. PARKER: NO FURTHER QUESTIONS.
THE COURT: RECROSS?
MR. SIMPSON: THANK YOU, YOUR HONOR.

RECROSS-EXAMINATION

BY MR. SIMPSON:

Q. DOCTOR, YOU'VE TESTIFIED REGARDING THE RISK OF INJURY TO THE WOMAN OF FETAL FRAGMENTS?

A. YES.

Q. YOU ARE TALKING ABOUT BONES?

A. YES.

Q. WHERE YOU HAVE HAD TO COMPRESS THE CALVARIUM TO COMPLETE THE DELIVERY, IS THAT RISK PRESENTED?

A. ABSOLUTELY.

Q. FROM --

A. PROBABLY THE HIGHEST.

Q. FROM THE BONES OF THE CALVARIUM?

A. CORRECT. THEY ARE VERY SHARP.

Q. DOCTOR, WOULD YOU BE REQUIRED TO COMPRESS THE CALVARIUM IN FEWER CASES IF YOU DILATED THE CERVIX MORE?

A. AS I SAID BEFORE, IT WOULD REQUIRE QUITE A SIGNIFICANT MORE DILATION, SO THE BENEFIT ISN'T THERE.

Q. BUT YOU ARE AT TIMES ABLE TO REMOVE THE FETUS WITHOUT COMPRESSING THE CALVARIUM?

A. YES.

MR. SIMPSON: THANK YOU, DOCTOR.

THE COURT: ANYTHING ELSE?

MS. PARKER: NO, YOUR HONOR.

THE COURT: THANK YOU, DR. SHEEHAN.

THE WITNESS: THANK YOU.

SHALL I LEAVE THIS HERE?

THE COURT: YOU CAN LEAVE IT ALL.

ALL RIGHT. PLEASE CALL YOUR NEXT WITNESS.

MS. MORRIS: YOUR HONOR, PLAINTIFFS CALL DR. ELEANOR DREY.

THE CLERK: PLEASE TAKE THE STAND. PLEASE RAISE YOUR RIGHT HAND.

ELEANOR DREY,

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

THE WITNESS: YES.

THE CLERK: PLEASE STATE YOUR NAME FOR THE COURT.

THE WITNESS: ELEANOR DREY.

THE CLERK: SPELL YOUR LAST NAME.

THE WITNESS: D-R-E-Y.

DIRECT EXAMINATION

BY MS. MORRIS:

Q. GOOD MORNING.

A. GOOD MORNING.

Q. DR. DREY, YOU ARE A PHYSICIAN AT SAN FRANCISCO GENERAL HOSPITAL; ISN'T THAT RIGHT?

A. YES.

Q. WHAT IS YOUR AREA OF MEDICAL SPECIALTY?

A. OBSTETRICS AND GYNECOLOGY.

Q. IS IT ALL RIGHT IF I REFER TO SAN FRANCISCO GENERAL HOSPITAL AS SFGH?
A. YES.
Q. WHAT IS YOUR TITLE AT SFGH?
A. I AM THE MEDICAL DIRECTOR OF THE WOMEN'S OPTION CENTER.
Q. ASIDE FROM BEING MEDICAL DIRECTOR OF THE WOMEN'S OPTION CENTER, WHAT OTHER PROFESSIONAL ACTIVITIES ARE YOU INVOLVED IN?
A. I'M A GENERALIST OBSTETRICIAN, GYNECOLOGIST, SO AS THAT, I WORK AS AN ATTENDANT. SO I ATTEND INPATIENT AND OUTPATIENT OBSTETRICS AND GYNECOLOGY.
Q. ANY OTHER PROFESSIONAL ACTIVITIES?
A. I TEACH RESIDENTS AND MEDICAL STUDENTS AND FELLOWS.
Q. AND IS THAT THROUGH SFGH OR SOME OTHER ENTITY?
A. THAT'S THROUGH THE UCSF.
Q. I WOULD LIKE TO TALK TO YOU ABOUT THE WOMEN'S OPTION CENTER.

WHAT IS THE BASIC MISSION OF THE WOMEN'S OPTION CENTER?

A. IT'S TO PROVIDE EXCELLENT CLINICAL CARE AND ABORTION AND IN CONTRACEPTION. OUR MISSION IS ALSO TO PERFORM RESEARCH AND ABORTION CARE AND TO TRAIN FUTURE ABORTION PROVIDERS.
Q. AND SPECIFICALLY WHAT SERVICES DOES THE WOMEN'S OPTION CENTER PROVIDE?
A. WE PROVIDE OPTIONS COUNSELING, CONTRACEPTION COUNSELING AND PROVISION, ABORTION COUNSELING AND PROVISION, AND PREGNANCY

TESTING.
Q. GENERALLY SPEAKING, TO WHOM DOES THE WOMEN'S OPTION CENTER PROVIDE THIS KIND OF CARE?
A. WE HAVE A VERY MIXED POPULATION. IT'S PREDOMINANTLY LOWER INCOME WOMEN, BUT WE ALSO SERVE HIGH RISK MEDICALLY-COMPLICATED PATIENTS.
Q. AND DO YOU SERVE PATIENTS JUST FROM THE SAN FRANCISCO GEOGRAPHIC AREA OR IS IT BROADER THAN THAT?
A. NO, ACTUALLY OUR PATIENTS ARE DRAWN FROM SORT OF ALL NORTHERN CALIFORNIA AND SOMETIMES OTHERS STATES AND OTHER COUNTRIES.

SO, WE ACTUALLY SERVE A LARGE GEOGRAPHIC REGION.
Q. YOU HAD MENTIONED A MOMENT AGO THAT YOU HAVE A GOOD NUMBER OF MEDICALLY COMPLEX CASES THAT ARE REFERRED TO YOU.

WHY ARE MEDICALLY COMPLEX CASES REFERRED TO THE WOMEN'S OPTION CENTER? IS THERE ANYTHING SPECIAL ABOUT IT THAT SPECIFICALLY -- THAT'S SPECIALLY EQUIPS IT TO HANDLE GREATER HEALTH RISKS?
A. WELL, WE ARE LOCATED IN A GENERAL TRAUMA CENTER AND A GENERAL HOSPITAL. SO, AS SUCH, WE HAVE FACILITIES SO THAT SHOULD A WOMAN HAVE A COMPLICATION IN THAT CASE, THEN WE WOULD BE ABLE TO HELP HER.
Q. NOW, YOU TESTIFIED THAT YOU ARE THE MEDICAL DIRECTOR. WHAT DOES THAT JOB INVOLVE?
A. IT INVOLVES MAKING SURE THAT WE PROVIDE EXCELLENT ABORTION

AND CONTRACEPTION CARE, SO OVERSEEING THE ACTIVITIES OF THE CLINIC PRIMARILY.

Q. DO YOU PERFORM ABORTIONS?

A. YES.

Q. DO YOU SUPERVISE ABORTIONS?

A. YES.

Q. DO YOU ESTABLISH PROTOCOLS FOR THE WOMEN'S OPTION CENTER?

A. YES.

Q. DO YOU SUPERVISE ANY EMPLOYEES AT THE WOMEN'S OPTION CENTER?

A. YES.

Q. WHO DO YOU SUPERVISE?

A. I AM THE DIRECT SUPERVISOR FOR THE HEAD NURSE, THE HEAD COUNSELOR AND ONE RESEARCH ASSISTANT, BUT THEN I GENERALLY SUPERVISE EVERYONE IN MY ROLE AS MEDICAL DIRECTOR.

Q. YOU MENTIONED TEACHING EARLIER, TEACHING MEDICAL STUDENTS AND RESIDENTS. DOES PART OF THAT TEACHING OCCUR AT THE WOMEN'S OPTION CENTER?

A. YES.

Q. DO YOU DO ANY ADMINISTRATIVE WORK IN CONNECTION WITH YOUR ROLE?

A. YES.

Q. CAN YOU DESCRIBE WHAT YOU DO?

A. I -- WELL, IN ADDITION TO THE FUNCTIONS THAT I DESCRIBED, I WORK WITH THE ADMINISTRATION OF THE HOSPITAL TO ENSURE THAT WE

CAN CONTINUE TO PROVIDE SAFE ABORTION AND CONTRACEPTION SERVICES.

Q. I WOULD LIKE TO TURN SPECIFICALLY TO THE PROVISION OF ABORTIONS AT THE WOMEN'S OPTION CENTER.

DOES THE CENTER PROVIDE WOMEN WITH D&E'S?

A. YES.

Q. UP TO WHAT GESTATIONAL AGE ARE D&E'S PERFORMED?

A. WE DO D&E'S UNTIL 23 WEEKS ONE DAY OR BIPARIETAL DIAMETER 56 MILLIMETERS.

Q. NOW, YOU SAY 23 WEEKS ONE DAY IS EQUIVALENT TO BIPARIETAL DIAMETER OF 56 MILLIMETERS. YESTERDAY, DR. SHEEHAN TESTIFIED THAT IN HER PRACTICE SHE DOES ABORTIONS TO 24 WEEKS, WHICH IS -- WHICH SHE DESCRIBED AS 56 MILLIMETERS BIPARIETAL -- BY BPD.

CAN YOU EXPLAIN THE DISCREPANCY BETWEEN YOUR TESTIMONY AND DR. SHEEHAN'S TESTIMONY IN THAT REGARD?

A. YES. I THINK THOSE OF US WHO USE ULTRASOUND DETERMINATION OF GESTATIONAL AGE DO SO BASED ON THE GROWTH CHARTS THAT ARE ACTUALLY PROGRAMMED INTO THE COMPUTER.

SO IF YOU HAD A MEASUREMENT OF A CERTAIN NUMBER OF MILLIMETERS BASED ON THAT GROWTH CHART ON THE ULTRASOUND, YOU WILL EITHER GET A MEASUREMENT AT 56 MILLIMETERS ACCORDING TO ONE COMPUTER, ONE ULTRASOUND GROWTH CHART WILL BE 23 WEEKS ONE DAY ANOTHER GROWTH CHART -- SORRY. I'M SPEAKING TOO FAST.

THE REPORTER: I'M SORRY, 23 --

THE WITNESS: A GROWTH CHART THAT IN ONE ULTRASOUND AT A BPD OF 56 MILLIMETERS IS READ AS 23 WEEKS ONE DAY AND ANOTHER ULTRASOUND WILL READ THE SAME MEASUREMENT AS 24 WEEKS.
BY MS. MORRIS:
Q. ARE YOU SAYING THAT WHAT REALLY MATTERS IS THE SIZE OF THE BPD?
A. THAT ULTIMATELY IS WHAT WE ARE ALL CONCERNED ABOUT IS THE SIZE OF THE FETUS AND SPECIFICALLY THE SIZE OF THE CALVARIUM.
Q. AND WHY IS 56 MILLIMETERS THE CUTOFF AT THE WOMEN'S OPTION CENTER?
A. THAT DECISION WAS MADE IN REFERENCE TO CONSIDERATIONS OF BOTH THE TECHNICAL DIFFICULTY OF THE PROCEDURES THAT WE WOULD BE PERFORMING, BUT ALSO IN REGARDS TO LIMITS ON VIABILITY.
Q. DOES THE WOMEN'S OPTION CENTER OFFER ABORTION METHODS OTHER THAN D&E?
A. WE DO.
Q. CAN YOU TELL ME WHAT THEY ARE?
A. WE ALSO DO SUCTION ABORTIONS, MEDICAL ABORTIONS, AND INDUCTION ABORTIONS.
Q. HOW MANY PHYSICIANS PROVIDE ABORTIONS AT THE WOMEN'S OPTION CENTER?
A. WE HAVE 16 ATTENDING PHYSICIANS AND THEY SUPERVISE A VARYING NUMBER OF RESIDENTS. SO THOSE ARE RESIDENT PHYSICIANS WHO ALSO PROVIDE ABORTIONS FOR FIRST-TRIMESTER ABORTIONS. THEY ALSO SUPERVISE MEDICAL STUDENTS WHO PROVIDE SOME OF THE

FIRST-TRIMESTER ABORTIONS, BUT NOT THE SECOND-TRIMESTER ABORTIONS.

Q. HOW MANY ABORTIONS DOES THE CENTER PROVIDE A YEAR ON AVERAGE?

A. APPROXIMATELY 2,000.

Q. AND OF THOSE 2,000 WHAT PERCENTAGE ARE SECOND-TRIMESTER ABORTIONS?

A. SLIGHTLY OVER HALF.

Q. AND OF THE SECOND-TRIMESTER ABORTIONS, WHAT PERCENTAGE ARE PERFORMED AT 20 WEEKS OR LATER?

A. APPROXIMATELY 60 PERCENT.

Q. WHY DOES THE WOMEN'S OPTION CENTER HAVE SUCH A HIGH PERCENTAGE OF PATIENTS AT 20 WEEKS OR LATER?

A. IT REALLY HAS TO DO WITH THE POPULATION THAT WE SEE OUR RESPONSIBILITY TO SERVE, AND THAT POPULATION IS POOR WOMEN. IN CALIFORNIA -- AS WELL AS MEDICALLY-COMPLICATED WOMEN.

SO WE, PREFERENTIALLY, WOMEN AT LATER GESTATIONS WHO HAVE MEDICAL COMPLICATIONS ARE REFERRED TO US BECAUSE WE ARE SEEN AS EXPERTS IN THE PROVISION OF LATE SECOND-TRIMESTER ABORTION.

BUT IN ADDITION TO THAT, WE SEE, AS PART OF OUR MISSION, SERVING THE POOR WOMEN OF NORTHERN CALIFORNIA AND REALLY THEY HAVE NOWHERE ELSE TO GO. THERE IS ONLY ONE OTHER CLINIC WHO CAN ACCEPT ALL TYPES OF MEDICAL OR THE STATE INSURANCE FOR THESE ABORTIONS AT 20 WEEKS AND ABOVE, AND THEY

DO -- THEY CAN ONLY ACCEPT VERY FEW OF THESE BECAUSE THEY REIMBURSE VERY LITTLE.

SO, ESSENTIALLY, WE END UP TAKING CARE OF ALL OF THE POOR WOMEN WHO NEED ABORTIONS AT 20 WEEKS AND ABOVE FOR ALL OF NORTHERN CALIFORNIA.

Q. I WOULD LIKE TO TALK ABOUT THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003, WHICH I WILL CALL THE ACT.

HAVE YOU READ THE ACT?

A. YES.

Q. WE HAVE A PORTION OF THE ACT BLOWN UP WHICH I WILL -- WITH PERMISSION?

THE COURT: YES.

BY MS. MORRIS:

Q. WOULD YOU PLEASE TAKE A MOMENT TO READ THAT, AGAIN?

DO THE PHYSICIANS AT THE WOMEN'S OPTION CENTER PERFORM ABORTIONS THAT FALL WITHIN THE DEFINITION OF PARTIAL-BIRTH ABORTION IN THE ACT AS YOU READ IT THERE?

A. YES.

Q. DO YOU YOURSELF PERFORM ABORTIONS THAT FALL WITHIN THIS DEFINITION?

A. YES.

Q. COULD YOU PLEASE EXPLAIN WHAT YOU MEAN BY THAT?

A. OUR -- THE TYPE OF ABORTIONS WE PROVIDE IN THE SECOND-TRIMESTER LARGELY IS D&E, BUT ANY TIME YOU DO A D&E ABORTION, DEPENDING ON THE DEGREE OF CERVICAL DILATION THAT YOU

HAVE ACHIEVED, THEN IT'S POSSIBLE BY GRASPING FETAL PARTS TO DELIVER THE FETUS BEYOND THE NAVEL, AND THEN TO HAVE TO CONTINUE THE PROCEDURE AND VIOLATE THE ACT.

Q. DO YOU HAVE ANY CONTROL OVER WHEN FETAL DEATH OCCURS IN THE COURSE OF THAT PROCEEDING?

A. WELL, I MEAN YOU DON'T HAVE ANY CONTROL OVER -- I MEAN, WHAT YOU ARE REALLY PAYING ATTENTION TO IS TRYING TO COMPLETE THE ABORTION SAFELY. SO, WHAT YOU ARE MAINLY TRYING TO DO IS EXTRACT THE PART SAFELY. SO, NOT EXACTLY.

Q. YOU ARE AWARE, ARE YOU NOT, THAT THERE IS AN INJUNCTION IN THIS CASE THAT PROTECTS THE PHYSICIANS AT SFGH FROM BEING CRIMINALLY PROSECUTED UNDER THE ACT?

A. YES.

Q. IF THAT INJUNCTION WERE LIFTED AND THE ACT WENT INTO FULL EFFECT, WHAT IMPACT WOULD IT HAVE ON PHYSICIANS AT THE WOMEN'S OPTION CENTER?

A. I THINK IT WOULD HAVE A LARGE IMPACT ON OUR PHYSICIANS. I THINK THAT IT WOULD BE VERY DIFFICULT FOR US TO CONTINUE TO PROVIDE SECOND-TRIMESTER ABORTIONS BECAUSE OF THIS ACT.

Q. CAN YOU SAY MORE ABOUT THE EFFECT THE ACT WOULD HAVE ON YOUR ABILITY TO PERFORM THOSE ABORTIONS?

A. I THINK THAT BECAUSE ANY KIND OF -- ANY D&E THAT WE DO COULD END UP FALLING UNDER THAT DEFINITION, THE PHYSICIANS WOULD BE CONCERNED THAT THEY WOULD BE VIOLATING THIS ACT AND, THEREFORE, THE PHYSICIANS WITH WHOM I WORK WOULD NO LONGER FEEL

COMFORTABLE PERFORMING D&E'S.

AND, IN FACT, I ALREADY MADE SOME CHANGES IN THE CLINIC JUST BECAUSE OF CONCERNS ABOUT THE ACT.

Q. CAN YOU GIVE ME SOME EXAMPLES OF CHANGES THAT YOU'VE MADE?

A. WELL, WE USUALLY, WE USED TO REALLY COUNSEL ALL PATIENTS ABOUT WELCOMING SOMEONE TO COME IN THE PROCEDURE WITH THEM TO SERVE AS A SUPPORT PERSON, WHETHER THAT BE A FAMILY MEMBER OR PARENT, A FRIEND, OR SOMEONE WHO COULD COME IN THE ROOM WITH THEM.

BECAUSE OF THIS ACT, I WAS CONCERNED THAT IN THE LATER PROCEDURES THOSE PEOPLE MIGHT MISINTERPRET WHAT WAS HAPPENING, AND SO I NO LONGER ENCOURAGE THE COUNSELORS TO BRING THIS UP.

IF A PATIENT REQUESTS FOR A SUPPORT PERSON TO BE WITH THEM, WE DON'T ABSOLUTELY RESTRICT IT, BUT WE NO LONGER OFFER IT SORT OF PART OF OUR ROUTINE COUNSELING LIKE WE USED TO.

I ALSO FELT THAT INSTEAD OF ALLOWING MEDICAL STUDENTS TO OBSERVE ALL OF THE PROCEDURES THAT WE DO, I WOULD NO LONGER ENCOURAGE THEM TO SEE THE LATER PROCEDURES, AGAIN, BECAUSE I WAS CONCERNED THAT THEY MIGHT INTERPRET SOMETHING THAT WE WERE DOING AS VIOLATING THE ACT AND I DIDN'T WANT TO CAUSE THAT CONCERN AMONG OUR STAFF.

Q. OTHER THAN THE IMPACTS THAT YOU HAVE ALREADY TALKED ABOUT, WHAT OTHER IMPACTS WOULD THE ACT HAVE ON THE WOMEN'S OPTION

CENTER IF IT WERE ENFORCED?
A. I DON'T THINK WE HAVE ENOUGH PHYSICIANS TO PERFORM SECOND-TRIMESTER ABORTIONS, AND I THINK WHAT WOULD END UP HAPPENING IS THAT POOR WOMEN WOULD HAVE NOWHERE TO GO IN NORTHERN CALIFORNIA, NOR WOULD WOMEN WITH MEDICAL COMPLICATIONS THAT MIGHT MAKE A D&E MORE DIFFICULT BECAUSE A HUGE NUMBER, I DON'T KNOW IF ALL OF THEM, BUT WE GET MOST WOMEN AS FAR AS I KNOW WHO HAVE REALLY ACUTE MEDICAL OR RISKY SURGICAL ISSUES.
Q. CAN YOU STATE BROADLY WHAT IMPACT YOU THINK THE ACT WOULD HAVE ON THE AVAILABILITY OF ABORTION SERVICES IN NORTHERN CALIFORNIA GENERALLY?
A. I THINK THAT IF YOU WERE -- WELL, I WAS GOING TO SAY IF YOU WERE INSURED YOU MIGHT HAVE SOMEWHERE TO GO, BUT I THINK THAT MANY PROVIDERS -- IN FACT, I HAVE HAD PROVIDERS CALL ME AND SAY THAT THEY NO LONGER ARE SURE WHETHER THEY SHOULD DO SECOND-TRIMESTER ABORTIONS BECAUSE THEY DON'T KNOW IF THEY WOULD BE VIOLATING THIS ACT.

SO, I WAS GOING TO SAY THAT IF YOU HAD INSURANCE, YOU MIGHT STILL BE ABLE TO FIND A PROVIDER. IF YOU DON'T HAVE INSURANCE OR IF YOU HAVE MEDI-CAL, YOU MIGHT NOT BE ABLE TO FIND A PROVIDER IN NORTHERN CALIFORNIA WHO COULD PROVIDE THESE SERVICES. SO I AM CONCERNED THAT WOMEN WOULD HAVE NOWHERE TO GO TO GET A SECOND-TRIMESTER ABORTION.

MR. SIMPSON: YOUR HONOR, WE MUST OBJECT. I THINK WE'RE MOVING INTO THE AREA OF SPECULATION, AND WE OBJECT AND

ASK THAT THE ANSWER BE STRICKEN.

THE COURT: I AM NOT GOING TO STRIKE THE ANSWER, BUT I TEND TO AGREE THAT SOME OF IT IS A BIT SPECULATIVE. I AM NOT GOING TO STRIKE IT.

PERHAPS YOU CAN MOVE ON TO ANOTHER AREA.

MS. MORRIS: YES, THANK YOU, YOUR HONOR.

BY MS. MORRIS:

Q. JUST ONE LAST TOPIC.

YOU HAD MENTIONED EARLIER THAT YOU GET A DISPROPORTIONATE NUMBER OF WOMEN COMING TO THE WOMEN'S OPTION CENTER WHO HAVE MEDICAL COMPLICATIONS OR JUST MEDICALLY COMPLEX CASES.

CAN YOU GIVE ME SOME EXAMPLES OF CASES LIKE THAT?

A. WE GENERALLY GET REFERRED WOMEN WHO HAVE HAD MULTIPLE OR EVEN ONE CESAREAN SECTION IN THE PAST, WOMEN WHO ARE MORBIDLY OBESE, WOMEN WHO HAVE LIMITED INTRAVENOUS ACCESS, WOMEN WITH PLACENTA PREVIA, WOMEN WHO HAVE SEVERE MEDICAL CONDITIONS AMONG OTHER COMPLICATIONS.

Q. AGAIN, THEY ARE REFERRED TO YOU BECAUSE?

A. BECAUSE OF OUR BEING A TRAUMA HOSPITAL, WE ARE ABLE TO HELP THEM WHERE A FREE-STANDING CLINIC MIGHT NOT FEEL COMFORTABLE TO DO THEIR ABORTION BECAUSE WE ARE SEEN AS THE SAFEST PLACE TO DO ABORTIONS FOR THESE WOMEN.

MS. MORRIS: THANK YOU. I HAVE NO FURTHER QUESTIONS.

THE COURT: AS I RECALL YESTERDAY, YOU ADVISED THAT YOU WERE SPLITTING UP THE EXAMINATION.

MS. MORRIS: YES.

THE COURT: SO PLANNED PARENTHOOD COUNSEL WISHES TO EXAMINE DR. DREY FURTHER?

MS. PARKER: YES, YOUR HONOR.

THE REASON IS SHE IS A PERCIPIENT WITNESS FOR THE CITY AND SHE'S OUR EXPERT.

DIRECT EXAMINATION

BY MS. PARKER:

Q. GOOD MORNING, DR. DREY.

HOW ARE YOU DOING?

A. OKAY.

Q. I AM BETH PARKER, ATTORNEY FOR PLANNED PARENTHOOD.

DR. DREY, HAVE YOU ALSO COME HERE PREPARED TO STATE YOUR OPINION AS TO THE SAFETY AND EFFICACY OF ADMINISTERING DIGOXIN TO CAUSE FETAL DEMISE BEFORE TERMINATION OF A SECOND-TRIMESTER ABORTION?

A. YES.

Q. AND BEFORE WE GO INTO YOUR OPINIONS, I JUST WANTED TO ASK YOU A FEW MORE BACKGROUND QUESTIONS.

IN ADDITION TO SERVING AS THE MEDICAL DIRECTOR OF THE WOMEN'S OPTIONS CENTER, I BELIEVE YOU ALSO INDICATED THAT YOU DO SOME TEACHING; IS THAT RIGHT?

A. YES, I DO.

Q. AND WHERE DO YOU DO THAT TEACHING?
A. I LARGELY DO IT AT THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO. SO THAT'S BOTH AT THE MEDICAL SCHOOL AND AT THE HOSPITAL AS ONE OF ITS SITES, BUT I ALSO TEACH AT OTHER UNIVERSITIES.
Q. DO YOU HAVE A TITLE AT UCSF? CAN WE CALL UNIVERSITY AT CALIFORNIA SAN FRANCISCO UCSF?
A. I'M AN ASSISTANT CLINICAL PROFESSOR IN THE DEPARTMENT OF OBSTETRICS, GYNECOLOGY, AND REPRODUCTIVE SCIENCES IS MY TITLE.
Q. WHAT ARE YOUR RESPONSIBILITIES AS AN ASSISTANT CLINICAL PROFESSOR?
A. IT IS TO TEACH RESIDENTS, MEDICAL STUDENTS, AND FELLOWS AS WELL AS TO DO CLINICAL CARE AND DO RESEARCH.
Q. DO YOU TEACH ANY METHODS OF ABORTION?
A. I DO.
Q. AND WHAT ARE THOSE METHODS?
A. I TEACH FIRST-TRIMESTER AND SECOND-TRIMESTER SURGICAL ABORTIONS. SO, THAT WOULD BE SUCTION ABORTION IN THE FIRST-TRIMESTER AND D&E IN THE SECOND-TRIMESTER.
WE ALSO TEACH INDUCTION TERMINATION AND MEDICAL ABORTION IN THE FIRST-TRIMESTER.
Q. WHAT DO YOU MEAN BY "MEDICAL ABORTION IN THE FIRST-TRIMESTER"?
A. THAT LARGELY IS USING THE MIFEPRISTONE, MISOPROSTOL AND IN THE FIRST-TRIMESTER.

Q. DO YOU ALSO DO RESEARCH?

A. YES.

Q. IN WHAT AREAS?

A. LARGELY ON CONTRACEPTION AND ABORTION.

Q. DO YOU HAVE ANY SPECIAL TRAINING THAT QUALIFIES YOU TO TEACH IN THIS AREA AND DO RESEARCH IN THIS AREA?

A. I DID A CLINICAL AND RESEARCH FELLOWSHIP IN FAMILY PLANNING.

Q. WHEN DID YOU DO THAT?

A. I DID THAT FROM 2000 TO 2002.

Q. WHERE?

A. AT UCSF.

Q. DO YOU HAVE ANY ONGOING ROLE IN THAT FELLOWSHIP PROGRAM?

A. I CONTINUE TO TEACH THE FELLOWS IN THAT PROGRAM AND ASSIST THEM WITH THEIR RESEARCH.

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

THE COURT: YES.

BY MS. PARKER:

Q. DR. DREY, I HAVE SHOWN YOU WHAT HAS BEEN MARKED AS EXHIBIT 33.

DO YOU SEE THAT?

A. YES.

Q. IS THAT YOUR C.V.?

A. YES.

Q. DID YOU PREPARE IT?

A. YES.
Q. IS IT BASICALLY -- IS IT TRUE AND CORRECT OR ACCURATE?
A. YES.
THE COURT: IS IT BASICALLY?
MS. PARKER: NOT BASICALLY.
BY MS. PARKER:
Q. IS IT ACCURATE?
A. IT IS ACCURATE. BUT, YOU KNOW, AS TIME PASSES, YOU ARE SUPPOSED TO KEEP IT UP TO DATE. SO I HAVEN'T MADE ANY MINOR ADDITIONS SINCE THEN.
MS. PARKER: I WOULD LIKE TO OFFER EXHIBIT 33 INTO EVIDENCE.
MR. SIMPSON: NO OBJECTION.
THE COURT: ADMITTED.
THE CLERK: 33 INTO EVIDENCE.
(PLAINTIFF'S EXHIBIT 33 RECEIVED IN EVIDENCE)
BY MS. PARKER:
Q. DR. DREY, HAVE YOU SERVED AS AN EXPERT WITNESS BEFORE IN A CASE INVOLVING THE PROVISION OF ABORTION SERVICES?
A. NO.
Q. HAVE YOU SERVED AS AN EXPERT WITNESS BEFORE?
A. NO.
Q. ARE YOU BEING COMPENSATED FOR PROVIDING EXPERT TESTIMONY IN THIS CASE?

A. NO.

MS. PARKER: I WOULD LIKE TO MOVE TO QUALIFY DR. DREY AS AN EXPERT WITNESS IN THE AREAS OF OBSTETRICS AND GYNECOLOGY IN THE PROVISION OF ABORTION.

THE COURT: ANY OBJECTION?

MR. SIMPSON: YOUR HONOR, I AM AFRAID WE DO HAVE TO OBJECT TO THE BREADTH OF THAT STATEMENT. DR. DREY'S EXPERT REPORT WAS VERY MUCH LIMITED TO THE INTRAUTERINE INJECTION OF DIGOXIN TO CAUSE FETAL DEMISE.

DURING HER DEPOSITION WE ASKED HER A LONG SERIES OF QUESTIONS AS TO WHETHER SHE'S OFFERING TESTIMONY AT TRIAL REGARDING OTHER THINGS. I CAN READ THAT SERIES TO THE COURT.

MS. PARKER: WE DON'T PLAN TO GO BEYOND THE DIGOXIN AREA, BUT I DO THINK SHE QUALIFIES AS AN EXPERT IN THESE AREAS, WHICH IS WHY I MOVED HER.

THE COURT: I DON'T KNOW IT IS NECESSARY ON THIS PARTICULAR SUBJECT TO PARSE OUT HER QUALIFICATIONS SO MINUTELY AS TO LIMIT HER TO THAT ONE AREA. SHE CLEARLY HAS EXPERTISE IN HER ROLE IN MORE THAN JUST THE AREA OF THE USE OF DIGOXIN.

SO, I UNDERSTAND IT'S BROADER THAN MOST OF THE OFFERS HAVE BEEN, AND PERHAPS YOU CAN NARROW IT IN SOME WAY, BUT I DON'T -- THOSE ARE TWO SEPARATE ISSUES WHAT SHE IS GOING TO TESTIFY ON TODAY IS SEPARATE FROM THE BREADTH OF HER QUALIFICATIONS. SHE IS CLEARLY, AND I BELIEVE YOU ALL HAVE STIPULATED TO THE BASIC QUALIFICATIONS OF ALL THE MEDICAL

PROVIDERS WHO HAVE MEDICAL DEGREES AND SOME DEGREE OF EXPERIENCE IN OB/GYN. SO SHE'S, IN OTHER WORDS, I AM GOING TO OVERRULE YOUR OBJECTION.

BY MS. PARKER:

Q. DR. DREY, YOU HAVE TOLD US THAT YOU ARE PREPARED TO STATE YOUR EXPERT OPINION ON THE SAFETY AND EFFICACY OF THE USE OF DIGOXIN IN THE SECOND-TRIMESTER ABORTION; IS THAT RIGHT?

A. YES.

Q. WHAT IS THAT OPINION?

A. MY OPINION IS THAT ALTHOUGH DIGOXIN IS SAFE IN MOST CASES, THAT THAT DOES NOT NECESSARILY MEAN THAT DIGOXIN IS SAFE IN EVERY CASE; THAT THERE'S SOME WOMEN IN WHOM -- AND THAT EVEN THOUGH DIGOXIN IS SAFE, THAT WE HAVE NOT REALLY DEMONSTRATED THAT IT IS ACTUALLY EFFECTIVE IN MAKING D&E PROCEDURES SAFER.

THERE ARE ALSO WOMEN IN WHOM DIGOXIN CANNOT BE USED BECAUSE IT IS CONTRAINDICATED. DIGOXIN DOES NOT WORK ALL THE TIME IN ORDER TO CAUSE FETAL DEMISE. DIGOXIN TECHNICALLY CANNOT BE ADMINISTERED IN SOME WOMEN DUE TO THEIR OBESITY, AND THAT'S ALL I CAN THINK OF RIGHT NOW.

Q. OKAY.

AND NOW YOU HAVE PROVIDED US WITH SEVERAL SORT OF ASPECTS OF THAT OPINION. WHAT ARE THE BASES FOR THESE OPINIONS ABOUT THE USE OF DIGOXIN?

A. THE BASES ARE THE RESEARCH STUDIES IN WHICH I PARTICIPATED AND MY CLINICAL EXPERIENCE.

Q. AND WHAT WERE THOSE RESEARCH STUDIES?
A. WE DID A STUDY ON THE SAFETY OF INTRA-AMNIOTIC DIGOXIN AND A STUDY ON THE EFFICACY OF INTRA-AMNIOTIC DIGOXIN.
Q. WOULD YOU JUST DESCRIBE FOR US WHAT A SAFETY STUDY IS?
A. A SAFETY STUDY, OFTEN YOU WILL HEAR TALKED ABOUT AS A PHASE I CLINICAL TRIAL. IT'S WHEN YOU HAVE A NONRANDOMIZED SMALL GROUP OF PATIENTS IN WHOM YOU ADMINISTER A CERTAIN INTERVENTION AND THEN YOU MAKE SURE THAT THAT INTERVENTION IS SAFE. USUALLY THAT'S A DRUG.
Q. WHAT IS AN EFFICACY STUDY?
A. AN EFFICACY STUDY IS WHERE YOU IDEALLY RANDOMIZE TWO GROUPS OF -- WELL, USUALLY TWO GROUPS OF SUBJECTS TO EITHER GET THE INTERVENTION OR NOT TO GET THE INTERVENTION, AND THEN YOU ACTUALLY SEE WHETHER THE INTERVENTION HAD THE INTENDED EFFECT OF IMPROVING THE HEALTH OR THE PROCEDURE THAT YOU ARE EVALUATING.
Q. SO YOU DID BOTH A SAFETY AND AN EFFICACY STUDY ON THE USE OF DIGOXIN?
A. YES.
Q. WHEN DID YOU DO THE SAFETY STUDY?
A. THE SAFETY STUDY WAS DONE IN 1998.
Q. WHEN WAS THE EFFICACY STUDY DONE?
A. IN 1999 TO 2000.
Q. WHY DID YOU DO THEM?
A. WELL, WE DID THEM BECAUSE, AS YOU'VE HEARD TESTIFY TO,

DIGOXIN IS REALLY USED WIDELY IN THE COMMUNITY OF PHYSICIANS WHO PROVIDE ABORTIONS BECAUSE THOSE PHYSICIANS -- WELL, THEY USE IT FOR A NUMBER OF REASONS, BUT I THINK IN PART THEY USE IT BECAUSE THEY BELIEVE THAT THE ABORTION WILL BE SAFER IF THEY USE DIGOXIN.

SO, WE WANTED TO STUDY THAT. THAT SEEMED AN IMPORTANT QUESTION BECAUSE YOU DON'T WANT TO DO UNNECESSARY OR POTENTIALLY DANGEROUS INTERVENTIONS IF YOU DON'T KNOW THAT THEY ACTUALLY WORK JUST BASED ON, YOU KNOW, CLINICAL EXPERIENCE.

BUT IN ORDER TO DO AN EFFICACY STUDY, YOU REALLY ETHICALLY NEED TO MAKE SURE THAT THE INTERVENTION IS SAFE. SO BEFORE WE COULD DO THE EFFICACY STUDY WE DID A SAFETY STUDY FIRST.

Q. BEFORE WE GET INTO THE DETAILS OF THE STUDIES I JUST WANT TO UNDERSTAND YOUR ROLE IN THE TWO OF THEM. WHAT WAS YOUR ROLE IN THE SAFETY STUDY?

A. MY ROLE IN THE SAFETY STUDY WAS TO HELP DESIGN IT, ADMINISTER IT AND ANALYZE THE RESULTS. AND THEN, I WAS -- I WROTE UP THAT STUDY.

Q. YOU WERE THE PRIMARY AUTHOR OF THE STUDY?

A. YEAH, I WAS THE LEAD AUTHOR.

Q. AND WHAT ABOUT THE EFFICACY STUDY? WHAT WAS YOUR ROLE IN THAT ONE?

A. AGAIN, I HELPED DESIGN THE STUDY, ADMINISTER AND SUPERVISE THE STUDY, AND HELPED IN THE ANALYSIS AND SOME OF THE WRITING.

Q. WERE OTHER PHYSICIANS AT UCSF INVOLVED IN THOSE TWO STUDIES?
A. YES.
Q. AND ON THE SAFETY STUDY, WHO ELSE PARTICIPATED?
A. THERE WERE TWO OTHER OBSTETRICIANS GYNECOLOGISTS, AND I BELIEVE THERE WAS TWO -- I CAN'T REMEMBER IF IT WAS TWO OR THREE. THERE WAS ALSO A CARDIOLOGIST AND A PHARMACOLOGIST, WHO IS ALSO A CARDIOLOGIST.
Q. AND HOW ABOUT THE EFFICACY STUDY, DID OTHER PHYSICIANS PARTICIPATE IN THAT STUDY, AS WELL?
A. YES.
Q. AND WHO WERE THEY?
A. MY MEMORY IS THEY WERE ALL OBSTETRICIAN GYNECOLOGISTS.
Q. BEFORE WE GET INTO THE STUDIES, CAN YOU DESCRIBE BRIEFLY HOW DIGOXIN IS GENERALLY USED? DO YOU KNOW HOW IT IS GENERALLY ADMINISTERED?
A. IT IS GENERALLY USED IN AN ORAL FORM FOR THE PATIENTS.
Q. IS THERE A PARTICULAR AMOUNT THAT IS USED?
A. THERE IS A RANGE OF DOSES THAT IS USED.
Q. AND HOW IS IT -- IS IT INJECTED, IF IT IS ORAL OR --
A. NO, IT IS ACTUALLY TAKEN IN PILL FORM IF IT IS ORAL. AND THAT IS THE MORE COMMON WAY FOR DIGOXIN TO BE USED.
Q. HOW ABOUT WHEN IT IS USED TO -- IN SECOND-TRIMESTER ABORTIONS?
A. IN SECOND-TRIMESTER ABORTIONS IT IS USED IN A SOLUBLE FORM,

SO IN A LIQUID FORM THAT CAN BE INJECTED, SO YOU WOULDN'T USE A PILL.

Q. AND IS THERE A CERTAIN AMOUNT THAT -- A CERTAIN AMOUNT THAT IS USED WHEN IT IS USED FOR SECOND-TRIMESTER ABORTIONS?

A. THERE IS A RANGE OF DOSES. THE MOST COMMON DOSE IS 1 MILLIGRAM. BUT THOSE DOSES HAVE RANGED IN THE COMMUNITY AS BEST WE WERE ABLE TO ASSESS FROM ABOUT HALF A MILLIGRAM TO 2 MILLIGRAMS.

Q. HOW IS IT GENERALLY ADMINISTERED WHEN IT IS USED FOR SECOND-TRIMESTER ABORTIONS?

A. IT IS INJECTED THROUGH THE PATIENT'S ABDOMEN, EITHER INTO THE AMNIOTIC FLUID OR INTO THE FETUS.

Q. ARE THOSE DIFFERENT ROUTES?

A. I WOULD CONSIDER THEM DIFFERENT ROUTES.

Q. CAN YOU DESCRIBE WHEN IT IS INJECTED INTRA-AMNIOTICALLY WHAT THAT MEANS?

A. WHAT YOU DO IN THAT CASE IS THAT YOU DIRECT THE NEEDLE INTO THE AMNIOTIC COMPARTMENT ESSENTIALLY THROUGH THE WALL OF THE ABDOMEN INTO THE UTERUS. AND THEN YOU ASSESS THAT YOU'RE IN THE AMNIOTIC SPACE BY SEEING AMNIOTIC FLUID. AND THEN, YOU INJECT THE DIGOXIN.

Q. AND HOW ABOUT WHEN IT IS ADMINISTERED INTRA-FETALLY? WHAT HAPPENS THERE?

A. IN THAT CASE YOU DIRECT THE NEEDLE TO GET IT INSIDE THE FETAL BODY.

Q. AT THE TIME YOU DID THE STUDIES IN THE LATE 1990'S, WAS DIGOXIN BEING USE AT THE WOMEN'S OPTIONS CENTER?
A. YES, IT WAS.
Q. HOW WAS IT BEING ADMINISTERED?
A. IT WAS LARGELY ADMINISTERED INTRA-AMNIOTICALLY.
Q. AND WAS THERE A TIME FRAME OF WHEN IT WAS GIVEN?
A. WHEN WE FIRST STARTED GIVING IT, WE ALWAYS GAVE IT AT THE TIME THAT WE WERE DOING OUR PRE-OPERATIVE EVALUATION, SO THAT THE PATIENT WOULD GET THE LAMINARIA PLACED. AND THEN, AFTER THAT, SHE WOULD HAVE THE DIGOXIN INJECTION.

AT THAT TIME WE WERE WAITING TWO DAYS WITH THE LAMINARIA IN PLACE. AND, SO, INITIALLY WE WERE GIVING DIGOXIN TWO DAYS BEFORE D&E.

Q. AND DID YOU EVER CHANGE THAT PROCEDURE, THAT TIME SCHEDULE?
A. WE DID. WHAT STARTED HAPPENING WAS WE HAD AN UNFORTUNATE NUMBER OF WOMEN WHO WERE SPONTANEOUSLY GOING INTO LABOR AND DELIVERING AT HOSPITALS SORT OF ALL OVER THE BAY AREA, AND IT WAS DISTRESSING TO EVERYONE.
Q. SO YOU CHANGED THE TIME SCHEDULE AFTER THAT?
A. WE DID.
Q. WHEN WAS DIGOXIN THEN PROVIDED?
A. THEN WE WOULD ONLY GIVE IT 24 HOURS BEFORE THE D&E.
Q. IS THERE A GESTATIONAL AGE AT WHICH DIGOXIN WAS BEING ADMINISTERED TO PATIENTS AT THE TIME YOU BEGAN THE STUDIES?
A. AT THE TIME WE BEGAN THE STUDY, IT WAS GENERALLY 20 WEEKS

AND ABOVE.
Q. AND WHY WAS THAT TIME FRAME USED?
A. THE MAIN REASON WE WERE ADMINISTERING DIGOXIN REALLY WAS TO MAKE THE PROCEDURE EASIER, BECAUSE THAT WAS THE BELIEF AMONG PROVIDERS. SO WE DID NOT THINK THAT WE NEEDED TO FACILITATE A PROCEDURE THAT WE ALREADY COULD DO WELL WITHOUT ANY HELP BEFORE 20 WEEKS.
Q. YOU INDICATED WHEN WE STARTED TALKING ABOUT DIGOXIN THAT IN OTHER CIRCUMSTANCES IT'S GIVEN ORALLY; IS THAT RIGHT?
A. YES.
Q. WHAT ARE OTHER USES OF DIGOXIN?
A. IT IS A CARDIAC MEDICATION, SO THAT IN THE GENERAL POPULATION IT IS USUALLY USED EITHER FOR TACHYARRHYTHMIAS, MEANING ARRHYTHMIA WHERE THE HEART IS BEATING VERY FAST, OR FOR HEART FAILURE.
Q. SO NOW I WOULD LIKE TO TALK ABOUT THE STUDIES. AND YOU INDICATED -- WELL, HOW DID YOU COME TO DO THE STUDIES?
A. I BECAME INVOLVED IN THE STUDIES BECAUSE I WAS A RESIDENT AT THE TIME AND I WORKED WITH ONE OF THE PREVIOUS FELLOWS IN FAMILY PLANNING.

AND SHE WAS BEGINNING TO THINK ABOUT DOING THIS EFFICACY TRIAL OF DIGOXIN, BECAUSE OF THE WIDE USE THAT IT HAD IN AN ABORTION-PROVIDING COMMUNITY.

AND I WAS INTERESTED IN HELPING HER DO HER RESEARCH. SO I HELPED HER AS SHE WENT THROUGH THE STEPS OF DESIGNING THE

FIRST STUDY WHICH PROVED TO BE THE SAFETY STUDY.
Q. BEFORE YOU ALL DID YOUR STUDY, HAD STUDY AND EFFICACY EVER BEEN STUDIED?
A. THERE WERE CASE REPORTS OF, AND JUST SORT OF REPORTS OF USE IN THE COMMUNITY, BUT THERE WEREN'T ANY RANDOMIZED TRIALS, NOR WERE THERE ANY SAFETY TRIALS.
Q. AND WHAT WAS THE FIRST STEPS YOU DID ONCE YOU DETERMINED THAT YOU WANTED TO CONDUCT A STUDY OF DIGOXIN?
A. SO THE FIRST STEP THAT WE DID WAS WE WROTE A PROTOCOL AND THEN TOOK IT TO THE INSTITUTIONAL REVIEW BOARD AT UCSF, WHICH IS CALLED "THE COMMITTEE ON HUMAN RESEARCH," OR CHR. AND AFTER THEY APPROVED OUR PROTOCOL, THEN WE PROCEEDED TO ENROLL PATIENTS.
Q. WHY DID YOU CONDUCT THE SAFETY STUDY FIRST?
A. WE REALLY WANTED TO DO THE EFFICACY TRIAL FIRST, BUT BECAUSE THERE REALLY HAD BEEN NO STUDY SHOWING THAT THIS USE OF DIGOXIN WAS SAFE IN A RESEARCH SETTING, WE THOUGHT THAT WE REALLY HAD TO DO THE SAFETY STUDY BEFORE WE COULD DO THE EFFICACY TRIAL.
Q. AFTER YOU COMPLETED THE STUDY, DID YOU WRITE IT UP?
A. YES.
Q. AND YOU INDICATED YOU WERE THE PRINCIPAL AUTHOR?
A. YES.
Q. DID YOU SUBMIT IT ANYWHERE?
A. YES, I DID.

Q. WHERE DID YOU SUBMIT IT?
A. THE JOURNAL THAT'S CALLED AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY.
Q. IS THAT A PEER REVIEW JOURNAL?
A. YES.
Q. WHAT IS A PEER REVIEW JOURNAL?
A. IN THE JOURNALS, AFTER YOU SUBMIT AN ARTICLE, THOSE ARTICLES ARE THEN SENT TO A NUMBER OF EXPERTS IN THE FIELD WHO COMMENT ON WHETHER THE ARTICLE NEEDS FURTHER -- WHETHER THE ARTICLE IS JUST PLAIN FLAWED AND UNACCEPTABLE, OR WHETHER IT NEEDS ADDITIONAL MODIFICATIONS. AND IT IS RETURNED TO THE AUTHORS WHO THEN ARE ABLE TO MAKE THOSE MODIFICATIONS.

AND IT'S RESUBMITTED. AND IF AT THAT POINT IT IS JUDGED TO BE ACCEPTABLE, IT IS PRINTED.

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

THE COURT: YES.

BY MS. PARKER:
Q. DR. DREY, I SHOW YOU WHAT HAS BEEN MARKED AS EXHIBIT 34. THAT'S AN ARTICLE ENTITLED"

"SAFETY OF INTRA-AMNIOTIC DIGOXIN ADMINISTRATION BEFORE LATE SECOND-TRIMESTER ABORTION BY DILATION AND EVACUATION."

IS THAT THE PEER-REVIEWED ARTICLE ON THE SAFETY OF DIGOXIN THAT YOU JUST DESCRIBED AND FOR WHICH YOU WERE THE PRINCIPAL AUTHOR?

A. YES.

MS. PARKER: YOUR HONOR, I WOULD LIKE TO OFFER EXHIBIT 34 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MR. SIMPSON: YOUR HONOR, WE DO HAVE TO OBJECT TO ADMITTING IT FOR ITS TRUTH. OBVIOUSLY, IT IS HEARSAY. AND I DON'T KNOW OF ANY HEARSAY EXCEPTION THAT APPLIES HERE OTHER THAN THE LEARNED TREATIES EXCEPTION, UNDER WHICH THE DOCUMENT ITSELF IS NOT ADMITTED INTO EVIDENCE.

THE COURT: ALL RIGHT.

MS. PARKER: YOUR HONOR, WE BELIEVE IT WOULD COME IN UNDER EXCEPTION 8031 AS A PRESENT SENSE IMPRESSION, BECAUSE IT IS A STUDY THAT SHE WROTE THAT WAS RECORDED AT OR NEAR THE TIME AT WHICH THE STUDY WAS CONDUCTED.

AND SO IT IS A MORE RELIABLE -- THAN HER TESTIMONY ABOUT THAT STUDY TODAY. IT IS ALSO RECORDED RECOLLECTION, I BELIEVE, UNDER 8035.

MR. SIMPSON: YOUR HONOR, I DON'T THINK WE HAVE HEARD FOUNDATIONAL QUESTIONS THAT HAVE ESTABLISHED --

THE COURT: EXCUSE ME. IT CERTAINLY IS NOT RECORDED RECOLLECTION, BECAUSE THAT REQUIRES A PRESENT FAILURE OF RECOLLECTION.

MS. PARKER: YOU'RE RIGHT.

THE COURT: SO THE ONLY EXCEPTION THAT COULD CONCEIVABLY APPLY WOULD BE THE PRESENT SENSE IMPRESSION, WHICH

SEEMS TO BE AN UNUSUAL SECTION TO APPLY TO A DOCUMENT SUCH AS THIS. BUT I AM NOT ENTIRELY PERSUADED THAT IT IS NOT APPROPRIATE.

DO YOU HAVE ANY OTHER ARGUMENTS YOU WANT TO MAKE ON THAT?

MS. PARKER: TO THE EXTENT THAT IT IS DESCRIBING OR EXPLAINING AN EVENT OR CONDITION AND THAT WOULD BE OBVIOUSLY THE TEST RESULTS THAT THE DECLARANT WAS RECEIVING, IN ADDITION. WE ARE ASSUMING THAT THE REPORT -- THAT AN APPROPRIATE FOUNDATION COULD BE ESTABLISHED THAT THAT WOULD BE APPROPRIATE.

THE COURT: SO YOU HAVEN'T ASKED SUFFICIENT QUESTIONS ABOUT THE CONDITIONS UNDER WHICH IT WAS MADE CONTEMPORANEOUS -- WHETHER OR NOT IT WAS MADE CONTEMPORANEOUS WITH THE PERCEPTION. THAT WOULD HELP.

MS. PARKER: YOU SAID I DID OR I DID NOT?

THE COURT: DID NOT. YOU NEED TO ASK FEW MORE QUESTIONS.

MS. PARKER: THAT IS FINE.

BY MS. PARKER:

Q. SO, DR. DREY, YOU INDICATED THAT YOU CONDUCTED THE STUDY, I BELIEVE, IN 1998; IS THAT RIGHT?

A. YES.

Q. AND THEN, AFTER YOU CONDUCTED THAT STUDY, DID YOU WRITE THAT STUDY UP?

A. YES.

Q. AND DID YOU CIRCULATE IT AMONGST OTHERS WHO HAD ALSO PARTICIPATED IN THE STUDY?
A. YES, ALL OF THE AUTHORS HAD TO REVIEW THE DRAFTS OF THE STUDY AS IT WAS WRITTEN.
Q. AND DOES EXHIBIT 34, WHICH IS THE ARTICLE, IS THAT AN ACCURATE REFLECTION OF THE STUDY THAT YOU CONDUCTED?
A. YES.
Q. AND WAS THAT DONE AT OR NEAR THE TIME OF WHEN YOU DID THE ACTUAL STUDY?
A. YES.
Q. AND THEN, DID YOU SUBMIT IT TO THE PEER REVIEW WITH JOURNAL AT OR AROUND OR SHORTLY AFTER THE TIME THAT YOU WROTE THE ARTICLE?
A. YES.
Q. AND CONDUCTED THE STUDY?
THE COURT: ALL RIGHT. ANY FURTHER OBJECTION ON FOUNDATION?
MR. SIMPSON: TWO FURTHER POINTS, YOUR HONOR. THE RULE SPEAKS OF AT OR NEAR THE TIME. I THINK THE IDEA BEHIND THE PERSONS WHO DRAFTED THAT PARTICULAR SECTION IS IT'S -- YOU SEE SOMETHING AND YOU EXCLAIM ON IT, AND, YOU KNOW, IT IS WHILE YOU ARE RECEIVING IT OR SHORTLY THEREAFTER. I DON'T WHEN YOU SEE SOMETHING AND YOU WRITE ABOUT IT OVER THE NEXT SEVERAL MONTHS, I DON'T THINK THAT IS SUPPOSED TO COME UNDER THE EXCEPTION.

AND ONE OTHER POINT, PLEASE, YOUR HONOR, IF I COULD -- I FORGOT WHAT THAT POINT WAS, YOUR HONOR. WE WOULD STILL OBJECT TO IT.

THE COURT: IT IS SOMEWHAT OF A STRETCH.

LET ME JUST ASK A FEW QUESTIONS.

YOU RECORDED THE INFORMATION THAT YOU OBSERVED THROUGHOUT THE COURSE OF THE STUDY.

THE WITNESS: RIGHT.

THE COURT: AND DID YOU DO THAT CONTEMPORANEOUSLY WITH YOUR PERCEPTIONS? FOR INSTANCE, DID YOU MAKE AN OBSERVATION AND IMMEDIATELY MAKE SOME NOTATION OF WHAT RESULTED?

THE WITNESS: RIGHT, YOU COLLECT THE DATA AT THE TIME THAT THE DATA IS BEING OBSERVED.

THE COURT: ALL RIGHT. AND DID YOU RECORD THE DATA THAT YOU OBSERVED IMMEDIATELY UPON MAKING THE OBSERVATION?

THE WITNESS: YES, OTHERWISE THERE WOULD BE NO ACCURATE WAY OF RECALLING THE INFORMATION, SO YOU HAVE TO DO IT AT THAT TIME.

THE COURT: THEN, IT JUST TOOK YOU A PERIOD OF TIME THEREAFTER TO COMPILE IT INTO AN ARTICLE. BUT THE DATA WAS ACTUALLY ALREADY RECORDED.

THE WITNESS: EXACTLY. AND WHEN YOU ARE WORKING WITH A NUMBER OF AUTHORS, ALL OF WHOM WANT TO MAKE SURE THAT THE INFORMATION IS ACCURATE, IT TAKES A CERTAIN AMOUNT OF TIME

TO CORRESPOND WITH VERY BUSY ACADEMICIANS TO DRAFT AN ARTICLE.

AND THEN, AGAIN, WHEN YOU GO TO THE PEER REVIEW JOURNAL, THEY, IN TURN, ALSO WILL ASK FURTHER QUESTIONS AND HAVE YOU GO BACK TO YOUR ORIGINAL DATA AND MAKE SURE THAT THOSE DATA ARE ACCURATELY REPRESENTED AND FULLY REPRESENTED IN YOUR ARTICLE.

THE COURT: RIGHT.

MR. SIMPSON: IF I COULD JUST MAKE ONE MORE POINT? I REMEMBERED MY ADDITIONAL POINT. THE WITNESS HAS TESTIFIED THAT THIS ARTICLE INCORPORATES COMMENTS THAT WERE MADE BY OTHER PERSONS, OTHER ACADEMICIANS. AND OBVIOUSLY THOSE OTHER ACADEMICIANS DID NOT PERCEIVE ANY OF THIS DATA THAT'S REFLECTED HERE.

AND SO WHAT WE ARE SEEING HERE IS NOT ONLY THE PERCEPTIONS OF WHAT THE PEOPLE WHO DID THE STUDY, BUT ALSO CHANGES THAT THEY MADE BASED ON THE COMMENTS FROM THE PEER REVIEW.

THE COURT: I HAVE SOME RELUCTANCE TO ALLOW IT IN UNDER THAT EXCEPTION. I WILL PERMIT HER TO TESTIFY ON IT. THE HALLMARK OF THE EXCEPTION IS OBVIOUSLY TRUSTWORTHINESS. TO THE EXTENT THAT SHE HAS INDEPENDENT RECOLLECTION OF IT, SHE MAY CERTAINLY TESTIFY ON IT.

AND I WILL ALLOW YOU ALL TO SUBMIT SOME AUTHORITY ONE WAY OR ANOTHER. IF YOU CAN SUBMIT AUTHORITY THAT THAT SECTION APPLIES TO THIS KIND OF DOCUMENT, I WOULD RECONSIDER

IT.

MS. PARKER: THANK YOU, YOUR HONOR.

BY MS. PARKER:

Q. SO WHAT WERE THE OBJECTIVES OF THE SAFETY STUDY?

A. THE OBJECTIVES WERE TO ANALYZE THE QUALITY OF DIGOXIN THAT WAS IN THE SERUM OF THE SUBJECTS; TO ALSO CHECK THE CLOTTING PARAMETERS OF THE SUBJECTS AND TO FOLLOW THEIR CARDIAC RHYTHMS WHILE THEY WERE -- AFTER THEY HAD RECEIVED THE DIGOXIN.

IN SUMMARY, IT WAS REALLY TO BE SURE THAT THE -- THIS ADMINISTRATION OF THIS DOSE OF DRUG WAS SAFE.

Q. SO I BELIEVE THE FIRST ONE YOU INDICATED THAT YOU WANTED TO ASSESS THE AMOUNT OF DIGOXIN THAT WAS IN THE SERUM; IS THAT RIGHT?

A. RIGHT.

Q. CAN YOU DESCRIBE WHAT THAT MEANS IN LAY TERMS?

A. SO ESSENTIALLY WHAT YOU ARE LOOKING AT IS OVER TIME WHAT -- WHEN YOU CHECK REPEATEDLY, HOW MUCH OF THE DRUG IS IN THE BLOOD OF THE SUBJECT OVER TIME, WHAT THE LEVELS DO, WHETHER THEY GO UP OR DOWN.

Q. AND THE SECOND THING YOU WERE LOOKING AT WAS -- I BELIEVE YOU CALLED IT "COAGULATION PARAMETERS"; IS THAT RIGHT?

A. YES. THAT IS LOOKING AT WHETHER THIS USE OF THE DRUG WOULD AFFECT THE SUBJECT'S ABILITY TO CLOT.

Q. THAT'S THE BLOOD TO CLOT?

A. YES, FOR THE BLOOD TO CLOT.

Q. AND THE THIRD THING YOU LOOKED AT WERE THE IMPACTS ON CARDIAC RHYTHMS?
A. RIGHT.
Q. CAN YOU DESCRIBE FOR US IN LAY TERMS WHAT THAT MEANS?
A. BECAUSE THIS IS A DRUG THAT IS INTENDED TO BE USED IN PART TO EFFECT CARDIAC RHYTHMS, IN OTHER WORDS, THE HEARTBEAT AND HOW THE HEART IS BEATING, WE WANTED TO MAKE SURE THAT THERE WEREN'T CARDIAC ARRHYTHMIAS OR IRREGULAR HEARTBEATS THAT WERE BASED ON THIS USE OF DIGOXIN.
Q. HOW DID YOU GO ABOUT DOING THE SAFETY STUDY?
A. SO WE SUBMITTED THE PROTOCOL TO THE INSTITUTIONAL REVIEW BOARD. AFTER THEIR APPROVAL, WE RECRUITED SUBJECTS WHO WERE APPROPRIATE FOR THE STUDY BASED ON OUR INCLUSION AND EXCLUSION CRITERIA.

IF THEY CONSENTED TO BE IN THE STUDY THEY RECEIVED THE USUAL PREOPERATIVE HISTORY, PHYSICAL AND ULTRASOUND.

THEY HAD BASELINE LABS DRAWN, AND THEY HAD CONTINUOUS CARDIAC MONITORING STARTED FOR AN HOUR BEFORE THE DIGOXIN ADMINISTRATION.

SO, THE WOMEN RECEIVED LAMINARIA, AND THEN THEY RECEIVED THE DIGOXIN ADMINISTRATION. AND THEN, THEY WERE ADMITTED OVERNIGHT FOR -- WELL, FOR APPROXIMATELY 24 HOURS SO THAT THEY COULD BE MONITORED, THEIR CARDIAC RHYTHMS COULD BE ASSESSED, AND WE COULD SERIALLY CHECK THEIR BLOOD FOR THE LABORATORY VALUES THAT WE WERE INTERESTED IN ASSESSING.

Q. YOU INDICATE YOU RECRUITED PATIENTS FOR THE STUDY. HOW MANY DID YOU RECRUIT?
A. WE RECRUITED EIGHT.
Q. WHY DID YOU SELECT ONLY EIGHT?
A. IN DESIGNING THE STUDY WE WORKED WITH ONE OF THE AUTHORS, DR. BENOWITZ, WHO IS AN EXPERT IN DESIGN OF SAFETY STUDIES.

HE IS BOTH A PHARMACOLOGIST AND AN INTERNAL MEDICINE PHYSICIAN. AND HE FELT THAT EIGHT WAS AN ADEQUATE NUMBER TO DETERMINE THE SAFETY OF INTERVENTION.

Q. DID YOU HAVE ANY EXCLUSION CRITERIA OR DID YOU EXCLUDE ANY TYPES OF PATIENTS FROM YOUR SAFETY STUDY?
A. WE HAD A SERIES OF EXCLUDING CRITERIA.
Q. WHAT WERE THEY?
A. WOMEN HAD TO BE AT LEAST 18 YEARS OLD.

THEY HAD TO BE ABLE TO CONSENT TO THE STUDY.

THEY HAD TO HAVE FETAL CARDIAC ACTIVITY. AND THEN, THEY WOULD BE EXCLUDED IF THEY HAD SIGNIFICANT MEDICAL ILLNESSES, CARDIOVASCULAR DISEASE, IF THEY WERE USING CARDIAC OR ANTIHYPERTENSIVE MEDICATIONS, IF THEY WERE ALLERGIC TO DIGOXIN, IF THEY HAD PREGNANCY COMPLICATIONS, AND IF THEY HAD MATERNAL WEIGHT GREATER THAN 30 PERCENT ABOVE IDEAL BODY WEIGHT, AND IF THEY HAD POOR VENOUS ACCESS OR ABNORMAL POTASSIUM LEVELS.

THE COURT: COUNSEL, IT IS TIME FOR OUR SECOND BREAK OF THE MORNING.

IS THIS A GOOD TIME TO STOP?

MS. PARKER: THANK YOU, YOUR HONOR.

THE COURT: WE WILL BREAK FOR 15 MINUTES.

THANK YOU.

(RECESS TAKEN AT 11:45 A.M.)

(PROCEEDINGS RESUMED AT 12:00 P.M.)

THE COURT: ALL RIGHT. LET'S CONTINUE WITH DR. DREY.

BY MS. PARKER:

Q. HI, DR. DREY. BEFORE THE BREAK, WE WERE TALKING ABOUT THE EXCLUSION CRITERIA THAT YOU USED FOR THE SAFETY STUDY YOU USED ON THE USE OF DIGOXIN, AND YOU LISTED A NUMBER OF EXCLUSION CRITERIA. I WANT TO ASK YOU A FEW QUESTIONS ABOUT SOME OF THEM, IF I COULD.

A. OKAY.

Q. ONE OF THEM, AS I RECALL, YOU EXCLUDED WOMEN WITH SIGNIFICANT CARDIOVASCULAR DISEASE?

A. YES, WE DIDN'T WANT -- SINCE IT WAS A SAFETY STUDY INVOLVING A SMALL NUMBER OF PATIENTS, WE DIDN'T WANT TO PUT -- POTENTIALLY PUT ANY WOMEN WHO HAD CARDIOVASCULAR DISEASE AT ANY UNINTENDED RISK.

Q. AND WHY WAS THAT? DID IT HAVE ANYTHING TO DO WITH THE DIGOXIN, IN PARTICULAR?

A. YES, BECAUSE DIGOXIN IS A CARDIAC MEDICATION.

Q. I THINK YOU ALSO INDICATED YOU EXCLUDED WOMEN WITH

PREGNANCY COMPLICATIONS?
A. WE DID.
Q. AND WHY WAS THAT?
A. PRIMARILY, AGAIN, BECAUSE THE STUDY WASN'T REALLY LOOKING AT HOW DIGOXIN MIGHT BE SAFE IN THE CASE OF PREGNANCY COMPLICATIONS. AND, IN PARTICULAR, THE PREGNANCY COMPLICATIONS OF HAVING EITHER TOO MUCH AMNIOTIC FLUID OR TOO LITTLE AMNIOTIC FLUID MIGHT CHANGE THE RESULTS THAT WE WOULD SEE.
Q. ANOTHER EXCLUSION CRITERIA WAS WOMEN WHO WERE MORE THAN 30 PERCENT OVER IDEAL WEIGHT?
A. THAT HAS TO DO WITH THE FACT THAT, WELL, THERE IS MORE THERE THERE. SO I THINK IF YOU HAVE A LARGER SUBJECT YOU WOULD EXPECT THE RESULTS POTENTIALLY TO BE DIFFERENT BASED ON THAT.

SO IF WE WERE TRYING TO SEE HOW SAFE IT WAS FOR THE AVERAGE PERSON, AND GIVEN THAT WE WERE ONLY GOING TO INVOLVE EIGHT SUBJECTS, WE DIDN'T WANT TO CHANGE THE RESULTS BY INVOLVING WOMEN WHO WERE VERY OBESE.

Q. WAS THERE ANY OTHER ASPECT OF -- FOR VERY OVERLY OBESE WOMEN THAT CAUSED YOU TO EXCLUDE THEM FROM THE STUDY?
A. IT'S TECHNICALLY DIFFICULT TO DO -- SOMEBODY TAKE MY BEEPER. SORRY.

IT TECHNICALLY CAN BE DIFFICULT TO DO INTRA-AMNOITIC INJECTION IF SOMEONE IS MORBIDLY OBESE.

Q. AND WHY IS THAT?
A. AGAIN, THERE IS MORE THERE. I MEAN, SO YOU ARE USING A

NEEDLE OF A GIVEN LENGTH, AND YOU HAVE TO GET THROUGH THE ABDOMINAL WALL, AND THEN, IN TURN, THROUGH THE UTERINE WALL TO GET INTO THE PLACE WHERE YOU NEED TO INJECT THE MEDICINE.

SO IT IS JUST NOT EASY SOMETIMES IF SOMEONE HAS A LOT OF WEIGHT IN FRONT.

Q. WERE ANY WOMEN ACTUALLY EXCLUDED FROM YOUR SAFETY STUDY?

A. YES, WE DID EXCLUDE SOME SUBJECTS.

Q. DO YOU RECALL WHAT THE REASONS WERE FOR THE ACTUAL EXCLUSIONS?

A. TWO SUBJECTS WERE EXCLUDED BECAUSE THEY HAD LOW POTASSIUM LEVELS, AND ONE SUBJECT WAS EX -- THOSE WERE THE TWO -- THOSE WERE THE TWO I REMEMBER.

Q. THE TOO HIGH POTASSIUM LEVELS?

A. LOW POTASSIUM LEVELS.

Q. LOW POTASSIUM. AND WHY WERE THEY EXCLUDED?

A. BECAUSE WE DIDN'T WANT TO POTENTIALLY HAVE ANY ARRHYTHMIA ASSOCIATED WITH THE DIGOXIN OR AFFECT THE RESULTS THAT WE WOULD SEE.

Q. OKAY. SO YOU HAD EIGHT SUBJECTS WHO WERE IN THE STUDY; IS THAT RIGHT?

A. YES.

Q. AND THEN, YOU WENT ABOUT CONDUCTING -- I THINK YOU GAVE SORT OF AN OVERVIEW OF THAT. CAN YOU JUST DESCRIBE HOW YOU DID THE ADMINISTRATION OF DIGOXIN IN THE STUDY?

A. AFTER THEY HAD RECEIVED THEIR LAMINARIA, WE WOULD STERILELY

PREPARE THEIR ABDOMEN, AND THEN INJECT THE DIGOXIN BY PUTTING A SPINAL NEEDLE THROUGH THE WALL INTO THE UTERUS. AND THEN, ONCE WE SAW THAT WE WERE IN THE AMNIOTIC FLUID SPACE BY SEEING AMNIOTIC FLUID, WE WOULD ACTUALLY INJECT THE MEDICATION.

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

THE COURT: YES.

BY MS. PARKER:

Q. DR. DREY, YOU HAVE BEEN REFERRING TO THE USE OF A NEEDLE TO DO THE PROCEDURE. I HAVE JUST HANDED YOU A NEEDLE. CAN YOU DESCRIBE FOR THE COURT WHAT THAT IS?

A. THIS IS A -- IT'S CALLED A 22 GAUGE SPINAL NEEDLE, AND IT IS THE TYPE THAT GENERALLY WE AND OTHER PHYSICIANS USE TO DO EITHER AMNIOCENTESIS OR TO INJECT DIGOXIN.

Q. CAN YOU SHOW THE COURT THE NEEDLE?

A. (INDICATING.) WHEN WE DO THE INJECTION, THIS ALLOWS YOU TO WITHDRAW FLUID OR INJECT. KIND OF FROM HERE TO HERE (INDICATING).

THE COURT: IT LOOKS LIKE IT IS 3 INCHES?

THE WITNESS: THREE-AND-A-HALF INCHES.

MR. SIMPSON: I AM SORRY?

THE COURT: COUNSEL, MR. SIMPSON, WOULD YOU LIKE TO COME UP?

MR. SIMPSON: I COULD NOT HEAR.

THE WITNESS: I AM SORRY. WHAT I SAID WAS YOU USUALLY DO THE INJECTION, AND THEN WITHDRAW THE STYLET. YOU DO

THE INJECTION WITH THE STYLET, AND OFTEN THEN YOU CAN WITHDRAW THE STYLET. MAKE SURE THERE IS AMNIOTIC FLUID SEEN, EITHER BY ASPIRATING OR JUST SEEING THE FLUID. AND THEN, YOU DO THE INJECTION.

BY MS. PARKER:

Q. IT'S BASICALLY TWO PARTS TO THE INJECTION?

A. YES. ONE, YOU KNOW, WHEN YOU ARE DOING AN INTRA-AMNIOTIC INJECTION, THE FIRST PART OF THE INJECTION AFTER CLEANING AND DOING ALL OF THAT IS MAKING SURE THAT YOU ACTUALLY ARE IN THE AMNIOTIC FLUID, AND THEN YOU INSTILL THE DIGOXIN.

Q. WHY DO YOU WANT TO ENSURE THAT YOU ARE IN THE AMNIOTIC FLUID?

A. IN OUR CASE WE THOUGHT IT WAS THE SAFEST WAY OF DOING IT, BECAUSE YOU'RE LESS LIKELY TO INADVERTENTLY PUT DIGOXIN IN THE WOMAN, SO EITHER TO DO AN INJECTION INTO HER UTERUS OR MORE SERIOUSLY INTO HER BLOOD VESSELS.

Q. SO YOU ARE AIMING FOR THE AMNIOTIC SAC WITH YOUR INJECTION?

A. YES.

Q. AND YOU DIDN'T DO IT INTRA-FETALLY IN THE STUDY?

A. NO.

Q. WHY WAS THAT?

A. AGAIN, BECAUSE IT TAKES MORE SKILL TO GET THE NEEDLE INTO THE FETUS. AND THERE IS MORE UNCERTAINTY ABOUT WHETHER YOU ARE IN THE FETUS POTENTIALLY OR IN THE UTERUS OF THE SUBJECT.

Q. SO AFTER YOU DID THE DIGOXIN ADMINISTRATION ON THE EIGHT

PATIENTS, DID YOU WRITE UP OR REACH SOME CONCLUSIONS ABOUT THE SAFETY?

A. WE THOUGHT THAT BASED ON OUR STUDY THAT DIGOXIN OVERALL APPEARED SAFE.

Q. AND CAN YOU SORT OF GIVE A LITTLE MORE INFORMATION ABOUT THAT IN LAYPERSON'S TERMS?

A. WELL, WHAT WE WERE LOOKING FOR WAS WHETHER IN MOST WOMEN YOU FELT YOU COULD ADMINISTER THIS DRUG SAFELY. SO WE LOOKED FOR THINGS THAT YOU WOULD WORRY ABOUT, LIKE CARDIAC RHYTHM PROBLEM THAT COULD LEAD TO EVEN TO DEATH, SO YOU WOULDN'T WANT TO HAVE ANY KIND OF DIGOXIN-ASSOCIATED CARDIAC RHYTHM PROBLEM.

AND THEN, WE ALSO WOULDN'T WANT TO USE THIS INTERVENTION IF IT CAUSED HER PROBLEMS IN CLOTTING BECAUSE THEN WHEN YOU WOULD DO YOUR PROCEDURE, ESSENTIALLY SHE WOULD BLEED MORE. SHE MIGHT HEMORRHAGE. AND THEN, YOU GENERALLY WOULD WANT TO MAKE SURE THAT THE AMOUNT OF DIGOXIN THAT SHE'S EXPOSED TO IS SAFE.

SO THAT YOU ARE NOT GETTING VERY, VERY HIGH BLOOD LEVELS OF DIGOXIN THAT YOU WOULD WORRY ABOUT IF YOU DID THIS, THIS INTERVENTION RELIABLY.

Q. HAVE YOU EVER SEEN ANY SITUATIONS WHERE YOU ARE CONCERNED ABOUT THE SAFETY OF THE USE OF DIGOXIN TO CAUSE FETAL DEMISE IN A SECOND-TRIMESTER ABORTION PROCEDURE?

A. NOT IN THIS STUDY. WE DID HAVE A COUPLE OF PATIENTS OUTSIDE OF THE STUDY WHERE WE THOUGHT WE HAD INJECTED THE

DIGOXIN INTO THE AMNIOTIC FLUID, BUT, IN FACT, THE WOMEN EXPERIENCED PAIN RIGHT AFTER THE INJECTION.

AND THE ONE THAT I AM MORE FAMILIAR WITH, I KNOW SHE WAS ADMITTED -- WELL, BOTH OF THEM WERE ADMITTED FOR OBSERVATION OVERNIGHT AND FOR CONTINUOUS CARDIAC MONITORING TO MAKE SURE THAT THEY DIDN'T DEVELOP ANY KIND OF ARRHYTHMIAS AND SO THAT WE COULD SEE THAT THEY DIDN'T HAVE VERY HIGH SERUM BLOOD LEVELS OF DIGOXIN. AND THE ONE I REMEMBER DID, IN FACT, HAVE VERY HIGH SERUM LEVELS OF DIGOXIN.

Q. DO YOU KNOW WHAT CAUSED THAT?

A. OUR PRESUMPTION WAS THAT DESPITE OUR THINKING THAT WE REALLY WERE IN THE RIGHT PLACE, GIVEN THE AMOUNT OF PAIN SHE EXPERIENCED AND THESE HIGH LEVELS, OUR CONCLUSION WAS THAT WE MUST HAVE INADVERTENTLY INJECTED INTO THE WALL OF THE UTERUS.

Q. AFTER YOU COMPLETED THE SAFETY STUDY, DID YOU DO ANY FURTHER STUDIES ON THE USE OF DIGOXIN?

A. WE DID THE EFFICACY TRIAL.

Q. WHAT WAS THE OBJECTIVE OF THAT TRIAL?

A. THE OBJECTIVE OF THAT TRIAL WAS TO SEE WHETHER INTRA-AMNIOTIC DIGOXIN, IN FACT, DID MAKE THE D&E ABORTIONS SAFER.

Q. AND WHY DID YOU DO THAT PARTICULAR -- WHY DID YOU DO THE EFFICACY STUDY?

A. BECAUSE IN ANY -- I MEAN, IDEALLY YOU LIKE TO DO BLINDED TRIALS, RANDOMIZED TRIALS, BECAUSE THAT IS THE BEST WAY OF

SEEING WHETHER YOUR BELIEF THAT AN INTERVENTION IS HELPFUL IN FACT REALLY IS HELPFUL, BECAUSE OFTEN, YOU KNOW, YOUR CLINICAL SENSE IS VERY MUCH SHAPED BY YOUR COLLEAGUES, BY YOUR CLINICAL EXPERIENCE. BUT IN A BLINDED TRIAL, IT IS KIND OF THE PUREST WAY TO SEE IF, IN FACT, YOUR WORKING HYPOTHESIS IS, IN FACT, TRUE.

Q. COULD YOU DO A BLINDED TRIAL FOR A SURGICAL PROCEDURE, BECAUSE THE DIGOXIN IS A TEST OF A MEDICINE, CORRECT?

A. I THINK WHAT'S SPECIAL AND WHAT MAKES BLINDED TRIALS WORK SO WELL WITH MEDICINES IS YOU CAN BLIND EVERYONE. YOU CAN BLIND THE PERSON WHO GAVE THE MEDICINE. YOU CAN BLIND THE PEOPLE DOING THE ANALYSIS OF THE DATA. YOU BLIND THE SURGEONS WHO ARE DOING THE PROCEDURES.

SO, THAT MAKES IT KIND OF EASY TO REALLY DO A REALLY ACCURATE ASSESSMENT OF WHETHER THE INTERVENTION HELPED.

UNFORTUNATELY, WITH SURGERY, YOU CAN'T -- IT WOULD BE QUITE DANGEROUS TO BLIND THE SURGEON. I THINK YOU REALLY -- YOU CAN'T -- YOU CAN'T TAKE AWAY -- YOU CAN DO TRIALS WHERE YOU PUT A SURGEON IN A ROOM AND YOU HAND THEM A PIECE OF PAPER AND YOU SAY:

"NOW DO THE SURGERY THIS WAY."

AND YOU CAN DO THAT, BUT THEN YOU ARE DEALING WITH THE FACT THAT THE SURGEON IS DOING IT A CERTAIN WAY YOU ARE TELLING THEM TO. THEY MAY OR MAY NOT ACTUALLY BELIEVE THAT THAT IS THE RIGHT WAY TO DO IT.

THEY MAY NOT BE EQUALLY EXPERIENCED IN BOTH WAYS OF DOING A PARTICULAR SURGERY. SO THEY MAY HAVE EXPERTISE IN ONE WAY AND COMFORT AND PREFERENCE FOR ONE TYPE OF SURGERY AS OPPOSED TO ANOTHER.

SO, I THINK THAT ONE OF THE THINGS THAT WE SURGEONS HAVE DIFFICULTY WITH IS HOW TO DESIGN A REALLY EXCELLENT TRIAL OF SURGICAL TECHNIQUES.

SO, WHAT WE RELY ON INSTEAD IS OFTEN MORE EXPERIENTIAL OR MORE RETROSPECTIVE DATA.

Q. AND COULD YOU DO A SAFETY STUDY FOR A SURGICAL PROCEDURE?

A. A SAFETY STUDY REALLY IS A TERM THAT WE MORE USE FOR HOW WE ANALYZE MEDICAL -- THE FIRST PART OF A MEDICAL TRIAL, TRIAL OF MEDICAL THERAPY.

Q. SO YOU INDICATED THAT THE TRIAL THAT YOU DID FOR THE EFFICACY STUDY WAS A BLINDED TRIAL?

A. RIGHT.

Q. AND WHAT IS A "BLINDED TRIAL"?

A. IN A BLINDED TRIAL WHAT YOU ARE AIMING TO DO IS HAVE, AS I WAS ALLUDING TO, YOU TRY TO HAVE NO ONE KNOW WHAT THE INTERVENTION WAS THAT A PARTICULAR SUBJECT RECEIVED. SO YOU GO TO A REALLY QUITE ELABORATE LENGTH TO MAKE SURE THAT NO ONE KNOWS WHAT MEDICATION -- NO ONE WHOSE EITHER PERFORMANCE OF AN EVALUATION -- OF A CERTAIN PROCEDURE OR WHO -- WHOSE EVALUATION OF THAT PROCEDURE COULD BE INFLUENCED.

SO YOU DON'T WANT THE SUBJECT TO KNOW, BECAUSE THEN

HE OR SHE MIGHT EVALUATE HER EXPERIENCE BASED ON THAT KNOWLEDGE. AND THEN, YOU DON'T WANT THE ASSESSORS TO KNOW. SO WHAT YOU END UP DOING IS TRYING TO USE AN IDENTICAL-APPEARING PLACEBO SO NO ONE WILL KNOW SO THAT IT DOESN'T ALTER YOUR ABILITY TO FAIRLY ASSESS THAT INTERVENTION.

MR. SIMPSON: YOUR HONOR, I DON'T KNOW WHETHER THERE WILL BE ANY MORE QUESTIONS ALONG THIS LINE, WE HAVE STRAYED WELL BEYOND DR. DREY'S EXPERT REPORT.

MS. PARKER: I AM MOVING ON, YOUR HONOR.

THE COURT: ALL RIGHT.

BY MS. PARKER:

Q. WERE THE RESULTS OF YOUR EFFICACY STUDY PUBLISHED?

A. YES.

Q. WERE YOU ONE OF THE AUTHORS?

A. YES.

Q. WHERE WAS IT PUBLISHED?

A. IT WAS PUBLISHED IN "OBSTETRICS AND GYNECOLOGY."

Q. WHEN WAS IT PUBLISHED?

A. IT WAS PUBLISHED IN --

Q. THAT'S ALL RIGHT. WE WILL GET THERE.

IS "OBSTETRICS AND GYNECOLOGY" A PEER REVIEW JOURNAL?

A. IT IS.

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

THE COURT: YES.

THE WITNESS: 2001.

BY MS. PARKER:

Q. IT WAS PUBLISHED IN 2001?

A. YES, IT WAS.

Q. DR. DREY, SHOWING YOU EXHIBIT 30, WHICH IS AN ARTICLE ENTITLED:

"DIGOXIN TO FACILITATE LATE SECOND-TRIMESTER ABORTION, A RANDOMIZED MASKED PLACEBO-CONTROLLED TRIAL."

IS THAT THE PEER-REVIEWED STUDY YOU JUST DESCRIBED?

A. YES.

Q. AND WERE YOU ONE OF THE AUTHORS OF THAT STUDY?

A. I WAS.

MS. PARKER: YOUR HONOR, I WOULD LIKE --

BY MS. PARKER:

Q. WAS THE ARTICLE WRITTEN SORT OF AT OR NEAR THE TIME AT WHICH THE STUDY WAS ACTUALLY CONDUCTED?

A. YES.

Q. AND DID IT CONTAIN DATA THAT WAS REPORTED AT OR NEAR THE TIME THAT THE STUDY WAS CONDUCTED?

A. YES.

Q. AND CONTAINED SUMMARIES OF THAT DATA?

A. YES.

Q. AND TO THE BEST OF YOUR MIND IS THAT DATA ACCURATE, TRUE AND CORRECT AT THE TIME IT WAS RECORDED?

A. YES.
Q. AND DOUBLE-CHECKED WHEN IT WENT INTO THE ARTICLE?
A. OH, YES.
MS. PARKER: YOUR HONOR, I WOULD LIKE TO INTRODUCE EXHIBIT 30 INTO EVIDENCE.
MR. SIMPSON: SAME OBJECTION, YOUR HONOR.
THE COURT: ALL RIGHT. SAME RULING.
WHILE IT SEEMS TO ME ON THE FACE OF IT THAT THE AUTHOR HERE THAT THESE ITEMS OUGHT TO COME IN. I AM STILL NOT PERSUADED THEY ARE NOT HEARSAY AND THAT THE PRESENT SENSE EXCEPTION APPLIES. SO MY RULING WILL BE THE SAME. SHE MAY TESTIFY ON THE DOCUMENT, BUT UNLESS YOU CAN CITE SOME AUTHORITY FOR THE APPLICABILITY OF THAT PARTICULAR SECTION I CAN'T LET IT IN ON THAT --
MS. PARKER: WE WILL DO SOME ADDITIONAL RESEARCH ON THAT, YOUR HONOR.
BY MS. PARKER:
Q. SO, DR. DREY, COULD YOU DESCRIBE FOR US HOW YOU WENT ABOUT DOING THE EFFICACY STUDY?
A. AGAIN. WE WROTE A PROTOCOL AND SUBMITTED THAT PROTOCOL TO THE INSTITUTIONAL REVIEW BOARD. AND AFTER THEY HAD APPROVED OUR PROTOCOL, WE ENROLLED 126 SUBJECTS. THOSE SUBJECTS WERE RANDOMIZED INTO TWO GROUPS. ONE GROUP -- IN BOTH GROUPS THEY WOULD GET THE USUAL PREOPERATIVE EVALUATION, THE USUAL ULTRASOUND AND USUAL LAMINARIA PLACEMENT.

BUT AFTER LAMINARIA PLACEMENT, WE ADMINISTERED EITHER NORMAL SALINE, AS A PLACEBO THAT LOOKS EXACTLY LIKE DIGOXIN. AND THEY RECEIVED THAT INJECTION INTRA-AMNIOTICALLY. AND THEN THEY RECEIVED THEIR D&E 24 HOURS LATER, AGAIN, BY A SURGEON WHO DIDN'T KNOW WHETHER THEY HAD GOTTEN EITHER PLACEBO, THE SALINE OR THE DIGOXIN.

Q. YOU INDICATED THERE WERE 126 WOMEN WHO WERE ENROLLED IN THE STUDY. AND WHAT TYPE OF WOMEN WERE THEY?

A. THESE WERE WOMEN WHO WERE SURE THAT THEY WERE GOING TO HAVE AN ABORTION. THEY WERE ABLE TO CONSENT. THEY SPOKE EITHER ENGLISH OR SPANISH. AND THEN, WE HAD, AGAIN, VERY SIMILAR EXCLUSION CRITERIA FROM THE SAFETY STUDY.

Q. DID THEY FALL WITHIN A CERTAIN GESTATIONAL AGE?

A. YES, THEY WERE ALL BETWEEN 20 AND 23 WEEKS, ONE DAY.

Q. AND YOU INDICATED THE EXCLUSION CRITERIA WERE ESSENTIALLY THE SAME AS THE EXCLUSION CRITERIA FOR THE SAFETY STUDY?

A. VERY SIMILAR.

Q. DID YOU END UP EXCLUDING ANY WOMEN FROM PARTICIPATING?

A. SOME WOMEN WHO WERE NOT ENGLISH OR SPANISH SPEAKERS WERE EXCLUDED. THERE WAS A PATIENT WHO WAS IN PRISON AND THEREFORE UNABLE TO CONSENT FAIRLY.

THERE WERE PATIENTS WHO HAD OBSTETRIC COMPLICATIONS, AND THEN THERE WERE WOMEN WHO WERE EXCLUDED FOR CONTRAINDICATIONS TO DIGOXIN. AND ONE OF THOSE WOMEN HAD RENAL FAILURE AND ANOTHER HAD UNCONTROLLED HYPERTHYROIDISM.

Q. DO YOU RECALL WHAT THE PREGNANCY COMPLICATION WAS THAT CAUSED THE EXCLUSION?

A. I BELIEVE THAT THEY HAD MULTIPLE GESTATIONS. THAT MEANS LIKE TWIN OR TRIPLET GESTATIONS.

AND THEN THERE WERE WOMEN WHO WANTED TO BE -- INTENDED TO BE RANDOMIZED, BUT ONE WOMAN CHANGED HER MIND AND DECIDED NOT TO HAVE THE ABORTION. AND THEN, ANOTHER WOMAN, HER AMNIOTIC -- HER WATER BROKE WHEN WE WERE PUTTING IN THE DILATORS.

Q. SO HOW WAS THE STUDY THEN CONDUCTED?

A. SO, THE SUBJECTS, AS I SAID, THEY RECEIVED THE USUAL EVALUATION. THEN, THEY HAD THE DILATORS PLACED. THEY HAD THE DIGOXIN INJECTED INTRA-AMNIOTICALLY. THAT WAS NOT DONE UNDER ULTRASONIC GUIDANCE, BUT CORRECT PLACEMENT OF THE NEEDLE WAS ASSESSED, AS I DESCRIBED, LOOKING FOR THE AMNIOTIC FLUID TO COME UP THROUGH THE NEEDLE.

AND THEN, THE EITHER 1 MILLIGRAM OF DIGOXIN OR THE PLACEBO WAS INJECTED. THEN, THEY ALSO HAD BASELINE LABS AND FOLLOWUP LABS. AND THEN, THEY HAD THE D&E DONE IN THE USUAL WAY, BY EITHER AN ATTENDING OR A RESIDENT SURGEON.

Q. WHAT WERE THE RESULTS OF THE EFFICACY STUDY? WHAT WERE THE CONCLUSIONS THAT YOU REACHED AFTER YOU CONDUCTED THE STUDY?

A. THE CONCLUSIONS WERE THAT THE USE OF INTRA-AMNIOTIC DIGOXIN DID NOT MAKE THE PROCEDURE SAFER BY ANY OF THE WAYS THAT WE COULD ASSESS IT.

Q. AND DID YOU SUMMARIZE THOSE RESULTS IN THE ARTICLE THAT YOU HAVE BEEN LOOKING AT, EXHIBIT 30, WHICH IS THE PUBLISHED STUDY?
A. WE DID.
Q. WHERE ARE THOSE SUMMARIZED?
A. THEY ARE BOTH SUMMARIZED IN THE RESULT SECTION, BUT ALSO IN THE ABSTRACT, WHICH IS AT THE BEGINNING OF THE ARTICLE. AND I MEAN, ESSENTIALLY WHAT THEY SAY IS IT DIDN'T MAKE THE PROCEDURE ANY SAFER BECAUSE IT WASN'T ANY FASTER. THERE WAS NO DIFFERENCE IN BLOOD LOSS. THERE WAS NO DIFFERENCE IN PAIN SCORES. THERE WAS NO DIFFERENCE IN THE SURGEON'S SENSE OF THE DIFFICULTY OF THE PROCEDURE, AND THERE WAS NO DIFFERENCE IN COMPLICATIONS.

THE ONLY DIFFERENCE, REALLY, WAS ACTUALLY THAT THE PATIENTS VOMITED MORE IN THE GROUP THAT GOT DIGOXIN.

Q. SO IS THAT SUMMARIZED IN ONE OF THE TABLES IN EXHIBIT 30?
A. YES. THE FIRST TABLE WAS A DESCRIPTION OF JUST HOW THE TWO GROUPS WERE THE SAME, WHICH IS THAT THE RANDOMIZATION WORKED WELL.

BUT IN THE SECOND TABLE WE SUMMARIZED THESE RESULTS.

Q. THAT IS TABLE 2?
A. YEAH.
Q. PUT TABLE 2 UP FOR THE COURT, AND YOU CAN SEE IT. IN THE LEFT-HAND COLUMN ARE THE THREE RESULTS THAT YOU WERE STUDYING; IS THAT RIGHT?
A. RIGHT. I MEAN, IT IS ALWAYS NICE WHEN YOU DO A STUDY LIKE

THIS TO TRY AND LOOK AT VARIOUS WAYS OF ASSESSING THE SAME OUTCOME, BECAUSE THEN YOU FEEL MORE CONFIDENT THAT YOU ACTUALLY AREN'T MISSING SOMETHING.

SO WE LOOKED AT TIME AND DIFFICULTY, BECAUSE WE THINK THAT TIME IS AN EFFECTIVE WAY OF JUDGING THE SAFETY OF THE PROCEDURE. AND THAT THEN WE ALSO PUT BLOOD LOSS AND PAIN.

AND THE WAY THAT YOU CAN SEE THAT WE DIDN'T SEE ANY DIFFERENCE IS IN THE P VALUES, WHICH IS IN THE THIRD COLUMN. AND IN THAT COLUMN YOU CAN SEE THAT THEY ARE ALL GREATER THAN .05, WHICH MEANS THAT THEY WERE ESSENTIALLY SIMILAR, THAT THOSE RESULTS WERE LIKELY DUE TO JUST CHANCE, ANY DIFFERENCE BETWEEN THE TWO GROUPS.

SO IN OTHER WORDS, THE PROCEDURES DIDN'T -- THEY WEREN'T SHORTER. THEY WEREN'T EASIER. THE SURGEONS THOUGHT THEY WERE EQUALLY DIFFICULT. THE TOTAL NUMBER OF COMPLICATIONS WAS THE SAME. THE BLOOD LOSS WAS THE SAME. WHEN WE CHECKED THE FOLLOWUP BLOOD COUNT FOR ANEMIA, THOSE WERE THE SAME.

THE NUMBER OF HEMORRHAGES WERE NOT STATISTICALLY DIFFERENT, AND PAIN WAS THE SAME AS BEST WE COULD JUDGE IT OVERALL.

Q. DID YOUR STUDY NOTE ANY ADVERSE EFFECTS FROM THE ADMINISTRATION OF DIGOXIN?

A. THERE WAS MORE VOMITING. THERE WAS SIGNIFICANTLY MORE VOMITING IN THE DIGOXIN GROUP.

Q. DID YOU INDICATE THAT ANYWHERE IN THE STUDY? IS THERE ANY

SORT OF SUMMARY TABLE ABOUT THE ADVERSE EFFECTS?
A. WE DESCRIBE THOSE IN TABLE 3.
Q. COULD YOU SHOW US WHERE? DESCRIBE FOR US THIS TABLE.
A. SO, THIS TABLE IS A LIST OF THE SYMPTOMS OR ADVERSE EFFECTS THAT ARE MOST COMMONLY ASSOCIATED WITH DIGOXIN.
AND AGAIN, IF YOU LOOK AT THAT WHOLE LIST OF SYMPTOMS, YOU KNOW, EVEN THOUGH WOMEN HAVE THEM IN BOTH GROUPS, IF YOU LOOK AT THE P VALUE, THE ONLY P VALUE THAT IS LESS THAN .05, MEANING STATISTICALLY SIGNIFICANT, IS FOR VOMITING. AND IN THAT, ABOUT 16 PERCENT OF THE DIGOXIN GROUP HAD VOMITING, WHEREAS ONLY 3 PERCENT OF THE PLACEBO GROUP HAD THAT SYMPTOM.
Q. IN YOUR OPINION, IS THAT A SIGNIFICANT DIFFERENCE BETWEEN THE TWO GROUPS?
A. YES, BECAUSE THE P VALUE MEANS THAT THAT IS ESSENTIALLY 98 PERCENT UNLIKELY TO HAVE OCCURRED BY JUST CHANCE ALONE.
Q. DID YOUR STUDY REACH ANY OTHER CONCLUSIONS OR MAKE ANY OTHER FINDINGS OF SIGNIFICANCE?
A. THAT THE DIGOXIN WAS NOT UNIFORMLY EFFECTIVE IN CAUSING FETAL DEMISE WITHIN THE APPROXIMATE 24-HOUR DURATION.
Q. WHAT WAS THE CONCLUSION ABOUT THE EFFECTIVENESS OF DIGOXIN CAUSING FETAL DEMISE?
A. IN 8 PERCENT OF THE SUBJECTS WHO RECEIVED DIGOXIN, THERE WAS NOTED TO STILL BE A FETAL HEARTBEAT AT THE TIME OF THE D&E.
Q. SO DO YOU HAVE ANY OVERALL CONCLUSIONS ABOUT THE STUDY, THE EFFICACY STUDY?

A. OUR OVERALL CONCLUSION WAS THAT DIGOXIN DID NOT MAKE THE D&E -- THE INTRA-AMNIOTIC DIGOXIN DID NOT MAKE D&E'S EASIER. IT DIDN'T MAKE THEM SAFER. AND IT DIDN'T IMPROVE THE PROCEDURE BY ANY OBJECTIVE MEASURE THAT WE COULD ASSESS.

THE ONLY SIGNIFICANT DIFFERENCE BETWEEN THE TWO GROUPS WAS THAT THE DIGOXIN GROUP HAD MORE VOMITING.

Q. SO DID YOU -- DO YOU HAVE ANY OPINIONS AS TO WHETHER DIGOXIN HAS THE POTENTIAL TO CAUSE ADVERSE MATERNAL OUTCOMES?

A. I DID. I MEAN, I THINK THAT CLEARLY CLINICAL EXPERIENCE HAS SHOWN US THAT DIGOXIN IS SAFE OVERALL. BUT, WE KNOW JUST SORT OF BY MEDICAL COMMON SENSE THAT IF YOU USE A MEDICINE OR AN INTERVENTION OFTEN ENOUGH, THERE CAN BE ADVERSE EVENTS ASSOCIATED WITH THAT MEDICATION.

SO, I MEAN, VOMITING IS UNPLEASANT, BUT IT IS NOT A PARTICULARLY SEVERE COMPLICATION FOR MOST PATIENTS. BUT, YOU KNOW, IF YOU USE A MEDICATION THAT POTENTIALLY HAS EFFECTS ON CARDIAC RHYTHM OR EVEN JUST THE AMNIOCENTESIS INJECTION PROCESS ITSELF, EVENTUALLY YOU MAY HAVE A RARE BUT SIGNIFICANT RISK ASSOCIATED WITH THAT.

Q. WHAT TYPE OF RARE BUT SIGNIFICANT RISKS COULD YOU HAVE FROM THE INJECTION OF DIGOXIN?

A. I MEAN, MOST DRAMATICALLY, BUT I AM SURE, VERY CLEARLY UNUSUALLY WOULD BE TO CAUSE AN ARRHYTHMIA THAT COULD EVEN LEAD TO THE STOPPAGE OF THE HEART, AND YOU WOULDN'T EXPECT TO SEE THAT OFTEN, AND APPARENTLY WE HAVEN'T. BECAUSE WE WOULD EXPECT

PEOPLE WOULD REPORT THAT, AND THAT CASE WOULD MAKE IT INTO THE MEDICAL LITERATURE, AND IT NEVER HAS.

SO THAT IS GOOD. BUT, THEN OTHER PROBLEMS COULD BE JUST MORE COMMONLY THE PROBLEMS LIKE INFECTION THAT IS CAUSED BY TAKING WHAT HAS BEEN A STERILE SPACE, USUALLY STERILE SPACE AROUND THE FETUS AND NOW BROACHING THAT AND ENTERING -- YOU KNOW, PUTTING SOMETHING IN THERE THAT IS POTENTIALLY GOING TO CAUSE AN INFECTION.

SO THAT IS A RISK LEADING -- CAUSING MISCARRIAGE BEFORE YOUR ABORTION PROCEDURE. THOSE ARE SOME OF THE RISKS.

Q. ARE THERE RISKS ASSOCIATED WITH THE INFECTION THAT COULD BE CAUSED BY, AS YOU SAID, BROACHING THE OTHERWISE STERILE SPACE?

A. I THINK FROM OBSTETRICS WE ARE UNFORTUNATELY ALL TOO AWARE OF HOW SERIOUS -- I AM SORRY -- INFECTIONS CAN BE WITHIN THE UTERUS. BECAUSE ESSENTIALLY WE VIEW THAT SPACE AS -- WE CALL IT "A GROWTH MEDIUM," ESSENTIALLY. IT IS A VERY RICH AREA FOR BACTERIA. POTENTIALLY COULD CAUSE A VERY SERIOUS INFECTION.

SO WE WORRY A LOT WHEN A WOMAN HAS AN INFECTION IN HER UTERUS THAT IT CAN SORT OF REALLY DEVELOP QUITE QUICKLY INTO A SERIOUS INFECTION AND CAUSE SEPSIS AND POTENTIALLY EVEN DEATH.

SO USUALLY IF A WOMAN HAS A SIGNIFICANT INFECTION IN HER UTERUS YOU WANT TO GET THAT INFECTION OUT OF HER UTERUS BECAUSE IT CAN BE SO LIFE-THREATENING.

Q. AND YOU WANT TO AVOID IT, AS WELL?

A. AND YOU WANT TO AVOID IT. YOU REALLY DON'T WANT TO POTENTIALLY TAKE THAT RISK UNLESS YOU HAVE A GOOD REASON TO.
Q. AND I DON'T THINK WE HAVE HAD BEFORE A DESCRIPTION OF WHAT SEPSIS IS. DO YOU MIND DESCRIBING THAT TO THE COURT?
A. SO SEPSIS IS WHEN YOU HAVE SUCH OVERWHELMING INFECTION, ESSENTIALLY THE BODY IN FIGHTING OFF THAT INFECTION SORT OF SHUTS DOWN. AND YOU END UP WITH LOW BLOOD PRESSURE AND POTENTIALLY DYING FROM THAT.
Q. ARE THERE ANY RISKS -- ARE THE RISKS WITH THE INJECTION OF DIGOXIN ANY DIFFERENT THAN THE RISKS THAT YOU EXPERIENCE WHEN YOU DO AMNIOCENTESIS?
A. OUR STUDIES DON'T REALLY LOOK AT THAT SPECIFICALLY, BUT FROM JUST CLINICAL KNOWLEDGE, THE DIFFERENCE ULTIMATELY IS THAT IN AN AMNIOCENTESIS YOU ARE WITHDRAWING FLUID. YOU ARE JUST -- SO THAT THE DIRECTION IS OUT. WHEREAS, IN THIS CASE YOU ARE ACTUALLY INSTILLING SOMETHING THAT HAS BEEN FROM THE OUTSIDE IN. AND THOUGH YOU TRY TO KEEP THE CONDITIONS STERILE, ONE WOULD THINK THAT YOU MIGHT HAVE MORE RISK OF INTRODUCING INFECTION GOING FROM THE OUTSIDE INTO THE UTERUS.
Q. AND HAVE YOU SEEN ANY SITUATIONS WHERE THE RISKS WERE INCREASED AS A RESULT OF THE USE OF DIGOXIN TO CAUSE FETAL DEMISE?
A. WELL, WE HAD THOSE TWO CASES WHERE WE DID NOTE THAT WE DID SOMETHING THAT CAUSED THE WOMEN TO HAVE HIGH DIGOXIN -- SERUM DIGOXIN LEVELS. SO THAT I HAVE SEEN PERSONALLY.

AND THEN, THERE ARE CASES WHERE WOMEN HAVE HAD SERIOUS INFECTIONS, EVEN LETHAL INFECTIONS FROM AMNIOCENTESIS. SO THAT IS RARE.

AND I WAS ASKED TO REVIEW A CASE WHERE A WOMAN RECEIVED INTRACARDIAC POTASSIUM CHLORIDE TO GET -- TO CAUSE FETAL DEMISE AND WHERE THE WOMAN SUFFERED A CARDIAC ARREST WHERE HER HEART STOPPED.

Q. DO YOU KNOW WHAT HAPPENED IN THAT CASE?

A. OH, SHE WAS RESUSCITATED. SHE HAD MEASURES TO RESUSCITATE HER, AND SHE LIVED.

Q. AND THEN, IN ADDITION TO THE ADVERSE MATERNAL OUTCOMES, YOU PREVIOUSLY TALKED ABOUT VOMITING AS A SIDE EFFECT?

A. RIGHT.

Q. IS THAT THE MOST SIGNIFICANT SIDE EFFECT THAT YOU ARE AWARE OF?

A. THAT WE SAW IN OUR STUDY.

Q. ARE YOU AWARE OF ANY OTHER SIDE EFFECTS FROM YOUR CLINICAL EXPERIENCE?

A. JUST THE DISCOMFORT OF THE INJECTION. I HAVEN'T SEEN -- PERSONALLY, I HAVEN'T SEEN OTHER SIDE EFFECTS FROM IT.

Q. SO AFTER YOU COMPLETED THE TWO SAFETY --

A. I AM SORRY, EXCEPT THE WOMEN MISCARRYING ALL OVER THE BAY AREA. THAT WAS ANOTHER SIDE EFFECT. SORRY.

Q. SO AFTER YOU COMPLETED THE SAFETY AND EFFICACY STUDIES, DID THE PRACTICES AT THE WOMEN OPTIONS CENTER CHANGE IN TERMS OF

THEIR USE OF DIGOXIN?
A. YEAH, WE -- I WOULD SAY THAT OUR PROVIDERS ALMOST IMMEDIATELY VERY MUCH DECREASED THEIR USE OF DIGOXIN BECAUSE WE HAD BEEN USING IT IN ORDER TO MAKE THESE PROCEDURES SAFER.

BUT WHEN, BY THE BEST STUDY WE KNOW HOW TO DO, WE DIDN'T SHOW THAT IT MADE THE PROCEDURES SAFER, WE PRETTY MUCH ABANDONED USING IT BEFORE D&E.

Q. AND WHY WAS IT ABANDONED?
A. BECAUSE YOU DON'T WANT TO FIRST CAUSE PAIN IN THE WOMAN. SECOND, PUT HER AT RISK FOR SOMETHING THAT YOU DON'T ACTUALLY THINK IS IN HER BENEFIT AS A PATIENT.
Q. DO YOU PERSONALLY OFFER DIGOXIN NOW TO YOUR PATIENTS?
A. YES.
Q. DO YOU DO IT ROUTINELY?
A. NO, I DON'T OFFER IT ROUTINELY. I WILL OFFER IT IF THE WOMAN SPECIFICALLY ASKS FOR IT, I WILL GO THROUGH MY UNDERSTANDING OF THE RISKS, BENEFITS AND ALTERNATIVES AS I WOULD NORMALLY CONSENT SOMEONE.

AND WE ALSO DO OFFER IT BEFORE INDUCTION TERMINATIONS OF 22 WEEKS AND ABOVE.

Q. DOES THE WOMEN'S OPTIONS CENTER HAVE ANY PROTOCOLS FOR THE USE OF DIGOXIN?
A. WE DO.
Q. WHY DO YOU HAVE THOSE PROTOCOLS?
A. THEY PROVIDE OUR DOCTORS WITH GUIDELINES THAT THEY CAN USE

TO PROVIDE INTRA-AMNIOTIC DIGOXIN SAFELY, SHOULD THEY CHOOSE TO USE IT.

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

THE COURT: YES.

BY MS. PARKER:

Q. DR. DREY, I WOULD LIKE TO SHOW YOU WHAT HAS PREVIOUSLY BEEN MARKED AS EXHIBIT 35. HAVE YOU SEEN THAT BEFORE?

A. YES.

Q. AND WHAT IS IT?

A. THAT IS OUR PROTOCOL FOR THE USE OF INTRA-AMNIOTIC DIGOXIN BEFORE D&E.

MS. PARKER: AND IF I MAY, YOUR HONOR, I WOULD LIKE TO PUT IT ON THE ELMO.

THE COURT: ALL RIGHT.

THE WITNESS: I HAVE TO SAY I NEVER NOTICED THIS BEFORE. OBVIOUSLY, IT IS REALLY JUST THE PROTOCOL ABOUT THE INTRA-AMNIOTIC USE OF DIGOXIN, IN GENERAL. BUT IT APPLIES TO D&E, AS WELL AS INDUCTION, BECAUSE THAT BOTH ARE MENTIONED. I HAVE NEVER NOTICED THAT BEFORE.

BY MS. PARKER:

Q. DOES THE PROTOCOL INCLUDE THE RISKS OF ADMINISTERING DIGOXIN?

A. YES, IT DOES.

Q. AND ARE THOSE RISKS ESSENTIALLY THE ONES THAT YOU HAVE BEEN SPEAKING ABOUT THIS MORNING?

A. YES. AND THE RISKS ARE ONES THAT ARE ASSOCIATED WITH THERAPEUTIC USE OF DIGOXIN. BUT WE ALSO ADDED THE RISK OF LACK OF EFFECTIVENESS. WE COULD INCLUDE THAT BECAUSE OF OUR -- THE DATA WE HAD RECEIVED FROM OUR CLINICAL TRIAL.

AND THEN, AGAIN, WE ALSO INCLUDED THE INFORMATION ABOUT VOMITING FROM OUR CLINICAL TRIAL.

Q. SO COULD YOU JUST READ THOSE SEVEN RISKS FOR THE RECORD?

A. THE RISKS ARE COMPLICATIONS OF AMNIOCENTESIS. AND THESE INCLUDE: AMNIONITIS, WHICH IS INFECTION; AMNIOTIC FLUID LEAKAGE; VAGINAL BLEEDING; THE ONSET OF SPONTANEOUS LABOR, WHICH I HAVE BEEN DISCUSSING AS MISCARRIAGE; LACK OF EFFECTIVENESS. DIGOXIN WAS NOT NOTED TO CAUSE FETAL DEATH WITHIN 24 HOURS ONE OUT OF 10 TIMES; GI SYMPTOMS, MOST FREQUENTLY NAUSEA AND VOMITING IN APPROXIMATELY 15 PERCENT; DIARRHEA OR ABDOMINAL PAIN; CARDIAC ARRHYTHMIAS, INCLUDING VENTRICULAR PREMATURE CONTRACTIONS, VENTRICULAR TACHYCARDIA; ATRIOVENTRICULAR DISSOCIATION; SINUS BRADYCARDIA; AV BLOCK AND COMPLETE HEART BLOCK; CNS -- THAT IS CENTRAL NERVOUS SYSTEM -- ABNORMALITIES; VISUAL DISTURBANCES, HEADACHE, WEAKNESS, APATHY AND PSYCHOSIS; AND, FINALLY DERMATOLOGIC REACTIONS, SUCH AS MACULOPAPULAR RASH.

MS. PARKER: YOUR HONOR, DID I ASK WHETHER I COULD ADMIT EXHIBIT 35 INTO EVIDENCE?

THE COURT: NOT YET.

MS. PARKER: MAY I DO SO?

THE COURT: YOU MAY DO SO.

ANY OBJECTION?

MR. SIMPSON: NO OBJECTION.

THE COURT: IT MAY BE ADMITTED.

THE CLERK: THIRTY-FIVE INTO EVIDENCE.

(PLAINTIFFS' EXHIBIT 35
WAS RECEIVED IN EVIDENCE.)

BY MS. PARKER:

Q. DOES EXHIBIT 35, THE PROTOCOL FOR INTRA-AMNIOTIC DIGOXIN, ALSO LIST CONTRAINDICATIONS?

A. IT DOES.

Q. AND ARE THOSE CONTRAINDICATIONS ONES YOU HAVE BEEN TESTIFYING BEFORE THIS MORNING?

A. THEY ARE.

Q. AND ARE THERE ANY OTHER SITUATIONS WHERE YOU WOULD NOT RECOMMEND THE USE OF DIGOXIN TO CAUSE FETAL DEMISE IN A LATE SECOND-TRIMESTER ABORTION?

A. THERE ARE SITUATIONS WHERE YOU REALLY DON'T POTENTIALLY HAVE TIME TO USE DIGOXIN. IF SOMEONE IS -- FOR EXAMPLE, IF YOU ARE DOING AN ABORTION BECAUSE SOMEONE IS IN THE PROCESS OF MISCARRYING, YOU MAY NOT HAVE TIME TO ACTUALLY THEN DO THE INJECTION IN AN ATTEMPT TO CAUSE FETAL DEMISE. AND I --

Q. ARE THERE ANY OTHER SITUATIONS, SORT OF MATERNAL HEALTH CONDITIONS WHERE YOU MIGHT NOT USE DIGOXIN?

A. WELL, IF THERE WERE MATERNAL CONTRAINDICATIONS YOU WOULD

NOT USE DIGOXIN. IF --

Q. AND IF YOU --

A. SORRY. AND IF THERE WERE MATERNAL INDICATION THAT YOU NEEDED TO DO THE PROCEDURE MORE QUICKLY, THE DIGOXIN MIGHT NOT HAVE HAD EFFECT.

Q. HAVE YOU HAD ANY RECENT SITUATIONS WHERE YOU HAVE ENCOUNTERED THIS WHERE THE SITUATION WAS DETERIORATING SO RAPIDLY THAT YOU DIDN'T HAVE ENOUGH TIME TO ADMINISTER DIGOXIN?

A. YES. THERE WAS A PATIENT WHO I TOOK CARE OF WHO WAS UNSURE ABOUT WHETHER SHE WANTED TO CONTINUE HER PREGNANCY, BUT THEN STARTED HAVING VERY HIGH BLOOD PRESSURES. AND BECAUSE SHE WAS CONCERNED ABOUT HER OTHER TWO CHILDREN AND THE RISKS TO HER HEALTH THAT THIS PREGNANCY APPEARED TO BE CAUSING, SHE DECIDED TO TERMINATE.

AND, IN FACT, BY THE TIME SHE MADE THAT DECISION HER BLOOD PRESSURES WERE SO HIGH THAT SHE HAD TO BE ADMITTED TO THE HOSPITAL WHILE WAITING FOR HER ABORTION. SO WE INTENDED TO DO THE ABORTION THE FOLLOWING DAY. SHE WAS DIAGNOSED WITH A CONDITION CALLED "SEVERE PREECLAMPSIA." AND IT WAS EVEN WORSE THAN THE USUAL SEVERE PREECLAMPSIA, BECAUSE IT WAS AFFECTING HER LIVER AND CAUSING HER LIVER TO FAIL.

AND IT WAS ALSO CAUSING HER TO LOSE HER ABILITY TO CLOT. AND SO WE PLACED LAMINARIA INTENDING TO DO THE ABORTION THE FOLLOWING DAY, BUT ACTUALLY BECAUSE HER PLATELETS, HER CLOTTING FACTORS CONTINUED TO DROP OVERNIGHT, I WAS ACTUALLY

CALLED INTO THE HOSPITAL IN THE MIDDLE OF THE NIGHT, AND WE DID HER D&E AT ABOUT 2:30 IN THE MORNING.

Q. DID YOU ADMINISTER DIGOXIN IN THAT CASE?

A. NO.

Q. DO YOU RECALL WHAT GESTATIONAL AGE SHE WAS?

A. I BELIEVE SHE WAS 22 WEEKS.

Q. I BELIEVE WHEN MS. MORRIS WAS ASKING YOU SOME QUESTIONS SHE TALKED TO YOU ABOUT THE IMPACT OF THE PARTIAL-BIRTH ABORTION BAN ACT ON THE WOMEN'S OPTIONS CENTER AT SAN FRANCISCO GENERAL; IS THAT RIGHT?

A. YES.

Q. AND YOU INDICATED THAT YOU WERE CONCERNED ABOUT THE IMPACT ON THE CENTER; IS THAT RIGHT?

A. YES.

Q. AND WHAT WOULD THAT IMPACT BE, JUST BRIEFLY?

A. I WOULD BE CONCERNED THAT WE WOULD NO LONGER BE ABLE TO PROVIDE THESE SERVICES, SECOND-TRIMESTER ABORTIONS. I MEAN, BY D&E.

Q. WOULD YOU CONSIDER USING DIGOXIN TO AVOID VIOLATING THE ACT?

A. THAT WOULD BE REALLY A VERY PAINFUL DECISION FOR ME TO MAKE, AND I WOULD REALLY HAVE TROUBLE DOING THAT.

Q. WHY IS THAT?

A. BECAUSE WHEN YOU USUALLY DO A MEDICAL INTERVENTION ON A PATIENT IT IS FOR HER BENEFIT. SO, IF I AM GOING TO USE

DIGOXIN, FOR EXAMPLE, IT'S -- AND WHEN I CONSENT HER FOR DIGOXIN, I AM SAYING THAT I THINK THIS IS FOR HER BENEFIT AND THAT THE RISKS ARE SMALL AND THAT WHATEVER BENEFIT IS INVOLVED IS WORTH THOSE RISKS.

I WOULDN'T EVEN HAVE ANY IDEA HOW TO CONSENT A PATIENT IF I AM GIVING DIGOXIN FOR MY BENEFIT AS A PROVIDER. SO I DON'T KNOW WHAT I WOULD SAY. I WOULDN'T BE SAYING THAT THIS IS FOR HER CLINICAL BENEFIT. I WOULD BE SAYING:

"WELL, I NEED TO GIVE YOU DIGOXIN BECAUSE OTHERWISE I CAN'T PERFORM YOUR ABORTION."

SO, IT IS NOT FOR HER CLINICAL BENEFIT. IT IS FOR ME. AND I JUST -- I WOULD FEEL VERY MUCH FORCED TO DO SOMETHING TO A PATIENT THAT WASN'T FOR HER. THAT WOULD JUST REALLY BE AWFUL FOR ME.

Q. AND ARE THERE SITUATIONS WHERE EVEN IF YOU USED DIGOXIN YOU WOULD STILL VIOLATE THE ACT?

A. WELL, FROM OUR STUDY, IF WE USED DIGOXIN AS WE FELT WAS SAFEST, WHICH -- AND THE WAY WE FELT WE COULD DO MOST RELIABLY, WHICH WAS INTRA-AMNIOTIC DIGOXIN, I WOULDN'T HAVE ACHIEVED FETAL DEMISE WITHIN 24 HOURS 8 PERCENT OF THE TIME.

SO IN THAT CASE, EVEN IF I GAVE DIGOXIN TO PROTECT MYSELF, IN FACT, I COULD STILL BE VIOLATING THE ACT IN TRYING TO THEN FINISH THE D&E.

AND THEN, THERE ARE SITUATIONS WHERE, AGAIN, IF I HAVE USED DIGOXIN, BUT THEN I FELT FOR CLINICAL REASONS I HAD

TO PROCEED WITH THE ABORTION BEFORE I HAD PLANNED, I WOULD BE VIOLATING THE ACT.

AND THEN, THERE ARE SITUATIONS THAT ARE EMERGENT WHERE A WOMAN'S HEALTH MAY BE AT RISK, BUT I DON'T HAVE TIME TO GIVE DIGOXIN, WHERE AGAIN I COULD BE VIOLATING THE ACT. AND I DON'T KNOW WHAT I WOULD DO IN THOSE SITUATIONS.

Q. WOULD THERE ALSO BE SITUATIONS -- WELL, I GUESS IF IT WAS CONTRAINDICATED YOU WOULDN'T BE USING IT.

A. RIGHT. YES, I MEAN, IN WOMEN IN WHO IT IS CONTRAINDICATED. THEN, THERE ARE THE WOMEN WHO I CAN'T GET THERE FROM HERE. I MEAN, IT'S FUNNY. LOOKING AT THIS NEEDLE, IN SOME WAYS IT LOOKS LONG. IF YOU ARE THE WOMAN WHO IS HAVING THE INJECTION, IT LOOKS QUITE LONG.

BUT IF YOU ARE THE DOCTOR DOING THE INJECTION, SOMETIMES IT JUST DOESN'T LOOK LONG ENOUGH, BECAUSE YOU CAN'T -- YOU KNOW, YOU CAN PUT IT UP TO THE HUB AND STILL NOT BE ABLE TO GET WHERE YOU WANT TO GO. SO IF I CAN'T PHYSICALLY GET THERE, I MIGHT NOT BE ABLE TO ADMINISTER DIGOXIN THAT WAY.

MS. PARKER: I HAVE NO FURTHER QUESTIONS, YOUR HONOR.

THE COURT: ALL RIGHT. CROSS-EXAMINATION.

CROSS-EXAMINATION

BY MR. SIMPSON:

Q. HI, DR. DREY.

A. HELLO.

Q. HOW ARE YOU?
A. FINE.
Q. I THINK THERE WAS A MOMENT A FEW MOMENTS AGO WHEN YOU SAID THAT YOU WOULD ADMINISTER DIGOXIN OR YOU COULD ADMINISTER DIGOXIN IN THE WAY THAT YOU BELIEVE IS MOST EFFECTIVE, WHICH IS INTRA-AMNIOTICALLY.
A. I SHOULD PROBABLY NOT HAVE SAID IT THAT WAY. I SHOULD HAVE SAID IN THE WAY THAT WE KNEW WE HAD SAFELY ADMINISTERED IT BY -- AS BEST WE COULD TELL BY GETTING IT INTO THAT SPACE. BUT I DON'T KNOW THAT IT IS MORE EFFECTIVE THAT WAY. I AM SORRY.
Q. THAT ACTUALLY IS NOT TRUE, IS IT?
A. NO, IT IS NOT -- I THINK IT IS PROBABLY NOT TRUE, THOUGH I DON'T KNOW THAT THERE HAVE BEEN STUDIES LOOKING AT THE TWO TO COMPARE THEM, BUT I DOUBT IT IS TRUE.
Q. WHAT IS THE OTHER OPTION YOU WERE REFERRING TO?
A. IT'S INTRA-FETALLY.
Q. YOU BELIEVE THAT WOULD BE MORE EFFECTIVE IN BRINGING ABOUT FETAL DEMISE?
A. I WOULD ASSUME THAT THAT IS TRUE, THOUGH I HAVE NOT SEEN ANY STUDIES LOOKING AT THAT.
Q. DOCTOR, WHEN DID YOU FINISH YOUR TRAINING AS A PHYSICIAN?
A. I COMPLETED MY TRAINING IN 2000.
Q. THAT WAS YOUR RESIDENCY, CORRECT?
A. RIGHT.
Q. WHEN DID YOU COMPLETE YOUR FELLOWSHIP?

A. IN 2002.
Q. YOU BECAME MEDICAL DIRECTOR OF THE WOMEN'S OPTIONS CENTER AT SAN FRANCISCO GENERAL LAST YEAR?
A. YES.
Q. NOW, DOCTOR, I AM A LITTLE CONFUSED ABOUT SOME OF THE TESTIMONY YOU GAVE AT THE BEGINNING OF THE DIRECT EXAMINATION HERE IN RELATION TO WHOM YOU SUPERVISE AT THE WOMEN'S OPTIONS CENTER.

AS MEDICAL DIRECTOR, YOU ARE NOT THE DIRECT SUPERVISOR OF THE NURSES OR COUNSELORS OR PHYSICIANS AT THE WOMEN'S OPTIONS CENTER; IS THAT CORRECT?
A. I AM THE DIRECT SUPERVISOR OF THEIR DIRECT SUPERVISOR. I AM THE DIRECT SUPERVISOR OF THE HEAD NURSE, THE HEAD COUNSELOR AND ONE RESEARCH ASSISTANT.

BUT THEN, I SUPERVISE ALL OF THEM BY HAVING REGULAR MEETINGS WITH ALL OF THE OTHER STAFF. SO, THOUGH THEY MAY NOT GET THEIR ANNUAL EVALUATIONS FROM ME, ULTIMATELY I AM SUPERVISING THEIR ACTIVITIES AND THEIR PERFORMANCE.
Q. DOCTOR, DID YOU GIVE A DEPOSITION IN THIS CASE?
A. I DID.
Q. I HAVE HANDED YOU, DOCTOR, WHAT I BELIEVE IS A COPY OF YOUR DEPOSITION TRANSCRIPT. DID YOU RECEIVE A COPY OF YOUR TRANSCRIPT AFTER THE DEPOSITION?
A. I DID.
Q. DID YOU REVIEW THE TRANSCRIPT?

A. I DID.
Q. DID YOU SIGN IT?
A. I DID.
Q. DID YOU FIND AS YOU READ THAT THE WAY IT RECORDED HOW YOU HAD TESTIFIED WAS ACCURATE?
A. I REALIZED AFTER MY TESTIMONY THAT I WAS THE SUPERVISOR OF THE HEAD NURSE AND THE HEAD COUNSELOR. I HAD NOT REALIZED THAT I WAS THEIR DIRECT SUPERVISOR IN THAT ROLE. SO I HAD TO REPORT THAT AFTER MY DEPOSITION.
Q. YOU WERE SO NEW IN THE ROLE THAT YOU DIDN'T REALIZE THAT?
MS. PARKER: OBJECTION; MISCHARACTERIZES THE TESTIMONY.
THE COURT: OVERRULED.
THE WITNESS: YES, THOUGH I PROBABLY -- I WISH I HAD KNOWN, YOU KNOW, EARLIER.
BY MR. SIMPSON:
Q. IS IT TRUE, DOCTOR, THAT THERE IS A FACULTY MEMBER FROM UCSF WHO IS ASSIGNED TO ATTEND AT THE WOMEN'S OPTIONS CENTER EACH DAY?
A. YES.
Q. AND IS IT TRUE THAT THAT FACULTY MEMBER SUPERVISES ALL OF THE ABORTIONS THAT ARE PROVIDED THAT DAY AT THE WOMEN'S OPTIONS CENTER?
A. YES, SUPERVISES OR PERFORMS.
Q. NOW, YOU HAVE TESTIFIED, OBVIOUSLY, TO A GREAT EXTENT ABOUT

THE INJECTION OF DIGOXIN TO CAUSE FETAL DEMISE BEFORE D&E. YOU YOURSELF HAVE ACTUALLY GIVEN SUCH INJECTIONS LESS THAN 50 TIMES, CORRECT?

A. AS BEST I CAN REMEMBER.

Q. CAN YOU TELL US AT THIS POINT, DOCTOR, APPROXIMATELY HOW MANY TIMES YOU HAVE DONE THAT YOURSELF?

A. MY BEST MEMORY WAS WHATEVER I SAID IN THE DEPOSITION, AND I THINK THAT WAS LESS THAN 50 TIMES -- FEWER THAN 50 TIMES.

Q. WAS IT FEWER THAN 25?

A. I WOULD HAVE TO LOOK, BECAUSE I WAS TRYING TO REMEMBER AT THAT TIME.

Q. NOW, DOCTOR, YOU HAVE REFERRED -- I BELIEVE IT WAS EARLY ON IN YOUR DIRECT EXAMINATION -- TO THE ORAL ADMINISTRATION OF DIGOXIN; IS THAT CORRECT?

A. YES.

Q. WHEN DIGOXIN IS ADMINISTERED ORALLY IS THAT FOR THERAPEUTIC PURPOSES?

A. YES.

Q. NOT FOR ABORTION?

A. RIGHT.

Q. AND DIGOXIN IS USED FOR HEART CONDITIONS?

A. YES.

Q. NOW, DOCTOR, CAUSING FETAL DEMISE BEFORE D&E MAKES THE FETAL TISSUE EASIER TO DISARTICULATE?

A. YES.

Q. IN YOUR EFFICACY STUDY, THE SECOND STUDY THAT YOU TESTIFIED TO IN YOUR DIRECT EXAMINATION, THE PHYSICIANS WHO PERFORMED THE D&E'S AFTER THE INJECTIONS, WHETHER WITH DIGOXIN OR PLACEBO, THOSE PHYSICIANS WERE ABLE TO GUESS WHETHER THE PATIENT RECEIVED THE DIGOXIN OR A PLACEBO 75 PERCENT OF THE TIME?

A. YES, BUT YOU WOULD HAVE EXPECTED THEM TO GET IT RIGHT 50 PERCENT OF THE TIME. SO 75 PERCENT OF THE TIME WASN'T REALLY AS HIGH AS WE EXPECTED.

THOSE OF US WHO HAD BEEN USING DIGOXIN THOUGHT WE WOULD ALWAYS KNOW. AND, IN FACT, WE WEREN'T AS RIGHT AS WE THOUGHT WE WOULD BE.

Q. AND THE REASON YOU THOUGHT THE DOCTORS WOULD ALWAYS KNOW IS THAT IT MAKES IT EASIER TO DISARTICULATE THE FETUS?

A. THE TISSUE IS SOFTER, SO IT IS EASIER TO DISARTICULATE, BUT THAT CAN ALSO MAKE IT EASIER TO ACTUALLY -- I AM SORRY -- MORE DIFFICULT TO ACTUALLY COMPLETE THE ABORTION.

Q. HOW IS THAT?

A. BECAUSE IF THE TISSUE IS VERY SOFT, INSTEAD OF BEING ABLE TO DRAW THE FETUS DOWN INTO THE LOWER PART OF THE UTERUS WHERE IT IS SAFER TO DO THE ABORTION, IT MAY STAY UP HIGHER IN THE UTERUS, AND YOU MAY HAVE TO HAVE MORE PASSES WITH THE FORCEPS TO DRAW THE FETUS OUT.

SO, THE DOWNSIDE OF HAVING SOFTER TISSUE IS THAT IF IT COMES APART VERY EASILY YOU HAVE TO MAKE MORE PASSES, AND YOU HAVE TO GO UP HIGHER IN THE UTERUS.

Q. I THINK YOU TESTIFIED TO THIS ALREADY, DOCTOR. WHEN YOU'RE INJECTING DIGOXIN TO CAUSE FETAL DEMISE, WHEN YOU WANT TO INJECT IT INTO THE AMNIOTIC FLUID, YOU CAN VERIFY THAT THE NEEDLE IS IN THE AMNIOTIC FLUID BY PULLING BACK ON THE SYRINGE, CORRECT?

A. YES.

Q. AND AMNIOTIC FLUID HAS A CERTAIN DISTINCTIVE APPEARANCE?

A. YES, OR TYPES OF APPEARANCES.

Q. FOR SOME PATIENTS, DOCTOR, IS IT TRUE THAT CAUSING FETAL DEMISE BEFORE EMPTYING THE UTERUS MAKES THE PROCEDURE EMOTIONALLY EASIER FOR THE PATIENT?

A. THAT CAN GO BOTH WAYS.

Q. CAN YOU EXPLAIN WITH YOU MEAN BY THAT, DOCTOR?

A. FOR SOME PATIENTS THEY MAY FIND IT MORE EMOTIONALLY UPSETTING TO HAVE THE DEMISE CAUSED BEFORE THE PROCEDURE.

Q. YOU HAVE A COPY IN FRONT OF YOU OF YOUR EFFICACY STUDY, DOCTOR?

A. YES.

Q. IF YOU COULD LOOK AT THE FIRST PAGE OF THAT STUDY, OF THAT ARTICLE. IN THE ABSTRACT, IN THE RESULTS SECTION, DO YOU SEE THE LAST SENTENCE OF THE RESULT SECTION WHERE IT SAYS:

"MOST SUBJECTS (91 PERCENT) REPORTED THAT THEY PREFERRED THEIR FETUSES WERE DEAD BEFORE THE ABORTIONS"?

A. YES.

Q. IS THAT CONSISTENT WITH YOUR RECOLLECTION OF THIS STUDY?
A. THAT IS CONSISTENT WITH MY RECOLLECTION. HOWEVER, WHAT MAKES ASSESSING THIS DIFFICULT IS THAT WHEN YOU ARE CONSENTING A PATIENT FOR A RANDOMIZED TRIAL, YOU HAVE TO STATE THAT THE REASON YOU ARE DOING THE TRIAL IS BECAUSE YOU'RE ASSESSING WHETHER THIS INTERVENTION IS HELPFUL. AND SO IN -- I THINK THE PATIENTS KIND OF ASSUME WHEN DOCTORS DO THINGS TO THEM THAT IT IS GOING TO HELP THEM.

SO THEN IF YOU SAY TO THEM:

"WELL, DO YOU WANT ME TO DO THIS THING TO YOU,"

THEY SAY, "WELL, YES, BECAUSE I THINK IT WILL BE HELPFUL."

SO IT MAKES IT HARDER TO MAKE A CONCLUSION ABOUT OUTSIDE OF THIS PARTICULAR STUDY WHERE THEY HAD BEEN CONSENTED PROPERLY FOR THE STUDY HOW MANY PATIENTS NECESSARILY WOULD PREFER THAT.

Q. WERE THERE PATIENTS TO WHOM YOU OFFERED PARTICIPATION IN THIS STUDY WHO SIMPLY DECLINED PARTICIPATION, NOT FOR A REASON THAT YOU WANTED TO EXCLUDE THEM?
A. YES.
Q. DO YOU THINK, DOCTOR, THAT SOME OF THOSE PATIENTS DECIDED NOT TO PARTICIPATE BUT FOR SOME REASON, FOR SOME STATEMENT THAT WAS MADE TO THEM BY A PERSONNEL AT SAN FRANCISCO GENERAL?
A. I DON'T KNOW.
Q. I AM JUST ASKING, DOCTOR, YOU'VE SAID THAT THAT THE

SENTENCE HERE REGARDING:

"MOST SUBJECTS REPORTED THAT THEY PREFERRED THEIR FETUSES WERE DEAD BEFORE THE ABORTIONS," YOU SAID THAT THAT COULD HAVE BEEN BECAUSE OF SOMETHING THAT THE DOCTORS SAID TO THEM.

AND I AM ASKING NOW: ARE THERE OTHER RESULTS OF THIS STUDY THAT COULD HAVE OCCURRED BECAUSE OF SOMETHING THE DOCTORS SAID TO THE SUBJECTS?

A. I THINK THAT WHAT IS GOOD ABOUT THIS TRIAL IS THAT MOST OF OUR RESULTS ARE ONES THAT WOULDN'T HAVE BEEN INFLUENCED BY WHAT WE SAID TO PATIENTS. AND PATIENTS DIDN'T KNOW WHAT MEDICATION OR PLACEBO THEY HAD RECEIVED. SO I THINK THAT THAT REALLY -- I WOULD HAVE TO LOOK THROUGH TO MAKE SURE I AM NOT MISSING ANYTHING.

BUT VIRTUALLY ALL OF THE RESULTS WOULD NOT HAVE BEEN EFFECTED BY ANYTHING THAT WE HAD SAID TO THEM.

Q. DOCTOR, ARE YOU FAMILIAR WITH THE PROCEDURE KNOWN AS AMNIOCENTESIS?

A. YES.

Q. I THINK YOU'VE TESTIFIED REGARDING THAT. WOULD YOU AGREE, DOCTOR, THAT A PHYSICIAN WITH THE SKILL TO PERFORM AN AMNIOCENTESIS WOULD ALSO HAVE THE SKILL TO PERFORM A DIGOXIN INJECTION?

A. YES.

Q. WOULD YOU CONCEDE, DOCTOR, THAT THE PARTIAL-BIRTH ABORTION

BAN ACT WOULD NOT APPLY WHERE THE PHYSICIAN HAS CAUSED FETAL DEMISE BEFORE EMPTYING THE UTERUS?

A. YES.

Q. DOCTOR, I BELIEVE YOU TESTIFIED THAT THE WOMEN'S OPTIONS CENTER WAS PROVIDING DIGOXIN INJECTIONS BEFORE YOUR TWO STUDIES WERE CONDUCTED; IS THAT CORRECT?

A. YES.

Q. WAS THE WOMEN'S OPTIONS CENTER OFFERING THAT OPTION TO ALL D&E PATIENTS?

A. I CAN'T SAY THAT IT WAS OFFERED TO ALL D&E PATIENTS. IT WOULD NOT HAVE BEEN OFFERED BEFORE 20 WEEKS.

Q. WAS IT BEING OFFERED, DO YOU KNOW, TO ALL D&E PATIENTS AFTER 20 WEEKS?

A. I DON'T KNOW. SOME OF THOSE DECISIONS ARE MADE BASED ON ATTENDING PREFERENCE, AND I DON'T KNOW AT THAT TIME WHAT EVERY ATTENDING PREFERRED.

Q. YOU DON'T KNOW WHAT THE PROTOCOL WAS BEFORE THAT TIME?

A. WELL, PROTOCOLS DON'T MEAN THAT EVERY PATIENT NECESSARILY HAS THE SAME INTERVENTION. ULTIMATELY PROTOCOLS ARE TO GUIDE CLINICAL CARE, BUT ULTIMATELY IT IS THE ATTENDINGS WHO DECIDE HOW TO TREAT PATIENTS.

Q. YOUR TWO STUDIES, DOCTOR, WERE NOT CONDUCTED, WERE NOT INITIATED BECAUSE OF ANY EVENT THAT OCCURRED IN A DIGOXIN INJECTION AT THE WOMEN'S OPTIONS CENTER, CORRECT?

A. NO.

Q. CAN YOU TELL US, THEN, WHY THE STUDIES WERE UNDERTAKEN?
A. THE STUDIES WERE UNDERTAKEN BECAUSE IT'S REALLY BEST PRACTICE TO MAKE SURE THAT THINGS THAT WE'RE DOING TO MAKE PROCEDURES SAFER OR MEDICINES THAT WE ARE USING, IN FACT, ARE SAFE OR ARE EFFECTIVE IN THEIR USE.

SO I THINK THAT BECAUSE ONE OF THE GOALS OF OUR CLINIC IN PARTICULAR IS TO IMPROVE THE PRACTICE OF ABORTION CARE WE HAVE AS PART OF THAT GOAL DOING RESEARCH AND ABORTION AND MAKING SURE THAT WE ARE OPTIMIZING THE SAFETY OF THE PROCEDURES THAT WE DO.

Q. SO --
A. AND THAT OTHER PROVIDERS DO, AS WELL.
Q. -- YOU WOULD NOT WANT TO DO A PROCEDURE UNTIL ITS SAFETY AND EFFECTIVENESS HAVE BEEN SHOWN IN STUDIES?
A. I THINK MEDICINE, UNFORTUNATELY, DEVELOPS IN A MORE GRADUAL PROCESS THAN THAT. SO THAT, YOU KNOW, AT SOME POINT RESPONSIBLE PRACTITIONERS START DOING PROCEDURES, AND THEN THESE PROCEDURES ARE EVALUATED SYSTEMATICALLY WHEN EXPERIENCE SHOWS THAT IT IS WORTH EVALUATING.
Q. SO YOU ARE SAYING, DOCTOR, THAT ONCE PROCEDURES ARE USED, AT LEAST AT SOME POINT AFTER THEIR USE BEGINS, THEY SHOULD BE SUBJECTED TO STUDY?
A. WELL, THAT'S IDEAL. YOU CAN'T DO THAT FOR ALL THINGS. I MEAN, AS I WAS EXPLAINING EARLIER ABOUT TRYING TO ASSESS SURGERY, FOR EXAMPLE. IDEALLY YOU WOULD ASSESS EVERY ASPECT OF

EVERY PROCEDURE THAT YOU DO AS A SURGEON.

WELL, IT'S REALLY NOT POSSIBLE OR FEASIBLE TO DO THAT FOR EVERY SURGERY OR EVERY ASPECT OF EVERY SURGERY. SO EVEN THOUGH WE REALLY LOVE THESE KINDS OF RANDOMIZED BLINDED TRIALS AND WE REALLY LOVE RELYING ON THEM AS PHYSICIANS, AND I THINK THAT THAT'S KIND OF OUR GOLD STANDARD. WE CAN'T ALWAYS RELY ON THEM. SO WE HAVE TO RELY ON AN ADDITIONAL SORT OF ART THAT IS A MIX OF CLINICAL EXPERIENCE, OTHER PHYSICIANS' EXPERIENCE, AND THEN RETROSPECTIVE STUDIES, IN ADDITION.

BECAUSE, FOR EXAMPLE, FOR SURGERIES, MOST SURGERIES ARE SAFE, YOU MAY HAVE TO LOOK BACK THROUGH LOTS AND LOTS OF SURGERIES TO SEE JUST HOW SAFE A PARTICULAR PROCEDURE IS.

AND IT IS HARD TO DISSECT EVERY PROCEDURE INTO ALL OF ITS COMPONENT PARTS.

Q. THE GOLD STANDARD IN THAT STUDY IS, AS I THINK YOU'VE SAID, PROSPECTIVE -- I AM SORRY -- YES, PROSPECTIVE STUDY, CORRECT?

A. I THINK AS THE GOLD STANDARD AS BEING A BLINDED, RANDOMIZED TRIAL, IF YOU CAN ACHIEVE THAT. BUT IT IS JUST NOT FEASIBLE IN DOING -- AND IT IS ALSO -- YOU ARE LOOKING AT A VERY SPECIFIC OUTCOME.

SO IT'S -- IN SOME WAYS YOU CAN -- YOU CHOOSE YOUR TARGET TO SEE WHAT YOU WANT TO STUDY IS VERY IMPORTANT, BECAUSE EVERY ONE OF THOSE STUDIES REQUIRES A HUGE INVESTMENT OF TIME AND SUBJECT ASSISTANCE. AND YOU'RE ONLY GOING TO BE ABLE TO ANALYZE THE THING THAT YOU RANDOMIZED VERSUS THE PLACEBO, FOR

EXAMPLE.

Q. A BLINDED, RANDOMIZED STUDY IS A PROSPECTIVE STUDY?

A. IT IS.

Q. IS THERE ANY REASON WHY DIFFERENCES IN SURGICAL PROCEDURES COULD NOT BE SUBJECTED TO A RETROSPECTIVE STUDY?

A. YOU CAN'T -- ONE OF THE PROBLEMS WITH THE RETROSPECTIVE STUDY IS THAT YOU ACTUALLY HAVE TO COLLECT THE DATA AND RELY ON THE DATA THAT SOMEONE ELSE HAS COLLECTED.

SO IF YOU WANT TO RETROSPECTIVELY ASSESS A SURGERY, YOU HAVE TO RELY ON WHAT WAS CHARTED, WHAT THE PHYSICIAN OR OTHER PEOPLE IN THE ROOM THOUGHT TO WRITE DOWN.

SO, FOR EXAMPLE, IF NO ONE WRITES DOWN AN ASPECT OF A PROCEDURE, AND THAT IS THE THING THAT YOU ARE MOST INTERESTED IN, YOU CAN'T DO YOUR RETROSPECTIVE STUDY, EVEN IF YOU WANT TO. SO THAT CAN BE A PROBLEM.

Q. DOCTOR, YOUR SAFETY STUDY, THE ONE THAT IS REPORTED IN EXHIBIT 34, WHICH I THINK YOU HAVE, THAT STUDY WAS DESIGNED TO DETERMINE WHETHER DIGOXIN INJECTION TO CAUSE FETAL DEMISE BEFORE AN ABORTION IS SAFE FOR THE PREGNANT WOMAN, CORRECT?

A. YES.

Q. THAT STUDY LOOKED AT THREE MEASURABLE RESULTS OF DIGOXIN INJECTION, I BELIEVE: SYSTEMIC ABSORPTION OF DIGOXIN; CARDIAC RHYTHM AND COAGULATION PARAMETERS?

A. YES.

Q. AND THOSE THREE RESULTS WERE CHOSEN BECAUSE IT WAS FELT

THAT THOSE WERE THE MOST SIGNIFICANT AREAS OF POTENTIAL RISK?
A. YES.
Q. YOUR STUDY, IN FACT, WAS DESIGNED TO SHOW THAT A LARGER STUDY COULD BE DONE SAFELY?
A. RIGHT.
Q. AND, DOCTOR, YOU WERE LISTED AS THE FIRST AUTHOR ON THAT STUDY BECAUSE YOU DID MOST OF THE WRITING?
A. YES.
Q. DOCTOR, I WOULD LIKE TO READ PART OF THE LAST PARAGRAPH OF THAT STUDY. SO WE ARE IN EXHIBIT 34, PAGE 1066, THE LAST PAGE. THE LAST PARAGRAPH STARTS:

"WE CONCLUDE THAT INTRA-AMNIOTIC ADMINISTRATION OF 1 MILLIGRAM DIGOXIN BEFORE TERMINATION OF PREGNANCY DURING THE LATE SECOND-TRIMESTER DOES NOT RESULT IN CLINICALLY-SIGNIFICANT ELEVATION OF MATERNAL SERUM DIGOXIN LEVELS; IS NOT ASSOCIATED WITH EVIDENCE OF DIGOXIN TOXICITY; DOES NOT ALTER MATERNAL CARDIAC RATE OR RHYTHM; AND DOES NOT CHANGE CLOTTING PARAMETERS."

SO YOUR STUDY, DOCTOR, FOUND NO RISK TO THE WOMEN IN ANY OF THOSE THREE AREAS THAT WERE CONSIDERED TO BE THE MOST SIGNIFICANTLY -- MOST SIGNIFICANT POTENTIAL AREAS OF RISK?
A. WE SAW NO RISK IN THE EIGHT SUBJECTS WE ENROLLED IN THE TRIAL.
Q. AND THE PURPOSE OF THE TRIAL WAS TO DETERMINE THE SAFETY OF

DIGOXIN INJECTION?
A. IT IS AN INITIAL ATTEMPT TO SAY THAT THE MEDICATION IS SAFE ENOUGH THAT YOU FEEL THAT YOU CAN PROCEED TO ADMINISTER IT TO A LARGE NUMBER OF PATIENTS. IT DOESN'T MEAN THAT EVEN IF YOU DO A SAFETY STUDY THAT THE MEDICINE IS NECESSARILY UNIVERSALLY SAFE.
Q. NOW, YOUR EFFICACY STUDY, DOCTOR, WHICH YOU HAVE IN EXHIBIT 30, THAT INVOLVED INJECTION OF DIGOXIN INTO 126 SUBJECTS, CORRECT?
A. YES.
Q. AND NO COMPLICATIONS OCCURRED IN ANY OF THOSE PATIENTS?
A. THERE WERE COMPLICATIONS. THERE WERE NO COMPLICATIONS THAT WE SPECIFICALLY ASSOCIATED WITH THE DIGOXIN INJECTION. I MEAN, THERE WAS ONE MAJOR COMPLICATION.
Q. BUT, AGAIN, IT WAS NOT ASSOCIATED WITH THE INJECTION?
A. WE -- YOU KNOW, THERE'S THE SCIENCE END OF IT. WE CAN'T SPECIFICALLY SAY IT WAS ASSOCIATED WITH THE DIGOXIN INJECTION. AT THE SAME TIME, I WAS EXPLAINING THAT MY CONCERN WITH DIGOXIN IS THAT, YOU KNOW, POTENTIALLY THE TISSUE IS SOFTER SO YOU HAVE TO REACH UP HIGHER IN THE UTERUS.

AND AS YOU HEARD EARLIER WHEN YOU HAVE TO REACH UP HIGHER IN THE UTERUS YOU ARE CONCERNED THAT YOU MIGHT PERFORATE THE UTERUS.

AND THE ONE PATIENT WHO HAD A UTERINE PERFORATION HAD RECEIVED DIGOXIN. NOW, YOU CAN'T CONCLUDE THAT IT WAS THE

DIGOXIN, BECAUSE THAT IS ONLY ONE PERSON. AND YOU NEED A MUCH, MUCH LARGER STUDY THAN REALLY PROBABLY ANYONE COULD EVER AFFORD TO DO.

SO, I MEAN, YOU CAN'T DEFINITELY SAY IT WAS THE DIGOXIN, BUT YOU COULD POTENTIALLY BE LEFT WITH A CONCERN THAT MAYBE IT WAS THE DIGOXIN, BUT YOU CAN'T CONCLUDE ANYTHING LIKE THAT.

Q. THE REASON YOU WOULD NEED SUCH A LARGE STUDY FOR THAT, DOCTOR, THAT'S BECAUSE D&E IN GENERAL IS SUCH A SAFE PROCEDURE?

A. RIGHT. AND SO YOU WOULD BE LOOKING AT RARE COMPLICATIONS. AND YOU HAVE, TO AS WE SAY, POWER THE STUDY WITH ENOUGH PEOPLE SO THAT YOU CAN SEE A SIGNIFICANT DIFFERENCE IN THOSE RARE COMPLICATIONS. THAT WOULD BE A HUGE STUDY AND INCREDIBLY EXPENSIVE.

Q. IF I COULD REFER YOU, DOCTOR, IN EXHIBIT -- IN YOUR EFFICACY STUDY, EXHIBIT 30.

IF YOU COULD LOOK AT THE FOURTH PAGE, PLEASE. THAT IS EXHIBIT -- I AM SORRY -- PAGE 474.

DID YOU REVIEW -- YOU DID NOT ACTUALLY -- WERE NOT PRIMARILY RESPONSIBLE FOR WRITING THE EFFICACY ARTICLE, CORRECT?

A. RIGHT.

Q. DID YOU REVIEW IT AFTER IT WAS WRITTEN?

A. YES.

Q. DID YOU PROVIDE ANY COMMENTS ON IT?

A. YES.
Q. IF I COULD REFER YOU TO PAGE 474, RIGHT-HAND COLUMN, THE LAST SENTENCE BEFORE THE FIRST FULL PARAGRAPH. THE FIRST FULL PARAGRAPH BEGINS:
"PROCEDURE PAIN."
AND I AM GOING TO READ THE SENTENCE RIGHT BEFORE THAT:
"THERE WERE NO COMPLICATIONS ASSOCIATED WITH.
INTRA-AMNIOTIC INJECTION."
DO YOU DEGREE WITH THAT, DOCTOR?
A. YES, I DO, BECAUSE I SAID THAT WAS SPECIFICALLY COMPLICATIONS WITH THE INJECTION ITSELF.
Q. DOCTOR, I HAVE GIVEN YOU EXHIBIT 31 IN THIS CASE. ARE YOU FAMILIAR WITH THAT BOOK?
A. YES.
Q. DO YOU USE IT?
A. YES.
Q. DO YOU CONSIDER IT TO BE RELIABLE?
A. YES.
Q. IF I COULD ASK YOU TO TURN TO PAGE 123, PLEASE. CHAPTER 10 STARTS THERE, CORRECT?
A. YES, IT DOES.
Q. HAVE YOU READ THAT CHAPTER BEFORE?
A. YES.
Q. IF YOU COULD TURN NOW TO PAGE 131. DOCTOR, WERE YOU IN THE

COURTROOM DURING DR. SHEEHAN'S TESTIMONY TODAY?
A. PART OF IT.
Q. WERE YOU IN THE COURTROOM WHEN I READ THE PARAGRAPH ON PAGE 131 THAT GOES FROM THE BOTTOM OF THE LEFT-HAND COLUMN TO THE TOP OF THE RIGHT-HAND COLUMN?
A. I WAS.
Q. DOES THE INFORMATION IN THAT PARAGRAPH SUPPORT THE FINDINGS OF YOUR STUDY REGARDING THE SAFETY OF DIGOXIN INJECTION?
A. IT SUPPORTS THAT OVERALL THE INJECTION OF DIGOXIN FOR FETICIDAL PURPOSES IS OVERALL SAFE.
Q. WE TALKED EARLIER, DOCTOR, ABOUT THE POTENTIAL OF INJECTING DIGOXIN INTO THE FETAL HEART AND THE EFFECTIVENESS OF THAT APPROACH. ASIDE FROM ITS EFFECTIVENESS IN CAUSING FETAL DEMISE, DO YOU BELIEVE THAT THAT APPROACH WOULD ALSO BE FASTER THAN INTRA-AMNIOTIC INJECTION?
A. I THINK IT IS LIKELY THAT IT'S FASTER, THOUGH, AGAIN, NO ONE HAS STUDIED THE TIME FRAME, SO WE ARE ASSUMING.
Q. DOCTOR, YOU TESTIFIED ON DIRECT ABOUT TWO CASES WHERE POTENTIAL COMPLICATIONS HAD OCCURRED AFTER DIGOXIN INJECTION. AND IN THE FIRST CASE I BELIEVE YOU TESTIFIED THAT THERE WAS SOME PAIN ON THE PART OF THE PATIENT?
A. RIGHT.
Q. IS IT CORRECT, DOCTOR, THAT IT WAS NOT DEFINITIVELY SHOWN THAT THAT PAIN WAS CAUSED BY THE DIGOXIN?
A. I THINK IT WOULD BE DIFFICULT TO DEFINITIVELY SHOW THAT.

BUT IT WAS SEVERE PAIN IMMEDIATELY AFTER THE INJECTION.
Q. IT WAS NOT SHOWN TO BE CAUSED BY THE INJECTION?
A. I DON'T KNOW HOW ELSE TO ASSUME THAT. WHY WOULD SHE SUDDENLY HAVE A SEVERE PAIN IN HER LOWER ABDOMEN IF IT WASN'T FROM THE INJECTION? I DON'T UNDERSTAND.
Q. THERE WERE NO LONG-TERM EFFECTS IN EITHER OF THOSE TWO CASES?
A. NO, THERE WERE NOT THAT I KNOW OF.
Q. AND THE SECOND CASE THAT YOU MENTIONED, DOCTOR, YOU DIDN'T MENTION ANY SYMPTOMS SUCH AS PAIN. AS FAR AS YOU KNOW WERE THERE NO SUCH SYMPTOMS?
A. I DON'T KNOW.
Q. DOCTOR, IN ADDITION TO THE POTENTIAL RISKS THAT WE HAVE DISCUSSED YOUR SAFETY STUDY ALSO RECORDED SIDE EFFECTS REPORTED BY THE SUBJECT; IS THAT CORRECT?
A. YES.
Q. TWO OF THE SIDE EFFECTS REPORTED WERE NAUSEA AND FATIGUE?
A. YES.
Q. THOSE ARE -- YOU CALL THOSE SIDE EFFECTS, NOT COMPLICATIONS, CORRECT?
A. RIGHT.
Q. AND AS SIDE EFFECTS, THEY WOULD NOT HAVE ANY LASTING EFFECT ON THE PATIENT?
A. IT WOULD BE UNLIKELY TO HAVE ANY LASTING EFFECT.
Q. IF I CAN REFER YOU, DOCTOR, TO EXHIBIT 34, YOUR ARTICLE ON

THE SAFETY STUDY. TABLE 3 ON THE THIRD PAGE OF THAT ARTICLE. IS IT CORRECT, DOCTOR, THAT AS REPORTED THERE IN TABLE 3, THE SIDE EFFECTS THAT WERE MOST OFTEN REPORTED IN SUBJECTS -- THAT SIDE EFFECTS WERE MOST OFTEN REPORTED IN THE SUBJECTS WHO HAD THE LOWEST LEVELS OF DIGOXIN IN THEIR BLOOD?

A. CAN YOU ASK THAT AGAIN? I AM SORRY.

Q. LET'S LOOK AT THE TABLE, TABLE 3. IT HAS FOUR COLUMNS. THE HEADING FOR THE FOURTH COLUMN I AM READING:

"MEAN PEAK DIGOXIN LEVEL IN PATIENTS WITH SIDE EFFECT."

DID I READ THAT CORRECTLY?

A. RIGHT.

Q. THE FOURTH COLUMN SAYS:

"MEAN PEAK DIGOXIN LEVEL IN PATIENT WITH OUTSIDE EFFECT."

A. RIGHT.

Q. THESE WERE SELF-REPORTED SIDE EFFECTS, CORRECT?

A. YES.

Q. DO YOU AGREE, DOCTOR, THAT THE NUMBERS ON THE FAR RIGHT-HAND COLUMN, THE FOURTH COLUMN, ARE LARGER THAN THE NUMBERS IN THE THIRD COLUMN?

A. YES.

Q. SO, THE PATIENTS WHO HAD THE LOWEST LEVELS OF DIGOXIN IN THEIR BLOOD REPORTED SIDE EFFECTS MOST OFTEN?

A. I AM NOT SURE YOU CAN CONCLUDE THAT. I THINK THAT WHAT IT

MEANS IS THAT OVERALL WHEN YOU LOOKED AT THE PATIENTS WHO HAD THE SIDE EFFECT VERSUS THE PATIENTS WHO DIDN'T, THAT THE PEAK OF THE DIGOXIN HAD A HIGHER MEAN IN THE PATIENTS WHO DID NOT HAVE SIDE EFFECTS.

SHOULD I SAY THAT AGAIN? IS THAT CONFUSING?

SO, IN OTHER WORDS, THE MEAN PEAK DIGOXIN LEVEL WAS, IN FACT, LOWER IN PATIENTS WITHOUT THE SIDE EFFECT. IS THAT RIGHT OR NO?

Q. DOCTOR, ISN'T IT TRUE THAT ONE OF YOUR SUBJECTS IN YOUR SAFETY STUDY REPORT IN EXHIBIT 34, ISN'T IT TRUE THAT ONE OF THE SUBJECTS IN THAT STUDY WEIGHED 222 POUNDS?

A. YES.

Q. WAS THAT SUBJECT OBESE?

A. I DON'T REMEMBER.

Q. DOCTOR, HOW LIKELY IS IT THAT A WOMAN OF 222 POUNDS WOULD NOT BE OBESE?

A. IT DEPENDS ON HER HEIGHT.

Q. IN YOUR EXPERIENCE AS A PHYSICIAN, AS A PHYSICIAN, DO YOU ROUTINELY KNOW THE WEIGHT OF THE PATIENTS THAT YOU TREAT?

A. NO.

Q. DOES YOUR STAFF WEIGH THE PATIENTS WHO COME TO YOUR CLINICS TO BE TREATED?

A. THEY DO, BUT I OFTEN DON'T REVIEW THEIR WEIGHT.

Q. DOCTOR, DO YOU THINK IT WOULD BE VERY LIKELY FOR A WOMAN OF 222 POUNDS NOT TO BE OBESE?

A. IT'S POSSIBLE. I MEAN, AGAIN, THERE IS OBESITY. THERE IS MORBID OBESITY. IT ALL DEPENDS ON HOW THE WEIGHT IS DISTRIBUTED ON A WOMAN OF A GIVEN HEIGHT.

Q. DOCTOR, YOU TESTIFIED THAT -- I BELIEVE YOU USED THIS TERM TWICE -- THAT DIGOXIN INJECTION WOULD TECHNICALLY BE MORE DIFFICULT OR TECHNICALLY CAN'T BE DONE IN A WOMAN WHO IS OBESE.

BY THAT DO YOU MEAN -- MAYBE I SHOULD ASK YOU TO EXPLAIN: WHAT DO YOU MEAN BY SAYING "TECHNICALLY" IN THAT CONTEXT?

A. I WILL HOLD UP MY NEEDLE AGAIN. SO, THIS LENGTH OF THE NEEDLE THAT WE USUALLY USE, AND WE USE IT. IT IS A STANDARD LENGTH OF NEEDLE. IT'S A THREE-AND-A-HALF INCH NEEDLE.

IF SOMEONE'S WHAT WE CALL "PANNUS," SO SOMEONE'S OVERLYING FAT THAT LIES ON THEIR ABDOMEN IS THICKER THAN THIS, IT WOULD BE IMPOSSIBLE. AND YOU DON'T JUST HAVE TO GET THROUGH THE FAT THAT LIES OVER THEIR MUSCLE AND THEIR FASCIA, BUT YOU ALSO HAVE TO GET TO THE UTERUS, THROUGH THE UTERUS AND INTO THE UTERINE CAVITY.

SO IF THOSE LAYERS ALL COMBINED ARE LONGER THAN THREE-AND-A-HALF INCHES, IT CAN BE DIFFICULT OR IMPOSSIBLE TO GET THE NEEDLE INTO THE RIGHT PLACE.

Q. BUT YOU CAN SIMPLY USE A LONGER NEEDLE, IF NECESSARY?

A. YES, BUT THEN IT IS HARDER TO DIRECT IT. AND SOMETIMES THERE JUST ISN'T A NEEDLE LONG ENOUGH. THAT HAS BEEN OUR EXPERIENCE.

Q. IF I CAN REFER YOU, AGAIN, DOCTOR, TO THE ARTICLE ON YOUR EFFICACY STUDY, ON THE FOURTH PAGE, PAGE 474, THERE IS A TABLE, TABLE 2.

AND THE FIRST RESULT THERE IN THE LEFT-HAND COLUMN, THE RESULT COLUMN, SAYS:

"PROCEDURE TIME AND DIFFICULTY."

AND A FEW LINES DOWN IT SAYS:

"SURGEON-RATED DIFFICULTY."

DO YOU SEE THAT?

A. YES.

Q. NOW, ON THE PLACEBO COLUMN, THE DIFFICULTY IS RATED THREE. ON THE DIGOXIN COLUMN, THE PLACEBO -- I MEAN, I AM SORRY -- THE DIFFICULTY IS RATED 2.5; IS THAT CORRECT?

A. THAT'S RIGHT.

Q. SO, AM I CORRECT IN UNDERSTANDING THAT OVERALL THE SURGEONS RATED THE DIFFICULTY -- RATED THE PROCEDURE AS LESS DIFFICULT WHEN THE PATIENT HAD RECEIVED DIGOXIN?

A. THEY -- NUMERICALLY, THAT'S CORRECT. BUT IT IS NOT STATISTICALLY SIGNIFICANT, MEANING THAT THIS RESULT WAS LIKELY DUE TO JUST CHANCE, BECAUSE IT WASN'T A LARGE ENOUGH DIFFERENCE.

SO IT -- ESSENTIALLY, IN TERMS OF HOW TO INTERPRET IT, YOU WOULD SAY THEY ARE THE SAME BECAUSE ANY DIFFERENCE IS PROBABLY JUST CHANCE.

Q. NOW, THE STATISTICAL SIGNIFICANCE OF A RESULT SHOWN IN THE

STUDY DEPENDS NOT ONLY ON THE NUMERICAL RESULT, BUT ALSO ON THE SIZE OF THE STUDY, CORRECT?

A. YES.

Q. SO, IF THESE SAME RESULTS, 3 AND 2.5, HAD BEEN ACHIEVED IN A LARGER STUDY, IF YOU HAD HAD 2000 SUBJECTS, AND YOU STILL HAD THOSE RESULTS, 3 AND 2.5, THEN PROBABLY THAT WOULD BE STATISTICALLY SIGNIFICANT, CORRECT?

A. YEAH. BUT, I THINK WHAT'S IMPORTANT ISN'T JUST STATISTICAL SIGNIFICANCE. IF YOU GET A LARGE ENOUGH STUDY YOU CAN FIND STATISTICALLY SIGNIFICANT DIFFERENCE OF .1 IN DIFFICULTY, BUT YOU WOULDN'T CARE, BECAUSE IT'S NOT CLINICALLY IMPORTANT.

SO WHAT YOU ARE LOOKING AT IS A STUDY THAT HAS ENOUGH SIZE THAT YOU HAVE A CLINICALLY-IMPORTANT RESULT THAT'S DIFFERENT.

SO, A DIFFERENCE BETWEEN 3 AND 2.5, YOU WOULD NOT ONLY HAVE TO PROVE THAT IT IS STATISTICALLY SIGNIFICANT, BUT THE OTHER TEST ABOUT WHETHER YOU CARE ABOUT IT IS WHETHER IT IS CLINICALLY IMPORTANT OR CLINICALLY SIGNIFICANT.

SO IN THIS CASE, YOU WOULD ALSO HAVE TO MAKE THAT CONCLUSION.

Q. BUT IF YOU DID HAVE A LARGE ENOUGH STUDY, IF YOU HAD A STUDY OF 2,000 OR 5,000 SUBJECTS, AND YOU HAD THOSE RESULTS, THAT DIFFERENCE IN DIFFICULTY, THAT WOULD BE CLINICALLY SIGNIFICANT, CORRECT?

A. NO. IT MIGHT BE STATISTICALLY SIGNIFICANT WITHOUT BEING

CLINICALLY SIGNIFICANT. SO IF YOU THINK THERE IS A WORLD OF DIFFERENCE IF SOMEONE ON A SIX POINT SCALE SAYS:

"WELL, THIS PROCEDURE IS 2.5 AND THE OTHER ONE IS A 3," YOU STILL HAVE TO REALLY USE YOUR CLINICAL JUDGMENT ABOUT WHETHER THAT REALLY IS THAT IMPORTANT. YOU KNOW, NOW, IF IT'S -- AGAIN, I MEAN, THAT IS WHERE, YOU KNOW, YOUR MEDICAL TRAINING AND YOUR READING OF THE LITERATURE COMES INTO IT. YOU REALLY ARE ALWAYS TRYING TO DECIDE: IS THIS A MEANINGFUL DIFFERENCE THAT I AM GOING TO CHANGE MY PRACTICE ON?

SO, YES. I MEAN, IF YOU HAD A LARGER STUDY AND YOU HAD HAD A 3 VERSUS A 2.5, YOU MIGHT HAVE FOUND STATISTICAL SIGNIFICANCE, AND THEN IT DEPENDS ON YOUR READING OF THE LITERATURE WHETHER THAT IS GOING TO CHANGE YOUR PRACTICE.

SO, DID THAT CLARIFY IT AT ALL?

Q. DOCTOR, AFTER THE NUMBERS 3 AND 2.5 ON THAT SAME LINE, THE NUMBERS IN PARENTHESES "(1 THROUGH 4)," DOES THAT MEAN THAT THE DOCTORS WERE ASKED TO RATE THE DIFFICULTY ON A SCALE OF 1 TO 4?

A. NO, IT WAS ON A SIX-POINT SCALE.

Q. ON A SCALE OF 1 TO 6?

A. YEAH.

IT MIGHT HAVE BEEN 0 TO 5. I DON'T REMEMBER. BUT IT COMES DOWN TO SIX OPTIONS.

Q. DOCTOR, YOU'VE TESTIFIED THAT YOU BELIEVE THERE ARE OCCASIONS IN WHICH THERE ISN'T TIME TO USE DIGOXIN; AM I STATING THAT TESTIMONY CORRECTLY?

A. YES.
Q. AND I BELIEVE YOU CITED A CASE OF SEVERE PREECLAMPSIA. WHY WAS DIGOXIN NOT ADMINISTERED? LET ME GO BACK. I BELIEVE YOU TESTIFIED THAT THE ABORTION IN THAT CASE OCCURRED IN THE MORNING?
A. YES.
Q. AND THE WOMAN HAD BEEN ADMITTED THE NIGHT BEFORE?
A. YES.
Q. WHY WAS DIGOXIN NOT ADMINISTERED THE NIGHT BEFORE?
A. WE DON'T GENERALLY USE DIGOXIN ANYMORE IN PATIENTS WHO ARE GOING TO HAVE A D&E, BECAUSE WE DON'T THINK IT MAKES THE D&E SAFER FOR THE WOMAN HAVING THE ABORTION.
Q. RIGHT.
A. SO BECAUSE SHE WAS GOING TO HAVE AN ABORTION THE FOLLOWING MORNING, THERE WOULD HAVE BEEN NO REASON TO GIVE HER DIGOXIN.
Q. BUT THERE WOULD HAVE BEEN NO REASON NOT TO GIVE HER DIGOXIN, CORRECT?
A. I ONLY DO THINGS TO PATIENTS IF I THINK IT IS IN THEIR BENEFIT. AND IF I DON'T THINK DIGOXIN IS IN HER BENEFIT, I AM NOT GOING TO GIVE HER DIGOXIN. I DON'T THINK IT MAKES THE PROCEDURE SAFER, BASED ON THE BEST STUDY THAT I KNOW OF, WHICH IS OUR GOLD STANDARD STUDY, WHICH IS RANDOMIZED, BLINDED, PLACEBO-CONTROLLED TRIAL.
SO BASED ON MY CONCLUSION THAT IT IS NOT GOING TO MAKE HER PROCEDURE SAFER, THAT IS MY READING OF THE LITERATURE,

THEN I AM NOT GOING TO DO THAT PROCEDURE TO HER. I AM NOT GOING TO DO AN INTERVENTION THAT IS, AT THE VERY LEAST, UNCOMFORTABLE, WITH SOME SMALL SIDE EFFECTS, AND THEN HAS A SMALL, SMALL RISK ASSOCIATED WITH IT, BUT NOT NO RISK, FOR NO BENEFIT FOR THE PATIENT.

Q. DOCTOR, IF 91 PERCENT OF PATIENTS REPORT THAT THEY PREFER THEIR FETUSES BE DEAD BEFORE THE ABORTION, WOULDN'T YOU SAY THAT IT IS TO THEIR BENEFIT TO DO THAT?

A. IF THAT 95 PERCENT WERE KNOWN IN A WAY THAT -- THAT I COULD TRUST THAT THAT WAS SORT OF THEIR UNINFLUENCED BELIEF, THEN I WOULD SAY YES, THERE IS SOME PSYCHOLOGICAL BENEFIT.

IT WOULD BE NEXT TO IMPOSSIBLE TO ASSESS THIS. IN FACT, I WENT THROUGH ALL OF THE STEPS OF DESIGNING A STUDY TO SEE IF WE COULD COME UP WITH A WAY OF ANSWERING THIS.

I EVEN WENT TO THE INSTITUTIONAL REVIEW BOARD. I WORKED WITH OTHER PEOPLE TO TRY AND DESIGN THIS STUDY. AND ULTIMATELY, I FELT LIKE THE STUDY WAS FLAWED. AS SOON AS YOU ASK SOMEONE THIS QUESTION AND ENROLL THEM IN A STUDY TO SEE, YOU KNOW, WHAT THEY THINK, YOU'VE ALREADY CHANGED WHAT THEY MIGHT HAVE ANSWERED.

SO I NEVER THOUGHT WE COULD GET A REASONABLE ANSWER TO THAT QUESTION.

Q. DID YOU HEAR DR. SHEEHAN'S TESTIMONY EARLIER TODAY, DOCTOR, TO THE EFFECT THAT AT PLANNED PARENTHOOD SAN DIEGO THEY OFFER DIGOXIN TO ALL PATIENTS AFTER A CERTAIN GESTATIONAL AGE?

A. YES, I DID.
Q. DID YOU HEAR HER SAY THAT ALL THE PATIENTS TO WHOM THEY MAKE THAT OFFER ACCEPT IT?
A. YES.
Q. DO YOU BELIEVE THAT THERE IS SOMETHING IN THE WAY THAT THEY MAKE THAT OFFER THAT INFLUENCES WHETHER THE PATIENTS ACCEPT IT?
A. EVERYTHING WE DO IN MEDICINE, THE WAY WE PRESENT IT TO PATIENTS, AFFECTS WHETHER THEY ACCEPT WHAT WE RECOMMEND TO THEM.
MR. SIMPSON: YOUR HONOR, COULD I APPROACH THE WITNESS?
THE COURT: YES.
MS. PARKER: WHAT EXHIBIT ARE YOU USING?
MR. SIMPSON: EXHIBIT A-44.
BY MR. SIMPSON:
Q. DR. DREY, I HAVE SHOWN YOU WHAT HAS BEEN MARKED AS EXHIBIT A -- I AM SORRY -- A-50. A-50, I AM SORRY. WHAT HAS BEEN MARKED AS EXHIBIT A-50 FOR THIS CASE. DOCTOR, DID YOU PROVIDE THIS DOCUMENT IN RESPONSE TO A SUBPOENA FROM THE GOVERNMENT IN THIS CASE?
A. YES.
THE COURT: EXCUSE ME. A-50?
MR. SIMPSON: A-50, YES.
THE COURT: A-50 IS AN E-MAIL.
MR. SIMPSON: EXCUSE ME, YOUR HONOR.

THE COURT: I MAY HAVE THE WRONG ONE. WHAT WAS IT, AGAIN?

MR. SIMPSON: I HAVE IT AS A-50 IN OUR BINDERS.

THE COURT: I WAS LOOKING AT PLAINTIFFS', PERHAPS. OKAY.

BY MR. SIMPSON:

Q. DOCTOR, IS THIS PAGE PART OF A SLIDE PRESENTATION THAT YOU GAVE?

A. YES.

Q. DO YOU HAVE ANY REASON TO QUESTION THE ACCURACY OF THESE FIGURES?

A. NO.

MR. SIMPSON: YOUR HONOR, WE WOULD LIKE TO OFFER EXHIBIT A-50 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. PARKER: NO, YOUR HONOR.

THE COURT: OKAY.

THE CLERK: A-50 INTO EVIDENCE.

MR. SIMPSON: MAY I APPROACH THE WITNESS AGAIN, PLEASE?

THE COURT: ALL RIGHT.

BY MR. SIMPSON:

Q. DOCTOR, I AM SHOWING YOU WHAT HAS BEEN MARKED A-44 IN THIS CASE. HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. YES.

Q. IF YOU CAN TURN TO THE LAST PAGE OF THAT DOCUMENT, PLEASE. IS THAT YOUR SIGNATURE THERE?

A. YES.

MR. SIMPSON: YOUR HONOR, WE WOULD LIKE TO OFFER EXHIBIT A-44 INTO EVIDENCE, PLEASE.

MS. PARKER: WE WILL OBJECT TO THAT TO A-50 --- I MEAN, I AM SORRY, TO A-50.

THE COURT: WELL --

MS. PARKER: I AM SORRY. I THINK WE GOT LOST HERE. WE ARE OBJECTING --

THE COURT: WHICH ONE ARE YOU OBJECTING TO?

MS. PARKER: -- TO A-50 BECAUSE IT IS -- SHE TESTIFIED IT'S THE PRESENTATION SHE PREPARED. SHE DID NOT TESTIFY THAT THESE ARE ANY STATISTICS. AND THEY CITE AN ARTICLE FROM 1988, WHICH WOULD BE HEARSAY.

MR. SIMPSON: YOUR HONOR, IN OUR EXHIBIT LIST --

THE COURT: WHICH ONE ARE WE TALKING ABOUT?

MR. SIMPSON: I AM SORRY. WE ARE TALKING NOW ABOUT A-50.

I HAVEN'T HEARD -- PERHAPS WE SHOULD FINISH WITH A-44 FIRST. I HAVEN'T HEARD --

THE COURT: YOU STARTED WITH 50 AND YOU WENT TO 44.

MR. SIMPSON: BECAUSE I THOUGHT THAT PLAINTIFFS' COUNSEL SAID THEY HAD NO OBJECTION TO 50.

THE COURT: RIGHT. I WAS ACTUALLY SURPRISED. I

DON'T SEE HOW THIS IS ANY DIFFERENT THAN THE TABLES THAT ARE CONTAINED IN THE STUDIES.

MR. SIMPSON: YOUR HONOR, IN OUR EXHIBIT LISTS WHEN PLAINTIFFS INDICATED THEIR OBJECTIONS TO OUR EXHIBITS, THEY DID NOT STATE AN OBJECTION TO A-50.

THE COURT: ALL RIGHT.

MS. PARKER: WELL, WE ARE RAISING IT NOW, YOUR HONOR. WE ARE LOOKING AT IT, AND IT APPEARS TO BE THERE IS NO FOUNDATION THAT SHE CREATED THESE STATISTICS. AND WE ARE ALSO OBJECTING ON HEARSAY GROUNDS, BECAUSE THEY ARE 14 YEARS OLD. THERE IS NO EVIDENCE THAT THESE --

THE COURT: LIKE I SAID, I DON'T KNOW WHAT THIS IS, FOR ONE.

TO THE EXTENT IT REPRESENTS A STUDY OF SOME KIND, HOW IS THIS ANY DIFFERENT THAN THE OTHER STUDIES YOU OBJECTED TO?

MR. SIMPSON: YOUR HONOR, I AM BASING MY CONDUCT AT THIS POINT ON THE FACT THAT THERE WAS NO OBJECTION STATED TO THIS DOCUMENT ON OUR EXHIBIT LIST.

THE COURT: ALL RIGHT. I AM GOING TO ENTERTAIN THE OBJECTION TO IT NOW. SO WHAT IS YOUR OBJECTION TO THE -- WHAT IS YOUR RESPONSE TO THE HEARSAY OBJECTION?

MR. SIMPSON: FRANKLY, I HAD NOT THOUGHT MUCH ABOUT THAT SINCE NO OBJECTION WAS STATED TO IT.

THE COURT: SO I AM NOT GOING TO ADMIT IT NOW. IF

YOU CAN ESTABLISH THAT IT IS NOT HEARSAY AND THAT THERE IS A PROPER FOUNDATION, WE CAN ADMIT IT.

MR. SIMPSON: OKAY.

THE CLERK: A-50 WITHDRAWN?

THE COURT: IT IS NOT WITHDRAWN. IT IS JUST NOT ADMITTED YET.

THE CLERK: NOT ADMITTED?

THE COURT: NOT ADMITTED YET.

MR. SIMPSON: BEFORE I FORGET, YOUR HONOR, WHY DON'T WE GO BACK TO A-44? I DON'T THINK WE HAVE HEARD FROM PLAINTIFFS' COUNSEL AS TO WHETHER THEY HAVE AN OBJECTION TO A-44.

MS. PARKER: YOUR HONOR, WE OBJECT TO A-44 TO THE EXTENT IT SEEKS TO INTRODUCE THE DOCUMENT RESPONSES FOR THE TRUTH. SHE DID VERIFY THE INTERROGATORY RESPONSES, WHICH I HAVE NO OBJECTION TO THAT.

MR. SIMPSON: IT IS FOR THE INTERROGATORIES THAT WE ARE OFFERING.

THE COURT: AND FOR ALL OF THEM?

MR. SIMPSON: SPECIFICALLY, NUMBER 24.

THE COURT: ALL RIGHT. THAT WILL BE ADMITTED. WE WILL ADMIT THE ENTIRE DOCUMENT, BUT I AM GOING TO REVIEW -- YOU ALL ARE GIVING ME SO MANY PIECES OF PAPER. I AM NOT REVIEWING ALL OF THE INTERROGATORIES IN THIS CASE. ONLY THE ONES YOU ARE IDENTIFYING.

MR. SIMPSON: I UNDERSTAND.

THE COURT: ADMITTED, A-44.

THE CLERK: A-44 INTO EVIDENCE.

(DEFENDANT'S A-44
WAS RECEIVED IN EVIDENCE.)

BY MR. SIMPSON:

Q. DOCTOR, BACK TO EXHIBIT A-50, THE PAGE FROM THE SLIDE PRESENTATION, DID YOU GATHER THE STATISTICS THAT ARE REFLECTED IN THAT DOCUMENT?

A. DID I GATHER THEM MYSELF? NO, BUT I HAVE READ THIS ARTICLE, BUT I -- IS THAT -- MAYBE I DIDN'T HEAR YOU CORRECTLY.

Q. DID YOU GATHER THE STATISTICS THAT ARE REFLECTED HERE?

A. I DIDN'T PERSONALLY GATHER THE STATISTICS THAT ARE REFLECTED HERE.

Q. WAS THAT DONE UNDER YOUR DIRECTION?

A. NO. IT WAS DONE WHILE I WAS STILL IN MEDICAL SCHOOL OR EVEN BEFORE THAT. WAY BEFORE I WAS IN MEDICAL SCHOOL. SORRY.

Q. I UNDERSTAND THAT. IT SAYS "1988."

A. YEAH.

Q. BUT, THIS PRECISE DOCUMENT, CAN YOU TELL ME HOW THAT WAS CREATED?

A. THIS WAS A SLIDE THAT WAS CREATED BY SOMEONE ELSE.

Q. WAS THAT PERSON WORKING UNDER YOUR DIRECTION?

A. NO.

Q. CAN YOU TELL ME, DOCTOR, WHETHER YOU HAVE KNOWLEDGE AS TO

THE INFORMATION REFLECTED HERE?
A. I'VE READ THE ARTICLE. I HAVEN'T GONE THROUGH PERCENTAGE BY PERCENTAGE TO MAKE SURE THAT THEY WERE CORRECT, YOU KNOW, TO THE LAST DIGIT. BUT THEY APPEAR CORRECT TO MY MEMORY OF THE ARTICLE.
Q. IS IT CORRECT THAT THIS DOCUMENT PURPORTS TO STATE THE PERCENTAGE OF PATIENTS -- OF WOMEN WHO REPORT THEIR REASONS FOR SEEKING ABORTION AFTER 16 WEEKS GESTATION?
A. I LOST YOUR QUESTION. I AM SORRY.
Q. IS IT CORRECT, DOCTOR, THAT THIS DOCUMENT PURPORTS TO REFLECT THE PERCENTAGE OF WOMEN WHO REPORT VARIOUS REASONS, THEIR REASONS FOR ABORTION AFTER 16 WEEKS GESTATION?
A. YES.
Q. I NOTICE THAT THE LAST ITEM HERE, THE LAST ITEM ON THE LIST IS THE AVERAGE NUMBER OF REASONS GIVEN. THE SECOND ITEM UP BEFORE THAT:
"FETAL ABNORMALITY DIAGNOSED LATE"?
A. RIGHT.
Q. TWO PERCENT. IN YOUR EXPOSURE TO THE MEDICAL LITERATURE, DOCTOR, DO YOU KNOW WHETHER THAT PERCENTAGE IS CORRECT?
A. I IMAGINE IT WOULD REALLY DEPEND ON WHAT SAMPLE OF -- YOU KNOW, YOU ARE DISCUSSING. SO --
Q. HAVE --
A. -- I DON'T KNOW IF I CAN MAKE THAT CONCLUSION. I MEAN, CERTAINLY OVERALL IT IS THE MINORITY OF PATIENTS. BUT WHETHER

IT IS 2 PERCENT OR SOME OTHER PERCENTAGE, I CAN'T SAY.
Q. OKAY. THANK YOU.
THE COURT: COUNSEL, IT IS 1:30.
MR. SIMPSON: I THINK I HAVE ONE QUESTION LEFT.
THE COURT: THEN YOU WILL BE FINISHED?
MR. SIMPSON: YES.
BY MR. SIMPSON:
Q. DOCTOR, YOU'VE TESTIFIED REGARDING A SLIGHT RISK OF INFECTION PRESENTED IN A DIGOXIN INJECTION, CORRECT?
A. YES.
Q. WOULD YOU AGREE, DOCTOR, THAT THAT RISK IS SO SMALL THAT IT IS BASICALLY OVERWHELMED BY THE OVERALL RISK OF INFECTION INVOLVED IN PERFORMING AN ABORTION, IN GENERAL?
A. NO, CERTAINLY NOT.
Q. WELL, LET'S TRY TO QUANTIFY THOSE RISKS. CAN YOU QUANTIFY FOR ME THE RISK OF AN INFECTION FROM A DIGOXIN INJECTION?
A. NO.
Q. CAN YOU QUANTIFY FOR ME THE RISK OF INFECTION INVOLVED IN A D&E, IN GENERAL?
A. I WOULD HAVE TO LOOK UP THE EXACT RISK. I CAN'T QUANTIFY THAT OFF THE TOP OF MY HEAD. BUT, I MEAN, I THINK THAT IT DEPENDS -- I MEAN, AS I SAID, YOU CAN HAVE A VERY SERIOUS INFECTION IF YOU HAVE THE INFECTION CONTAINED WITHIN THE UTERUS. SO THAT THE INFECTION IS ESSENTIALLY BREWING WHILE YOU ARE WAITING TO DO THE D&E.

IT IS A VERY DIFFERENT QUESTION IF YOU HAVE AN INFECTION DURING -- THAT IS ACQUIRED DURING THE COURSE OF DOING A D&E. SO, IT'S PROBABLY VERY DIFFERENT RISKS OF SEPSIS AND SEVERE CONSEQUENCES OF SEPSIS IF YOU WERE TO GET A DIGOXIN INJECTION AND YOU WERE TO GET INFECTED FROM IT, BUT I CAN'T QUANTIFY THAT.

Q. IF AN INFECTION WERE INTRODUCED IN THE COURSE OF A DIGOXIN INJECTION, NECESSARILY, THE INFECTION WOULD BE REMOVED IN THE COURSE OF THE ABORTION, CORRECT?

A. YES, BUT THERE IS A TIME DELAY BETWEEN WHEN YOU HAVE DONE THE DIGOXIN INJECTION AND WHEN YOU DO THE D&E. SO IN THAT DELAY YOU ARE EXPOSING THE WOMAN TO THE RISK, YOU KNOW, OF THE INFECTION.

Q. IF AN INFECTION, AN INTRA-AMNIOTIC INFECTION WERE TO OCCUR, ONE OF THE FIRST THINGS THE DOCTOR SHOULD DO IS EMPTY THE UTERUS, CORRECT?

A. THAT'S TRUE. BUT, AGAIN, IT DEPENDS HOW DILATED THE CERVIX IS WHETHER YOU CAN DO THAT AT THAT TIME OR IF MORE TIME HAS TO PASS BEFORE YOU CAN ACTUALLY EMPTY THE UTERUS.

MR. SIMPSON: THANK YOU, DOCTOR. THAT'S ALL I HAVE.

THE COURT: THAT WAS SEVEN QUESTIONS.

MR. SIMPSON: I AM SORRY. WHEN A LAWYER SAYS "ONE MORE QUESTION" IT'S ALWAYS GOING TO BE MORE. I APOLOGIZE.

THE COURT: ALL RIGHT. WE ARE GOING TO ADJOURN FOR THE DAY.

MS. PARKER: WE HAVE NO REDIRECT, YOUR HONOR.

THE COURT: ALL RIGHT. THANK YOU.

MS. PARKER: THANK YOU VERY MUCH.

THE COURT: YOU ARE EXCUSED.

WE WILL RECONVENE ON THURSDAY MORNING AT 8:30. SEE YOU THEN.

(THEREUPON, THIS TRIAL WAS CONTINUED UNTIL THURSDAY, APRIL 1ST, 2004, AT 8:30 O'CLOCK A.M.)

I N D E X