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PAGES 374 - 477

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,	)	THURSDAY, APRIL 1, 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

THURSDAY, APRIL 1, 2004 8:30 A.M.

THE COURT: GOOD MORNING, COUNSEL. ARE YOU READY FOR THE NEXT WITNESS?

MS. PARKER: YES, YOUR HONOR.

YOUR HONOR, BEFORE WE DO THAT, I WOULD LIKE TO ADVISE YOU THAT WE HAVE NO WITNESSES FOR TOMORROW. I THINK WE INDICATED THAT MIGHT BE THE CASE EARLIER IN THE WEEK, AND THERE IS SOME POSSIBILITY WE MAY REQUEST YOUR HONOR TO GO A LITTLE BIT LATER ON MONDAY. WE WILL HAVE A BETTER SENSE OF THAT AFTER WE --

THE COURT: HOW MANY WITNESSES DO YOU PLAN ON CALLING TODAY?

MS. PARKER: ONE.

THE COURT: WHO IS THAT?

MS. PARKER: DR. DOE.

THE COURT: AND WHO DO YOU HAVE FOR MONDAY?

MS. PARKER: DR. BROEKHUIZEN AND DR. CREININ.

THE COURT: AND THAT WILL BE ALL OF YOUR WITNESSES WITH THE EXCEPTION DR. CHASEN?

MS. PARKER: WE ALSO HAVE DR. WESTHOFF WHO WAS PLANNING TO COME ON TUESDAY.

THE COURT: TUESDAY OF NEXT WEEK?

MS. PARKER: YES.

THE COURT: YOU ALL WILL BE READY TO START WITH YOUR

WITNESSES ALSO ON TUESDAY?

MR. SIMPSON: ON THURSDAY, YOUR HONOR.

THE COURT: ON THURSDAY.

ALL RIGHT. IT SEEMS AS THOUGH YOU HAVE WORKED THIS OUT. AS LONG AS WE CAN GET IT IN DURING THE TIME THAT I SET ASIDE, THEN I GUESS IT'S OKAY.

MS. PARKER: THANK YOU, YOUR HONOR.

OUR NEXT WITNESS IS DR. DOE.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

DR. DOE

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

THE WITNESS: I DO.

THE CLERK: PLEASE TAKE THE STAND. PLEASE STATE YOUR NAME FOR THE COURT.

MS. PARKER: HE'S --

THE COURT: IT'S FINE. HE IS TESTIFYING UNDER THE PSEUDONYM. WE WILL REFER TO YOU AS DR. DOE.

THE WITNESS: THANK YOU.

DIRECT EXAMINATION

BY MS. PARKER:

Q. GOOD MORNING, DOCTOR. I AM BETH PARKER, ONE OF THE ATTORNEYS FOR PLANNED PARENTHOOD.

HAVE YOU COME TO COURT TODAY PREPARED TO STATE YOUR OPINION ABOUT THE PARTIAL-BIRTH ABORTION BAN ACT AND THE IMPACT

IT WILL HAVE ON YOUR PRACTICE?
A. YES.
Q. BEFORE WE GET INTO THAT OPINION, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR PRACTICE.
YOU'RE AN OB/GYN; IS THAT CORRECT?
A. CORRECT.
Q. AND DO YOU HAVE A SPECIALTY?
A. I HAVE A SUBSPECIALTY IN PERINATOLOGY OR MATERNAL-FETAL MEDICINE. THEY ARE THE SAME FIELD.
Q. ARE YOU BOARD CERTIFIED IN ANY FIELD?
A. I AM BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY AND I'M BOARD ELIGIBLE IN MATERNAL-FETAL MEDICINE.
Q. WHAT DOES THAT MEAN TO BE BOARD ELIGIBLE?
A. I HAVE COMPLETED MY FELLOWSHIP. I HAVE PASSED MY WRITTEN EXAM FOR THE BOARD, AND I AM CURRENTLY COLLECTING CASES FOR -- TO SIT FOR THE ORAL EXAM.
Q. AND IN CALIFORNIA DO YOU NEED TO PRACTICE A PERIOD OF TIME BEFORE YOU CAN GET YOUR CERTIFICATION FOR OB/GYN, AND THEN FOR PERINATOLOGY?
A. WELL, NOT ONLY IN CALIFORNIA, BUT THROUGHOUT THE UNITED STATES. TO BE BOARD CERTIFIED YOU HAVE TO PRACTICE FOR A PERIOD OF TIME, COLLECT THOSE CASES, AND THEN, THE EXAM, ORAL EXAM, IS BASED PARTIALLY ON THOSE CASES.
I HAD TO DO THAT FOR GENERAL OBSTETRICS/GYNECOLOGY AND THEN, AGAIN, FOR MATERNAL-FETAL MEDICINE.

Q. WHERE DO YOU CURRENTLY PRACTICE?
A. CALIFORNIA PACIFIC MEDICAL CENTER.
Q. WHAT POSITION DO YOU HOLD THERE?
A. I'M A STAFF PHYSICIAN AND A MEMBER OF THE MATERNAL-FETAL MEDICINE ASSOCIATES.
Q. YOU RECENTLY JOINED CALIFORNIA PACIFIC MEDICAL CENTER; IS THAT RIGHT?
A. CORRECT, IN OCTOBER.
Q. WHERE WERE YOU BEFORE THAT?
A. I WAS AT THE UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO.
Q. WHAT DEPARTMENT WERE YOU IN AT UCSF?
A. DEPARTMENT OF OBSTETRICS, GYNECOLOGY AND REPRODUCTIVE SCIENCES IN THE DIVISION OF PERINATAL MEDICINE.
Q. DID YOU DO A FELLOWSHIP THERE?
A. YES, I DID MY MATERNAL-FETAL MEDICINE FELLOWSHIP AT UCSF.
Q. DID YOU ALSO WORK AT THE FETAL TREATMENT CENTER AT UCSF?
MR. QUINLIVAN: YOUR HONOR, I KNOW THESE ARE JUST BACKGROUND QUESTIONS, BUT THESE ARE LEADING QUESTIONS.
THE COURT: BUT BECAUSE THEY ARE BACKGROUND, I GENERALLY PERMIT LEADING FOR BACKGROUND.
MR. QUINLIVAN: VERY WELL. THANK YOU.
THE COURT: AND YOU MAY DO SO, AS WELL.
MR. QUINLIVAN: OKAY. VERY WELL. THANK YOU, YOUR HONOR.
THE WITNESS: THE FETAL TREATMENT CENTER WAS AN

ENTITY THAT WAS IN THE CONJUNCTION WITH THE DEPARTMENT OF SURGERY AND THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY.

BY MS. PARKER:

Q. AND WHAT DOES IT DO? WHAT DOES IT DO?

A. THE GOAL OF THE FETAL TREATMENT CENTER IS REALLY TO PROVIDE ACCURATE PRENATAL DIAGNOSIS AND THE TERMINATION, IF CERTAIN FETAL ABNORMALITIES MIGHT BE AMENABLE TO PROCEDURES IN UTERO THAT COULD CORRECT, SAY, A DEFECT AND CONTINUE THE PREGNANCY ON, AND THEN HOPE THAT THAT WOULD BE A BETTER OUTCOME THAN JUST REPAIRING THE DEFECT AFTER BIRTH.

Q. AND WHAT ROLE DID YOU PLAY AT THE FETAL TREATMENT CENTER?

A. I WAS THE PRIMARILY THE OBSTETRICIAN WHO COUNSELED THE PATIENTS AHEAD OF THE PROCEDURES, HELPED TO MAKE THE DIAGNOSIS. IF THE PATIENTS HAD THERAPY WERE PRESENT AT THE THERAPIES, AND THEN TOOK CARE OF THEIR PREGNANCIES AFTER THE THERAPIES.

Q. AND DID YOU DO THAT AS PART OF THE TEAM?

A. YES, IT WAS A VERY BIG TEAM. IT INCLUDED PERINATOLOGISTS, PEDIATRIC SURGEONS, NEONATOLOGISTS.

Q. AND WHAT IS A NEONATOLOGIST?

A. A NEONATOLOGIST IS A PEDIATRICIAN WHO HAS DONE A FELLOWSHIP IN NEONATOLOGY. AND THAT IS THE CARE OF THE PREMATURE BABIES, BASICALLY.

THERE IS ALSO ANESTHESIOLOGISTS, RADIOLOGISTS AND A SOCIAL WORKER AS PART OF THE TEAM.

Q. HOW LONG DID YOU WORK AT THE FETAL TREATMENT CENTER?

A. I STARTED DOING SOME WORK DURING MY FELLOWSHIP AT UCSF, AND THEN I WAS ON STAFF AT UCSF FOR FIVE YEARS AFTER THAT. THE WHOLE DURATION I WAS INVOLVED WITH THE FETAL TREATMENT CENTER.
Q. DID YOU ALSO TEACH AT UCSF?
A. YES.
Q. WHAT DID YOU TEACH?
A. I TAUGHT CLINICAL OBSTETRICS AND GYNECOLOGY TO MEDICAL STUDENTS AND RESIDENTS.
Q. DO YOU CURRENTLY FOCUS ON BOTH ON ISSUES OF MATERNAL CONDITIONS AND FETAL ABNORMALITIES?
A. YES.
Q. WHAT TYPES OF PATIENTS DO YOU SEE CURRENTLY IN YOUR PRACTICE?
A. IT'S A MIXTURE OF WOMEN WHO HAVE MEDICAL PROBLEMS GOING INTO A PREGNANT THAT MAY IMPACT THE PREGNANCY, AS WELL AS CONDITIONS THAT DEVELOP DURING A PREGNANCY THAT MAKE IT MORE COMPLICATED, OR THE DIAGNOSIS OF FETAL ABNORMALITIES.
Q. AND WHAT TYPE OF PATIENT CARE DO YOU PROVIDE?
A. I -- A FEW PATIENTS OF ONGOING CARE DURING THEIR ENTIRE PREGNANCY. THE MAJORITY OF PREGNANT -- OF WOMEN AS CO-MANAGING THEIR CONSULTS, AND THEN PROVIDING PRENATAL DIAGNOSTIC SERVICES, WHICH INCLUDE ULTRASOUND AND AMNIOCENTESIS.
Q. WHAT IS AMNIOCENTESIS?
A. IT IS A PROCEDURE USED TO TRY TO DIAGNOSE A CHROMOSOME ABNORMALITY IN UTERO. WE TAKE A VERY SMALL NEEDLE UNDER

ULTRASOUND GUIDANCE, PLACE IT THROUGH THE INTERNAL ABDOMINAL WALL INTO THE UTERINE CAVITY WHERE THE AMNIOTIC FLUID IS; WITHDRAW SOME AMNIOTIC FLUID AND THEN REMOVE THE NEEDLE.

THE AMNIOTIC FLUID THEN CAN BE TESTED FOR A VARIETY OF THINGS, PARTICULARLY IN THESE SITUATIONS THE CHROMOSOMES OF THE FETUS.

Q. DO ALL OB/GYN'S REGULARLY PERFORM AMNIOCENTESES?

A. ALL OB/GYN'S ARE TRAINED INITIALLY IN THEIR RESIDENCY TO DO AN AMNIOCENTESIS. THE VAST MAJORITY OF GENERAL OB/GYN'S DO NOT PERFORM AMNIOCENTESES REGULARLY IN THEIR PRACTICE.

IN THE STATE OF CALIFORNIA, THE AFP PROGRAM HAS KIND OF DE FACTO MADE IT THAT ONLY PERINATOLOGISTS PERFORM GENETIC AMNIOCENTESES. THE AFP PROGRAM IS A PROGRAM USED TO TRY TO DETECT CERTAIN BIRTH DEFECTS AND KARYOTYPE ABNORMALITIES.

IT IS PERFORMED FROM A SERUM OR BLOOD TEST ON THE PATIENT. IF THE RESULTS ARE ABNORMAL SHE IS THEN REFERRED TO A CENTER CALLED A PRENATAL DIAGNOSTIC CENTER. THOSE CENTERS ARE VERY CLOSELY-REGULATED IN REGARDS TO THEIR ULTRASOUND ABILITIES AND THE OUTCOMES OR COMPLICATIONS THAT THEY HAVE WITH AMNIOCENTESES.

AND BY THIS MECHANISM IT IS KIND OF DE FACTO MADE THAT ONLY THE PERINATOLOGISTS WIND UP DOING GENETIC AMNIOCENTESIS IN CALIFORNIA.

Q. AND HOW MANY OF THOSE PRENATAL DIAGNOSTIC CENTERS ARE THERE IN SAN FRANCISCO, FOR EXAMPLE?

A. I THINK THERE ARE FOUR IN SAN FRANCISCO.
Q. DO YOU ALSO DO WHAT IS KNOWN AS CVS? FIRST, WHY DON'T YOU TELL THE COURT WHAT CVS IS?
A. CVS OR CHORIONIC VILLUS SAMPLING IS ANOTHER TYPE OF PROCEDURE TO DIAGNOSE KARYOTYPE OR CHROMOSOME ABNORMALITIES. IT IS BASICALLY A BIOPSY OF THE PLACENTA. IT IS DONE AT AN EARLIER GESTATIONAL AGE, AND I WAS NOT TRAINED TO DO THIS PROCEDURE IN MY FELLOWSHIP, SO I DO NOT DO IT.
Q. DO YOU PERFORM ABORTIONS IN THE SECOND-TRIMESTER?
A. YES.
Q. UNDER WHAT CIRCUMSTANCES?
A. THE CIRCUMSTANCES THAT I PROVIDE THE ABORTIONS ARE IN CONDITIONS OF MATERNAL DISEASE THAT COULD CERTAINLY WORSEN DURING THE COURSE OF A PREGNANCY. CONDITIONS THAT DEVELOP DURING A PREGNANCY THAT PUTS THE MATERNAL HEALTH POTENTIALLY TO WORSEN OR IN FETAL CONDITION -- FETAL ABNORMALITIES.
Q. OKAY. SO YOU DESCRIBED THREE CIRCUMSTANCES WHERE YOU MIGHT PERFORM AN ABORTION IN THE SECOND-TRIMESTER. I WOULD LIKE TO TALK BRIEFLY ABOUT EACH OF THOSE, IF I MIGHT.
COULD YOU GIVE US SOME EXAMPLES WHERE CONTINUING THE PREGNANCY WOULD COMPROMISE THE MOTHER'S HEALTH?
A. THERE ARE A LOT OF MEDICAL CONDITIONS THAT CAN ON DO IT SPECIFICALLY ONE IS SOMETHING CALLED EISENMENGER'S SYNDROME. THIS IS A MEDICAL CONDITION THAT IS DUE TO USUALLY A CONGENITAL HEART ABNORMALITY THAT ALLOWS COMMUNICATION OF BLOOD FROM THE

RIGHT SIDE OF THE HEART TO THE LEFT SIDE OF THE HEART.

THE NORMAL SITUATION IS THAT THE BLOOD PRESSURE IN THE PULMONARY VASCULATURE IS MUCH LOWER THAN THE BLOOD PRESSURE IN THE SYSTEMIC VASCULATURE. YOU GET A LITTLE BIT OF A SHUNT OF BLOOD TO THE LUNGS.

THAT IS NOT A BIG PROBLEM. HOWEVER, IT EVENTUALLY CAUSES THE PULMONARY VASCULAR PRESSURE TO INCREASE QUITE A BIT. WHEN YOU ADD PREGNANCY TO THE MIX IN THESE PATIENTS THAT HAVE THIS DISEASE THEIR SYSTEMIC PRESSURE DROPS DRAMATICALLY DURING PREGNANCY. IT'S A NORMAL PHENOMENA OF PREGNANCY. AND YOU CAN GET A REVERSAL OF THE SHUNT OF BLOOD, SO THE BLOOD WILL THEN GO FROM THE RIGHT TO THE LEFT WITHOUT GOING THROUGH THE LUNGS.

THE PATIENTS BECOME -- HAVE LESS AND LESS OXYGEN IN THEIR BLOOD, AND THIS BECOMES VERY DANGEROUS. IN THE OBJECT DISTRIBUTING LITERATURE, THE MORTALITY OF THIS DISEASE IN PREGNANCY IS 50 PERCENT. HOWEVER, IT'S POORLY DONE RETROSPECTIVE KIND OF CASE SERIES.

IN THE EXPERIENCE OF APPROXIMATELY -- PROBABLY THE LAST EIGHT PATIENTS THAT WE TOOK CARE OF AT UCSF WITH THIS CONDITION ALL OF THE WOMEN DIED POSTPARTUM.

THE COURT: WHAT WAS THE CONDITION AGAIN?

THE WITNESS: EISENMENGER'S SYNDROME.

BY MS. PARKER:

Q. AND WHAT IS "POSTPARTUM"?

A. AFTER DELIVERY.

Q. COULD YOU GIVE US SOME EXAMPLES OF SOME OF THE FETAL ABNORMALITIES THAT YOU SEE COMPLICATE PREGNANCY OR MIGHT SUGGEST AN ABORTION IN THE SECOND-TRIMESTER?

A. THE MOST COMMON I SEE ARE KARYOTYPE OR CHROMOSOME ABNORMALITIES. THOSE COULD BE TRISOMY 21, WHICH IS DOWN'S SYNDROME. TRISOMY 21. TRISOMY 18 OR TRISOMY 13. THESE ARE THE MOST COMMON CHROMOSOME ABNORMALITIES THAT I SEE.

THERE ARE OTHER STRUCTURAL FETAL ABNORMALITIES, SUCH AS CONGENITAL HEART DISEASE, DIAPHRAGMATIC HERNIA OR SPINA BIFIDA.

Q. AND HOW LATE DO YOU PERFORM ABORTIONS?

A. I PERFORM ABORTIONS TO AN EQUIVALENT OF 23.1 WEEKS GESTATIONAL AGE.

Q. HOW DO YOU MEASURE THAT?

A. I MEASURE THAT BY THE BIPARIETAL DIAMETER, WHICH IS AN ULTRASOUND MEASUREMENT OF THE FETAL HEAD. AND MY CUTOFF IS 56 MILLIMETERS.

Q. WHY DO YOU NOT GO BEYOND 23.1 WEEKS GESTATIONAL AGE?

A. IN MY TRAINING WHEN I LEARNED THE PROCEDURES I WASN'T TRAINED TO GO BEYOND THIS SIZE OF A FETAL HEAD.

Q. WHAT METHODS OF ABORTION DO YOU USE IN THIS SECOND-TRIMESTER?

A. I USE DILATION AND EVACUATION AND INDUCTION OF LABOR.

Q. AND WHAT IS THE BREAKDOWN OF THOSE TWO TYPES, APPROXIMATELY?

A. APPROXIMATELY 75 PERCENT D&E AND 25 PERCENT INDUCTION.

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

THE COURT: YES.

BY MS. PARKER:

Q. DR. DOE, I HAVE SHOWN YOU WHAT HAS BEEN MARKED AS EXHIBIT 32. DO YOU SEE THAT?

A. YES.

Q. IS THAT YOUR CURRICULUM VITAE?

A. YES.

Q. IS THE INFORMATION IN IT CURRENT?

A. YES.

Q. IS IT TRUE AND CORRECT?

A. YES.

MS. PARKER: YOUR HONOR, I WOULD LIKE TO OFFER 32 INTO EVIDENCE.

THE COURT: ALL RIGHT. ANY OBJECTION?

MR. QUINLIVAN: NO OBJECTION, YOUR HONOR. I -- WELL --

THE COURT: THE COPY I HAVE HAS NOT BEEN REDACTED.

MS. PARKER: HAS NOT BEEN REDACTED?

THE COURT: NO.

MR. QUINLIVAN: THAT WAS MY CONCERN. I DID NOT KNOW: WAS THIS A REDACTED VERSION OR NOT?

MS. PARKER: YES. WE WILL SUBSTITUTE WITH A REDACTED VERSION. I APOLOGIZE. I THOUGHT WE HAD.

THE COURT: ACTUALLY, I AM NOT EVEN SURE THE REDACTED VERSION GIVES ENOUGH INFORMATION THAT IT IS EVEN -- YOU WILL NEED TO ADMIT IT INTO EVIDENCE. YOU ALL HAVE STIPULATED TO HIS BASIC QUALIFICATIONS. I DON'T SEE THAT YOU NEED TO HAVE --

MS. PARKER: THE C.V. INTO EVIDENCE?

THE COURT: -- THE C.V. INTO EVIDENCE.

MS. PARKER: THEN, WE WON'T DO THAT.

THEN, WE WILL MOVE TO QUALIFY DR. DOE AS AN EXPERT WITNESS IN THE AREAS OF OBSTETRICS AND GYNECOLOGY, PERINATOLOGY AND ABORTION PRACTICE AND PROCEDURE.

THE COURT: ANY OBJECTION?

MR. QUINLIVAN: NO OBJECTION, YOUR HONOR.

THE COURT: IT WILL BE ACCEPTED.

BY MS. PARKER:

Q. DR. DOE, HAVE YOU EVER TESTIFIED AS AN EXPERT BEFORE IN A CASE INVOLVING ABORTION?

A. NO.

Q. ARE YOU BEING COMPENSATED FOR PROVIDING EXPERT TESTIMONY IN THIS CASE?

A. NO.

Q. DO YOU HAVE ANY AFFILIATION WITH PLANNED PARENTHOOD?

A. NO.

Q. SO I WANT TO GO BACK AND TALK A LITTLE BIT ABOUT SOME OF THE CONDITIONS THAT YOU TREAT. DO YOUR PATIENTS EVER CHOOSE TO

END THEIR PREGNANCY DUE TO A MATERNAL HEALTH CONDITION?
A. YES, THEY DO.
Q. AND DOES THIS SOMETIMES ARISE WHEN MEDICAL CONDITIONS -- WITH MEDICAL CONDITIONS THAT A WOMAN HAD BEFORE BECOMING PREGNANT?
A. YES.
Q. I KNOW YOU GAVE US AN EXAMPLE OF EISENMENGER'S SYNDROME. ARE THERE OTHER EXAMPLES YOU COULD PROVIDE?
A. OTHER EXAMPLES WOULD BE PRIMARY PULMONARY HYPERTENSION, AGAIN, CAN LEAD TO SOME OF THE SAME PROBLEMS WHERE THE PULMONARY VASCULATURE HAS VERY HIGH BLOOD PRESSURE LEADING TO LOW OXYGEN IN THE BLOOD AND HIGH RISK OF MORTALITY.

ANOTHER CONDITION WOULD BE TYPE I DIABETES WITH MULTIPLE VASCULAR COMPLICATIONS. AND WHAT I MEAN BY THAT IS THAT THEIR KIDNEYS ARE AFFECTED AND DON'T HAVE NORMAL KIDNEY FUNCTION, OR THEY HAVE KIDNEY -- THEY WON'T HAVE NORMAL KIDNEY FUNCTION, OR IMPAIRED VISION, BECAUSE THE DIABETES HAS AFFECTED THE BLOOD VESSELS THAT SUPPLY BLOOD TO THE EYES.

Q. AND ARE THERE ANY OTHERS THAT YOU CAN THINK OF, CONDITIONS THAT A WOMAN HAS BEFORE SHE BECOMES PREGNANT?
A. NONE RIGHT NOW.
Q. OKAY. AND WOULD THE PATIENT KNOW SHE HAS THESE DISEASES BEFORE SHE BECAME PREGNANT?
A. THE PATIENT MAY KNOW THIS OR MAY NOT KNOW THAT SHE HAS THESE DISEASES, DEPENDING ON HER ACCESS TO CARE AND HOW OFTEN

SHE'S SEEN A PHYSICIAN AND WHETHER THE PHYSICIAN HAS NECESSARILY PICKED UP ON THESE PROBLEMS OR NOT.

Q. IF SHE CHOSE TO TERMINATE THE PREGNANCY, WHEN IN THE PREGNANCY WOULD SHE MAKE THAT DECISION, TYPICALLY?

A. WELL, I MEAN, IDEALLY IT WOULD BE AS SOON AS POSSIBLE, BECAUSE THE ONGOING PROCESS COULD CONTINUE TO EFFECT THE DISEASE. BUT OFTEN THESE DECISIONS AREN'T -- OR DISEASES AND REFERRALS AREN'T MADE UNTIL THE SECOND-TRIMESTER.

Q. ARE PATIENTS SOMETIMES FORCED TO -- OR ARE PATIENTS SOMETIMES CHOOSE TO END A PREGNANCY DUE TO A MEDICAL CONDITION THAT IS CREATED BY THE PREGNANCY?

A. YES.

Q. AND COULD YOU GIVE US SOME EXAMPLES OF THOSE?

A. IT WOULD BE RARE, HOWEVER. SEVERE PREECLAMPSIA IS SOMETHING THAT COULD PRESENT IN THE SECOND-TRIMESTER. THEN CERVICAL INCOMPETENCE, THE PREMATURE RUPTURE OF MEMBRANES, TO OTHER CONDITIONS.

Q. WHAT IS PREECLAMPSIA?

A. PREECLAMPSIA IS A DISEASE OF PREGNANCY THAT IS PROBABLY DUE TO A PLACENTAL ABNORMALITY. IT MANIFESTS ITSELF BY HYPERTENSION IN THE PATIENT, AS WELL AS PROTEIN IN THE URINE, AND CAN THEN EFFECT ALL ORGAN SYSTEMS WITHIN THE BODY.

Q. AND IS IT FAIRLY SERIOUS, PREECLAMPSIA?

A. YES, IT IS VERY SERIOUS. AND PRETTY MUCH PRENATAL CARE WAS DEVELOPED TO DIAGNOSE PREECLAMPSIA. THE WHOLE REASON THAT --

IF YOU KNOW AT MANY PRENATAL VISITS YOU HAVE YOUR BLOOD PRESSURE TAKEN AND YOU GIVE A URINE SAMPLE IT IS ALL TO BE ABLE TO PICK UP PREECLAMPSIA.

Q. WHAT HAPPENS IF PREECLAMPSIA IS NOT DIAGNOSED?

A. IF PREECLAMPSIA IS NOT DIAGNOSED IT COULD LEAD TO KIDNEY FAILURE, RUPTURE OF THE LIVER, A SEIZURE AND ULTIMATELY DEATH.

Q. AND YOU INDICATED THAT PREECLAMPSIA SOMETIMES ARISES IN THE SECOND-TRIMESTER?

A. CORRECT.

Q. AND WHEN THAT OCCURS WHAT CHOICES DOES THE PREGNANT WOMAN FACE?

A. IT REALLY DEPENDS AT WHAT POINT IN THE SECOND-TRIMESTER, BUT IF IT IS CERTAINLY BEFORE VIABILITY, IT IS UNLIKELY AND UNSAFE TO TRY TO CONTINUE THE PREGNANCY TO VIABILITY, AND REALLY THE ONLY CHOICE IS TERMINATION OF THE PREGNANCY.

Q. YOU INDICATED ANOTHER EXAMPLE WAS CERVICAL INCOMPETENCE OF A CONDITION THAT IS CREATED BY THE PREGNANCY ITSELF. WHAT IS CERVICAL INCOMPETENCE?

A. THE CERVICAL INCOMPETENCE IS THAT THE CERVIX IS UNABLE TO KIND OF HOLD AND MAINTAIN THE PREGNANCY, PER SE. THE CERVIX IS STRUCTURALLY WEAKER, FOR SOME REASON, AND WILL JUST KIND OF, WITHOUT PAIN OR CONTRACTIONS, DILATE AND OPEN UP. AND USUALLY THESE CAN LEAD TO EXTREMELY PREMATURE DELIVERY, OR COULD LEAD TO A SUBSEQUENT OTHER PROBLEM WAS PREMATURE RUPTURE OF THE MEMBRANES.

Q. AND WHAT HAPPENS IF CERVICAL INCOMPETENCE OCCURS IN THE SECOND-TRIMESTER? WHAT CHOICES DOES THE PREGNANT WOMAN FACE?
A. THE CHOICES INVOLVE KIND OF WHAT WE CALL EXPECTANT MANAGEMENT, KIND OF PUTTING THE PERSON TO BED AND HOPING THAT THE PREGNANCY DOESN'T KIND OF PROCEED TO GO ON TO DELIVER. BUT IT IS HIGH RISK OF DELIVERING A FETUS THAT'S EXTREMELY PREMATURE.

ANOTHER OPTION IS SOMETHING CALLED A "RESCUE CERCLAGE" IN WHICH WE TRY TO PUT A STITCH INTO THE CERVIX AND CLOSE IT UP.

IN THE SITUATION WHERE THE CERVIX IS ALREADY DILATED FROM CERVICAL INCOMPETENCE AND DOING THIS AFTER THE FACT RATHER THAN AS A PROPHYLACTIC MEASURE, THE RESULTS ARE PRETTY DISMAL WITH THE RESCUE CERCLAGE.

AND THEN, THE FINAL CHOICE WOULD BE A TERMINATION OF PREGNANCY.

Q. ARE THEIR RISK FACTORS FOR WOMEN WHO HAVE CERVICAL INCOMPETENCE?
A. YES. THEY INCLUDE WOMEN WHOSE MOTHERS TOOK DES. IT IS A MEDICATION THAT WAS A HOPE TO TRY TO DECREASE THE CHANCE OF MISCARRIAGE. HOWEVER, IN THE FEMALE OFFSPRING OF WOMEN WHO TOOK THIS MEDICATION, THEY ARE AT HIGHER RISK FOR A NUMBER OF GYNECOLOGIC COMPLICATIONS: CERVICAL INCOMPETENCE IS ONE OF THOSE.

OTHER KNOWN RISK FACTORS ARE GREATER THAN THREE

SECOND-TRIMESTER TERMINATIONS AND CERTAIN COLLAGEN VASCULAR DISEASES COULD PUT THE PATIENT AT RISK FOR CERVICAL INCOMPETENCE.

Q. AND ARE THERE WOMEN WHO HAVE NO RISK FACTORS WHO DEVELOP CERVICAL INCOMPETENCE?

A. YES.

Q. IS THAT A MAJORITY OF THE CASES OR NOT?

MR. QUINLIVAN: OBJECTION, LEADING.

THE COURT: OVERRULED.

THE WITNESS: I WOULD SAY MOST PATIENTS YOU CAN IDENTIFY SOME RISK FACTOR, BUT THERE IS A CONSIDERABLE NUMBER OF PATIENTS THAT HAVE NO RISK FACTORS WHATSOEVER.

BY MS. PARKER:

Q. AND I THINK THE THIRD EXAMPLE YOU GAVE US OF A HEALTH CONDITION THAT CAN DEVELOP DURING PREGNANCY THAT MIGHT CAUSE A WOMAN TO CHOOSE TO TERMINATE THE PREGNANCY WAS PREMATURE RUPTURE OF THE MEMBRANES; IS THAT RIGHT?

A. YES.

Q. AND COULD YOU DESCRIBE FOR US WHAT THAT IS?

A. THAT HAPPENS WHEN THE AMNIOTIC MEMBRANES HAVE A HOLE RUPTURE IN THEM, AND THE AMNIOTIC FLUID LEAKS OUT. THIS PUTS THE PATIENT AT CONSIDERABLE RISK FOR INFECTION AND POTENTIALLY VERY SEVERE INFECTION. RESULTS IN TRYING TO MAINTAIN THE PREGNANCY AT THIS POINT ARE KIND OF UNIFORMLY DISMAL. THE USUAL RECOMMENDATION IS FOR BOTH MATERNAL HEALTH AND FOR THE

POOR POTENTIAL OUTCOMES FOR THE FETUS IS TO TERMINATE THE PREGNANCY.

Q. WHAT IS THE GENERAL TIME FRAME THAT THESE THREE CONDITIONS THAT YOU'VE TALKED ABOUT MANIFEST THEMSELVES?

A. ALL IN THE SECOND-TRIMESTER.

Q. AND IF A PREGNANCY TERMINATION WERE INDICATED FOR THEIR CONDITIONS, WHEN WOULD THAT PREGNANCY TERMINATION OCCUR?

A. IN THE SECOND-TRIMESTER.

Q. DO YOUR PATIENTS EVER CHOOSE TO END THEIR PREGNANCY DUE TO A FETAL ANOMALY?

A. YES.

Q. CAN YOU GIVE US SOME EXAMPLES OF THOSE?

A. I WOULD SAY THE FIRST EXAMPLE IS A CATEGORY OF CHROMOSOME ABNORMALITIES, AND THESE INCLUDE TRISOMY 21, ALSO KNOWN AS DOWN'S SYNDROME; TRISOMY 18; TRISOMY 13. HOWEVER, THERE ARE A NUMBER OF OTHER FETAL CHROMOSOME ABNORMALITIES THAT ARE LESS COMMON THAT ARE SOMETIMES DIAGNOSED.

Q. ARE ANY OF THESE LETHAL?

A. YES, TRISOMY 18 AND TRISOMY 13 ARE CONSIDERED LETHAL.

Q. WHAT IS TRISOMY 18? HOW DOES THAT SHOW ITSELF?

A. TRISOMY 18 IS A CONDITION WHERE THERE IS THREE COPIES OF CHROMOSOME NUMBER 18. IT IS USUALLY -- WELL, NOT ALWAYS, BUT OFTEN CAN BE DIAGNOSED PRENATALLY BY KIND OF A MULTITUDE OF FETAL ABNORMALITIES THAT ARE -- THAT CAN BE SEEN, STRUCTURAL ABNORMALITIES THAT CAN BE SEEN ON ULTRASOUND, OFTEN PROMPTING

AMNIOCENTESIS.

ADDITIONALLY, THE AFP TEST HELPS SCREEN FOR TRISOMY 18, SO YOU CAN IDENTIFY SOME WOMEN WHO MIGHT BE AT HIGHER RISK FOR THIS, AND THEN WARRANT THE AMNIOCENTESIS.

Q. AND HOW DOES -- WHAT ABOUT TRISOMY 13?

A. TRISOMY 13, THERE'S NOT A BLOOD TEST THAT HELPS SCREEN FOR IT, BUT USUALLY THE FETUS HAS STRUCTURAL ABNORMALITIES THAT ARE CONSISTENT WITH THE CONDITION.

Q. YOU INDICATED THERE WERE ADDITIONAL FETAL ABNORMALITIES IN ADDITION TO THE CHROMOSOMAL ONES YOU JUST MENTIONED?

A. YES. THOSE CAN BE IDENTIFIED, I GUESS, AS STRUCTURAL ABNORMALITIES. THOSE INCLUDE CONGENITAL HEART DISEASE. NOW, SOME ASPECTS OF CONGENITAL HEART DISEASE ARE VERY MILD AND CAN BE VERY NORMAL, WHILE OTHERS ARE VERY SEVERE AND MAY DIE OR HAVE A VERY, VERY DIFFICULT LIFE WITH MULTIPLE HOSPITALIZATIONS AND SICK THEIR ENTIRE LIFE.

A CONDITION CALLED "CONGENITAL DIAPHRAGMATIC HERNIA" IS A SITUATION WHERE THE DIAPHRAGM DOESN'T FORM APPROPRIATELY, AND LIVER AND INTESTINES CAN BE UP INTO THE CHEST. THIS DOES NOT ALLOW THE LUNGS TO DEVELOP APPROPRIATELY, AND IT IS VERY HIGH, HIGH LIKELIHOOD OF DEATH AT DELIVERY. OR IF THE INFANTS DO SURVIVE, THEY HAVE MULTIPLE, MULTIPLE MEDICAL PROBLEMS AND REQUIRE MULTIPLE SURGERIES, LONG STAYS IN HOSPITALIZATION, AND BASELINE INTELLIGENCE IS SIGNIFICANTLY DECREASED.

Q. IN ADDITION TO CONGENITAL HEART DISEASE AND CONGENITAL

DIAPHRAGMATIC HERNIA, ARE THERE ANY OTHER STRUCTURAL ABNORMALITIES?

A. ONE OF THE OTHER OR TWO MOST COMMON ONES ARE NEURAL TUBE DEFECTS, WHICH COULD BE -- ANENCEPHALY IS ON ONE SPECTRUM IS WHERE A BRAIN DOESN'T APPROPRIATELY DEVELOP. AND THERE IS DEVELOPMENT OF THE CRANIUM UP TO THE LEVEL OF THE EYES, WITH NOTHING BEYOND THAT.

THERE IS A BRAIN STEM, BUT NO MORE BRAIN TISSUE AND THEY HAVE NO HIGHER FUNCTIONING WHATSOEVER. AS WELL AS ANOTHER TYPE OF NEURAL TUBE DEFECT IS SOMETHING CALLED "SPINA BIFIDA" WHERE THERE IS AN OPENING OR SPLAYING OF THE SPINE THAT ALLOWS THE EXPOSURE OF THE SPINAL CORD. AND OFTEN THE PATIENTS ARE PARALYZED FROM THAT LEVEL DOWNWARDS.

Q. ARE ANY OF THESE STRUCTURAL ANOMALIES LETHAL OR POTENTIALLY FATAL TO THE FETUS?

A. SOME OF THEM CAN BE LETHAL, YES, AND MANY OF THEM ARE ASSOCIATED WITH DECREASED LIFE EXPECTANCY FOR THE INFANT, AS WELL AS MAJOR DIFFICULTIES KIND OF GROWING UP AND HOSPITALIZATIONS, MULTIPLE INFECTIONS, OTHER SUCH THINGS.

Q. SO IN ADDITION TO THE TRISOMIES, AND THEN THE STRUCTURAL ANOMALIES, ARE THERE ANY OTHER TYPE OF FETAL ANOMALIES?

A. THERE ARE OTHER FETAL ABNORMALITIES THAT I GUESS WE CAN COIN KIND OF AS GENETIC, THAT THERE IS A PARTICULAR SINGLE GENE THAT IS MISSING.

EXAMPLES OF THESE ARE SOMETHING CALLED TAY-SACHS

DISEASE OR CANAVAN'S DISEASE.

ANOTHER EXAMPLE IS SOMETHING CALLED SPINAL MUSCULAR ATROPHY. MANY OF THESE ARE DEGENERATIVE, NEUROLOGIC CONDITIONS. THE FETUS IS BORN ALIVE, HOWEVER EVENTUALLY THE INFANTS STOPS MAKING ITS MILESTONES, AND THEN KIND OF DETERIORATES AND ULTIMATELY DIES.

Q. AND YOU INDICATED THESE WERE GENETIC DISEASES. ARE THEY SEEN IN CERTAIN POPULATION GROUPS?

A. THEY ARE OFTEN IN SOME POPULATION GROUPS THAT HAVE HIGHER RISKS OF AUTOSOMAL RECESSIVE DISEASES. AND THIS IS WHERE BOTH PARENTS ARE CARRIERS FOR A PARTICULAR GENE AND YOU HAVE TO BE MISSING BOTH COPIES OF THE GENE FOR THE DISEASE TO MANIFEST.

A POPULATION SUCH AS THE ASHKENAZI JEWS ARE ONE THAT IS AT PARTICULARLY HIGHER RISK FOR TAY-SACHS AND CANAVAN'S DISEASE.

FRENCH CANADIANS ARE AT HIGHER RISK FOR TAY-SACHS, AS WELL. THERE ARE GENES THAT EFFECT HEMOGLOBIN, WHICH IS THE BLOOD-CARRYING MOLECULES. AND IN POPULATIONS, MEDITERRANEAN AND AFRICAN POPULATIONS, AS WELL AS ASIAN POPULATIONS, THEY ARE AT HIGHER RISK TO HAVE THALASSEMIA.

Q. IN WHAT GENERAL TIME FRAME OF PREGNANCY ARE ABORTIONS FOR FETAL CONDITIONS TYPICALLY PERFORMED?

A. THEY ARE TYPICALLY PERFORMED IN THE SECOND-TRIMESTER.

Q. WHY IS THAT?

A. BECAUSE DIAGNOSIS ISN'T MADE UNTIL THE SECOND-TRIMESTER.

Q. HOW IS DIAGNOSIS DONE FOR THESE VARIOUS FETAL ABNORMALITIES?

A. THE CHROMOSOME ABNORMALITIES ARE DONE BY AMNIOCENTESIS OR CHORIONIC VILLUS SAMPLING.

THE STRUCTURAL ABNORMALITIES ARE DIAGNOSED BY ULTRASOUND. AND THAT ULTRASOUND REALLY NEEDS TO BE PERFORMED IN THE SECOND-TRIMESTER BECAUSE IT IS JUST TOO DIFFICULT TO SEE SOME OF THESE STRUCTURES AT AN EARLIER GESTATIONAL AGE.

Q. SO WHEN YOU ARE DOING THE ULTRASOUND DIAGNOSIS FOR THE STRUCTURAL ABNORMALITY, APPROXIMATELY WHEN DOES THAT ULTRASOUND HAPPEN?

A. USUALLY BETWEEN 18 AND 20 WEEKS GESTATION.

Q. AND WHEN YOU USE ULTRASOUND, CAN YOU DO A COMPLETE DIAGNOSIS OF THE STRUCTURAL ABNORMALITY?

A. SOMETIMES YOU CAN. SOMETIMES YOU CAN'T.

Q. IF YOU CAN'T, DO YOU NEED TO DO ANY ADDITIONAL DIAGNOSIS?

A. SOMETIMES AMNIOCENTESIS IS DONE. THERE ARE CONDITIONS SOMETIMES THAT WE KNOW THAT THIS IS A VERY SEVERE CONDITION, BUT WE DON'T HAVE THE EXACT DIAGNOSIS. WITHOUT HAVING THE EXACT DIAGNOSIS WE CAN'T GIVE A RECURRENCE RISK. AND WE MIGHT RECOMMEND A FETAL AUTOPSY BE DONE.

Q. LET'S TALK FOR A MOMENT ABOUT THE AMNIOCENTESIS. YOU INDICATED THAT WAS ANOTHER DIAGNOSTIC TOOL THAT YOU USE TO DETERMINE A CHROMOSOMAL ANOMALY; IS THAT RIGHT?

A. YES.

Q. AND WHEN IS AMNIOCENTESIS TYPICALLY DONE?
A. TYPICALLY DONE BETWEEN 15 AND 20 WEEKS GESTATION.
Q. AND HOW LONG DOES IT TAKE TO GET THE RESULTS?
A. APPROXIMATELY SEVEN TO 14 DAYS.
Q. AND DOES AMNIOCENTESIS PRESENT ANY SPECIAL RISKS TO THE PREGNANT WOMAN?
A. YEAH. THE RISKS OF AMNIOCENTESIS AS KIND OF WITH ANY PROCEDURE ARE BLEEDING AND INFECTION, AND IN THIS SITUATION, ALSO, KIND OF LOSS OF THE PREGNANCY.
Q. DO YOU TYPICALLY DO AMNIOCENTESIS ON EVERY PREGNANT WOMAN?
A. NO. YOU COULD ARGUE MAYBE BE OFFERED FOR EVERY PREGNANT WOMAN, BUT IT IS TYPICALLY OFFERED TO WOMEN THAT APPEAR TO BE AT HIGHER RISK FOR THESE PROBLEMS. IT'S BEEN IN THE UNITED STATES KIND OF AGE 35 AND BEYOND.

BUT IF WE ALSO DIAGNOSE AN ABNORMALITY IN ULTRASOUND OR THEIR BLOOD AFP TEST IS ABNORMAL, THE PATIENT IS REFERRED TO GENETIC COUNSELING AND TALKING ABOUT THE RISKS OF HAVING ONE OF THESE ABNORMALITIES AND THE RISKS OF THE PROCEDURES. AND THEN, THEY DECIDE WHETHER THEY WANT TO PROCEED WITH THE PROCEDURE.
Q. ARE THERE ANY FETAL ANOMALIES OF THE ONES YOU HAVE TALKED ABOUT OR OTHERS THAT WILL ACTUALLY INCREASE THE RISKS OF PREGNANCY?
A. THERE IS ONE PARTICULAR CHROMOSOME ABNORMALITY THAT COULD INCREASE THE RISK OF PREECLAMPSIA AT A VERY EARLY GESTATIONAL AGE, AND THIS IS CALLED TRIPLOIDY.

Q. AND WHAT HAPPENS WITH TRIPLOIDY? WHY DON'T YOU FIRST TELL US WHAT TRIPLOIDY IS?

A. TRIPLOIDY IS THAT YOU HAVE A KARYOTYPE OF 69XXY. SO YOU HAVE AN EXTRA KIND OF PATH TO THE KARYOTYPE, SO IT IS WAY TOO MANY. YOU HAVE PLACENTA AND FETAL ABNORMALITIES, AND YOU HAVE VERY LARGE PLACENTA. AND IT APPEARS TO BE, FOR SOME REASON WE DON'T UNDERSTAND, A MUCH HIGHER RISK OF DEVELOPMENT OF PREECLAMPSIA, AND USUALLY DEVELOPMENT OF PREECLAMPSIA IN THE SECOND-TRIMESTER.

Q. AND WHAT -- WHEN THAT HAPPENS, WHAT IS THE GENERAL RECOMMENDED COURSE?

A. TERMINATION OF PREGNANCY.

Q. AND WHY IS THAT?

A. BECAUSE THE FETUS ISN'T NORMAL, FOR ONE. AND FOR NUMBER TWO, THAT THE PREECLAMPSIA WILL PROCEED AND THE POTENTIAL COMPLICATIONS OF THE PREECLAMPSIA ARE VERY SEVERE, AS I HAD MENTIONED EARLIER.

Q. NOW, YOU INDICATED THAT YOU CURRENTLY USE TWO METHODS OF ABORTION IN THE SECOND-TRIMESTER; IS THAT RIGHT?

A. YES.

Q. I THINK THE FIRST ONE YOU MENTIONED WAS A D&E?

A. CORRECT.

Q. DILATION AND EVACUATION. WHAT IS YOUR GOAL IN PERFORMING A D&E ABORTION?

A. MY GOAL IS TO DO THE PROCEDURE AS SAFELY AS I CAN FOR THE

WOMAN.
Q. AND HOW DO YOU ACHIEVE THAT?
A. I ACHIEVE THAT BY TRYING TO MAKE AS FEW PASSES INTO THE UTERUS.
Q. WHY IS THAT?
A. BECAUSE WE KNOW THAT THE MAJOR RISKS OF THE PROCEDURE ARE ASSOCIATED -- ARE INFECTION, BLEEDING, UTERINE PERFORATION. AND BY MAKING A PASS WITH THESE INSTRUMENTS INTO THE UTERUS THAT IS WHEN YOU ARE AT RISK FOR HAVING THESE COMPLICATIONS.
THE MORE TIMES YOU HAVE TO GO INTO THE UTERUS, THE HIGHER CHANCE THERE IS OF A COMPLICATION.
Q. WHAT DO YOU BASE THAT OPINION ON, THAT YOU WANT TO DO IT AS FEW PASSES AS POSSIBLE?
A. COMMON SENSE, EXPERIENCE, AND I GUESS EXTRAPOLATION FROM OTHER STUDIES THAT WE KNOW OF, A CERTAIN PROCEDURE CAUSES THE POTENTIAL RISK OF SOMETHING. THE MORE YOU DO THAT, THE HIGHER THE CHANCE OF THAT COMPLICATION.
Q. CAN YOU DESCRIBE FOR US HOW YOU PERFORM A D&E PROCEDURE? AND ACTUALLY, BEFORE YOU DO THAT, WOULD IT BE HELPFUL IF YOU USED A PICTURE OF A --
A. YES.
Q. -- OF THE ANATOMY?
A. YES, I THINK SO.
MS. PARKER: MAY I APPROACH THE WITNESS, YOUR HONOR?
THE COURT: YES.

THE WITNESS: FIRST OF ALL, WE WILL COUNSEL THE PATIENT REGARDING HER OPTIONS AND WHAT SHE WANTS TO DO WITH THE PROCEDURE. WE TALK ABOUT THE RISK AND BENEFITS, AND I ALSO TALK ABOUT THE RISK AND BENEFITS OF INDUCTION OF LABOR, DEPENDING ON WHAT THE EXACT INDICATION FOR THE PREGNANCY TERMINATION IS.

USUALLY A DAY PRIOR TO THE PROCEDURE, THEN, IF SHE WISHES TO PROCEED, WE DO A PLACEMENT OF LAMINARIA. AND WE PUT A SPECULUM WITHIN THE VAGINA WHICH OPENS UP AND ALLOWS US TO VISUALIZE THE CERVIX, WHICH IS RIGHT HERE (INDICATING).

WE PLACE THE LAMINARIA, WHICH ARE KIND OF OSMOTIC DILATORS, INTO THE CERVIX AFTER WASHING IT OFF WITH AN IODINE SOAP AND PUTTING SOME LOCAL ANESTHESIA INTO THE CERVIX.

THE FOLLOWING DAY THE PATIENT WOULD COME, IN MY SITUATION, TO THE HOSPITAL. SHE WOULD MEET THE PREOPERATIVE NURSE. SHE WOULD MEET THE ANESTHESIOLOGIST. SHE WOULD HAVE AN IV STARTED. SHE WOULD HAVE SOME BLOOD WORK DRAWN.

I WOULD MEET AGAIN WITH THE PATIENT TO MAKE SURE SHE DIDN'T HAVE ANY QUESTIONS PRIOR TO THE PROCEDURE. AND THEN, SHE WOULD BE TAKEN TO THE OPERATING ROOM.

BY MS. PARKER:

Q. BEFORE WE GO THERE, I HAVE COUPLE OF QUESTIONS ABOUT THE LAMINARIA. HOW MANY, TYPICALLY, DO YOU USE, LAMINARIA?

A. IT DEPENDS ON THE GESTATIONAL AGE OF THE FETUS AND ON WHETHER OR NOT THE PATIENT'S HAD A VAGINAL DELIVERY BEFORE.

Q. AND WHAT IS THE FACTORS WITH GESTATION AGE? IS IT MORE OR LESS?
A. THE BIGGER THE GESTATIONAL AGE, THE OLDER THE FETUS IS, THE BIGGER THE FETUS IS GOING TO BE, THE MORE DILATATION I AM GOING TO NEED. THAT MEANS THE MORE LAMINARIA I AM GOING TO PUT IN.
Q. DO YOU EVER USE A SECOND SET OF LAMINARIA?
A. SOMETIMES I USE A SECOND SET OF LAMINARIA, DEPENDING AGAIN ON GESTATIONAL AGE AND HOW MANY I AM ABLE TO PLACE THE FIRST TIME.
Q. CAN YOU PREDICT THE AMOUNT OF DILATION YOU ARE GOING TO GET FROM THE LAMINARIA?
A. YOU CAN HAVE A VERY ROUGH PREDICTION, BUT MOST OF THE TIME I CAN'T PREDICT THAT WELL HOW MUCH DILATATION I AM GOING TO HAVE.

I THINK I HAVE -- I AM GOING TO KNOW ENOUGH TO COMPLETE THE PROCEDURE. WHETHER IT IS VERY DILATED OR JUST ENOUGH TO DO THE PROCEDURE, I THINK IS VERY, VERY HARD FOR ME TO BE ABLE TO PREDICT.

Q. SO YOU INDICATED THE WOMAN COMES BACK 24 HOURS LATER. DOES SHE STAY IN THE HOSPITAL FOR THE FIRST 24-HOUR PERIOD?
A. NO, SHE DOESN'T. SHE HAS THE LAMINARIA PLACED, AND THEN SHE IS ABLE TO GO HOME.
Q. SO YOU INDICATED SHE COMES BACK ON THE SECOND DAY, AND THEN WHAT HAPPENS?
A. SHE COMES BACK THE SECOND DAY. AGAIN, SHE'S MET THE NURSE,

THE ANESTHESIOLOGIST, ASKED ANY OTHER QUESTIONS THAT SHE HAS.

SHE IS THEN -- WE MAKE SURE SHE IS THE CORRECT PATIENT. SHE IS THEN TAKEN TO THE OPERATING ROOM, AND SHE'S GIVEN A GENERAL ANESTHETIC.

NEXT, THE PATIENT IS PLACED IN STIRRUPS, AND THEN A -- HER PERINEUM, PART ON THE OUTSIDE OF THE VAGINA AND LEGS ARE PREPPED WITH A BETADINE SOLUTION.

NEXT, THE SPECULUM IS PLACED AGAIN WITHIN THE VAGINA. I REMOVE THE LAMINARIA THAT HAVE BEEN THERE PREVIOUSLY AND MAKE SURE THE DILATATION IS ADEQUATE FOR THE PROCEDURE.

I AGAIN PREP BOTH THE VAGINA AND CERVIX WITH THIS IODINE SOAP.

NEXT, I ADMINISTER A MEDICATION CALLED VASOPRESSIN, WHICH IS A VASOCONSTRICTING AGENT THAT WILL HELP DECREASE BLOOD LOSS, AND I GIVE THIS INJECTION INTO THE CERVIX.

I USE ULTRASOUND WHEN I DO THE PROCEDURE, SO I HAVE CONTINUOUS ULTRASOUND WATCHING WHILE I DO THE PROCEDURE BECAUSE I THINK IT DECREASES THE RISK OF UTERINE PERFORATION. AND THAT IS HOW I WAS TRAINED.

NEXT, A SUCTION CANNULA IS PLACED WITHIN THE CERVIX UP INTO THE FUNDUS OF THE UTERUS, AND THEN THERE IS KIND OF A TURN OF THE WRIST AND THE AMNIOTIC FLUID IS THEN ASPIRATED.

Q. WHAT DO YOU MEAN BY "ASPIRATED?

A. THE CANNULA IS ATTACHED TO A SUCTION MACHINE. IT IS KIND OF -- THE AMNIOTIC FLUID IS THEN SUCKED OUT.

NEXT, I PROCEED WITH USING A FORCEPS INSTRUMENT CALLED A BIERER FORCEPS, USUALLY, TO EXTRACT THE FETAL TISSUE.

UPON COMPLETION OF THE PROCEDURE, THAT I MAKE SURE THAT ALL FETAL PARTS ARE PRESENT, AND I MAKE SURE THAT THE PLACENTA IS REMOVED.

I WATCH TO SEE IF THERE IS ANY CONTINUED BLEEDING, EITHER FROM THE CERVIX OR ABOVE THE CERVIX FROM THE UTERUS. ONCE I AM SURE THAT THERE IS NO FURTHER BLEEDING, AN INSTRUMENT, WHICH I FORGOT TO MENTION, THAT IS PUT ON THE ANTERIOR OF THE CERVIX, CALLED A "TENACULUM" TO KIND OF HELP HOLD IT IN PLACE, I REMOVE THAT. AND I REMOVE THE SPECULUM. THE PATIENT IS WOKEN UP AND TAKEN TO THE RECOVERY ROOM.

Q. DO YOU EVER USE MISOPROSTOL, AND WHAT IS MISOPROSTOL?

A. MISOPROSTOL IS A MEDICATION THAT CAN BE USED TO INDUCE LABOR.

Q. DO YOU EVER USE IT DURING THE D&E PROCEDURE?

A. I SOMETIMES USE MISOPROSTOL IN THE D&E PROCEDURE IF I HAVE A VERY ADVANCED GESTATIONAL AGE OR A CERVIX THAT I COULDN'T GET MANY LAMINARIA IN. I SOMETIMES HAVE THE PATIENT COME THE DAY OF THE PROCEDURE A LITTLE BIT EARLIER, AND WE GIVE MISOPROSTOL PRIOR TO KIND OF SOFTEN THE CERVIX AND MAKE IT DILATE A LITTLE BIT MORE.

SOMETIMES, ADDITIONALLY, WHICH I DIDN'T MENTION, SOMETIMES THE CERVIX ISN'T QUITE DILATED AS MUCH AS I NEED, AND WE HAVE INSTRUMENTS TO HELP DILATE THAT. AND OCCASIONALLY I

HAVE TO DO THAT. AND WHEN, IN MY EXPERIENCE, WHEN I HAVE GIVEN MISOPROSTOL AHEAD OF TIME, THAT DILATATION APPEARS TO BE A LITTLE BIT EASIER IF I NEED TO DO IT.

Q. DO SOME WOMEN DELIVER THE FETUS PARTIALLY AS A RESULT OF THE MISOPROSTOL?

A. YES, THEY CAN.

Q. AND WHEN THAT HAPPENS, COULD THE FETUS BE OUTSIDE THE UTERUS PAST THE NAVEL OF THE FETUS?

A. OUTSIDE THE UTERUS, YES, AND POTENTIALLY EVEN OUTSIDE THE VAGINA.

Q. AND COULD IT BE ALIVE?

A. YES.

Q. AND WHEN THAT HAPPENS, HOW DO YOU COMPLETE THE PROCEDURE?

A. USUALLY, IF THE FETUS IS COMING OUT, THE EASIEST METHOD IS TO TRY TO DO HOW WE WOULD DO A BREECH. IT OFTEN COMES OUT IN A BREECH PRESENTATION. AND, AGAIN, THAT IS FEET FIRST, HEAD SECOND. WE DO THE SIMILAR MANEUVERS THAT WE WOULD DO TO DO A BREECH DELIVERY.

HOWEVER, SOMETIMES THE CERVIX IS NOT DILATED ENOUGH TO ALLOW THE CALVARIUM TO PASS.

Q. AND WHAT DO YOU THEN DO?

A. I WOULD SEPARATE THE CALVARIUM FROM THE BODY.

Q. WHEN YOU PERFORM THE EVACUATION IN THE TYPICAL D&E, DO YOU EVER NEED TO CONVERT THE LIE OF THE FETUS OR THE DIRECTION OF THE FETUS?

A. SOMETIMES. SOMETIMES THE FETUS IS, AGAIN, WHAT WE WOULD CALL VERTEX OR CEPHALIC. AND THAT IS WHEN THE HEAD IS PRESENTING AT THE CERVIX.

THE HEAD IS THE DIFFICULT -- THE MOST DIFFICULT PORTION TO DELIVER IN THESE PROCEDURES, AND OCCASIONALLY I WILL SEE IF I CAN DELIVER THE CRANIUM INITIALLY. OFTEN THAT DOESN'T WORK, AND I WOULD NEED TO REACH IN A LITTLE BIT HIGHER UP WITH THE FORCEPS, GRASP THE LOWER EXTREMITY AND PULL DOWN, AND THAT KIND OF CONVERTS THE PRESENTATION TO A BREECH PRESENTATION.

Q. WHEN YOU ARE DOING YOUR REGULAR PROCEDURE, DOES IT EVER HAPPEN THAT YOU BRING OUT THE FETUS INTACT OR PARTIALLY INTACT UP TO THE HEAD?

A. YES, SOMETIMES IT DOES.

Q. APPROXIMATELY HOW MANY TIMES DOES IT HAPPEN IN YOUR PROCEDURES?

A. MAYBE 15 TO 20 PERCENT.

Q. AND WHEN THIS HAPPENS, DO YOU CONSIDER IT TO BE A DIFFERENT PROCEDURE FROM AN ABORTION THAN ONE WHICH IS DISARTICULATED BEFORE THAT POINT?

A. I DON'T THINK IT IS DIFFERENT, AND I FEEL FORTUNATE WHEN IT HAPPENS IN SOME WAYS, BECAUSE I THINK THAT I WILL THEN HAVE LESS PASSES INTO THE UTERUS, AND I THINK LESS CHANCE FOR INJURY OR INFECTION.

Q. BEFORE BEGINNING THE D&E PROCEDURE, CAN YOU PREDICT IF THAT IS GOING TO HAPPEN OR NOT?

A. I DON'T THINK YOU CAN PREDICT. THERE HAVE BEEN PLENTY OF CASES WHERE I THINK I AM GOING TO BE ABLE TO GET OUT THE FETUS WITHOUT DISARTICULATING IT, AND I CANNOT. BUT THERE HAVE BEEN CASES WHERE I THINK I AM GOING TO HAVE A -- IT IS GOING TO BE A DIFFICULT ONE, A HARD ONE, AND I AM ABLE TO DELIVER THE FETUS INTACT.

Q. AND IS THERE ANYTHING THAT DETERMINES WHETHER IT WILL BE ABLE TO COME OUT INTACT OR PARTIALLY INTACT?

A. I MEAN, I THINK ULTIMATE CERVICAL DILATATION DOES, BUT THEN, EVEN BEYOND THAT SOMETIMES I THINK IT IS THEREFORE UNPREDICTABLE.

Q. IN YOUR OPINION, IS IT SAFER IF THE FETUS EMERGES INTACT OR PARTIALLY INTACT?

A. IN MY OPINION, IT IS SAFER IF IT EMERGES PARTIALLY OR AS INTACT AS POSSIBLE. I THINK IT IS SAFER.

Q. AND WHY IS THAT?

A. BECAUSE THEN I HAVE TO MAKE FEWER PASSES INTO THE UTERUS WITH MY INSTRUMENTS, AND THAT WOULD DECREASE CHANCES OF INFECTION, CHANCES OF UTERINE PERFORATION OR CERVICAL LACERATION.

Q. IN YOUR OPINION, ARE THERE ANY SPECIAL HEALTH RISKS IF THE FETUS EMERGES INTACT OR PARTIALLY INTACT?

A. NO.

Q. HOW LONG DOES THE EVACUATION PART OF THE D&E PROCEDURE TAKE WHEN YOU DO IT?

A. USUALLY 15 TO 30 MINUTES.
Q. DO YOU KNOW WHEN IN THE COURSE OF THAT PROCEDURE THE FETUS DIES?
A. NO.
Q. DO YOU EVER PAY ATTENTION TO THAT?
A. NO.
Q. DO YOU EVER USE DIGOXIN TO CAUSE FETAL DEMISE?
A. NO.
Q. WHY NOT?
A. IN READING THE STUDIES, I AM NOT CONVINCED THAT IT HAS ANY PARTICULAR BENEFIT. AND IT POTENTIALLY HAS SOME RISKS. AND I TRY NOT TO DO THINGS, MEDICAL PROCEDURES, THAT HAVE VERY LITTLE BENEFIT AND HAVE SOME RISK ASSOCIATED WITH THEM.
Q. NOW, YOU ALSO INDICATED YOU DO INDUCTION ABORTIONS. THAT'S THE OTHER METHOD OF ABORTION YOU USE? COULD YOU -- UNDER WHAT CIRCUMSTANCES WOULD YOU DO AN INDUCTION OR RECOMMEND AN INDUCTION?
A. I WOULD RECOMMEND AN INDUCTION IN SITUATIONS WHERE THE DIAGNOSIS OF THE FETAL ABNORMALITY -- THAT IS OFTEN WHAT THE INDICATION WOULD BE FOR THE PROCEDURE -- IS UNCLEAR. AND, AGAIN, WITHOUT KNOWING THE DIAGNOSIS, IT IS VERY HARD TO GIVE A RECURRENCE RISK TO THESE COUPLES.
IF WE HAVE AN INTACT FETUS WHERE AN AUTOPSY CAN BE PERFORMED WE HAVE A BETTER CHANCE OF ARRIVING AT WHAT THE DIAGNOSIS IS, AND THEN A BETTER CHANCE OF HAVING THE RECURRENCE

RISK.

BUT IF WE HAVE KIND OF AN UNCLEAR DIAGNOSIS I USUALLY RECOMMEND INDUCTION OF LABOR, INSTEAD.

Q. CAN YOU DESCRIBE FOR US THE PROCEDURE YOU USE TO DO AN INDUCTION ABORTION?

A. AGAIN, I WOULD THOROUGHLY COUNSEL THE PATIENT REGARDING THE RISKS AND BENEFITS OF BOTH PROCEDURES. IF SHE ELECTED TO PROCEED WITH INDUCTION OF LABOR, SHE WOULD COME INTO THE HOSPITAL, HAVE AN IV STARTED, AND THEN HAVE MISOPROSTOL TABLETS PLACED WITHIN HER VAGINA, USUALLY IN WHAT IS CALLED THE POSTERIOR FORNIX, OR RIGHT BEHIND THE CERVIX, BACK HERE (INDICATING).

Q. IS THAT TYPICALLY DONE IN THE HOSPITAL?

A. YES.

Q. AND THEN, WHAT HAPPENS AFTER THE MISOPROSTOL IS INSERTED?

A. IT TAKES SOME TIME TO KIND OF WORK TO SOFTEN THE CERVIX, MAYBE GET IT TO DILATE A LITTLE BIT AND BASICALLY INDUCE LABOR. PROBABLY IN THE BULK OF THE PATIENTS IT TAKES 24 HOURS DURATION BEFORE DELIVERY, BUT IT CAN BE AS LONG AS 48 HOURS.

APPROXIMATELY 90 SOME PERCENT OF PATIENTS WILL DELIVERY WITHIN 48 HOURS AFTER INITIATING THIS PROCESS.

Q. AND WHEN DURING IN INDUCTION DOES FETAL DEMISE OCCUR; DO YOU KNOW?

A. I DON'T KNOW. IT REALLY DEPENDS ON GESTATIONAL AGE, AND SOMETIMES THE FETUS IS BORN ALIVE.

Q. ARE THERE EVER CIRCUMSTANCES WHERE AN INDUCTION HAS TO BE CONVERTED INTO A D&E PROCEDURE?

A. YES. I HAVE A PARTICULAR EXPERIENCE IN THAT IF THE INDUCTION FAILS, IT JUST DOESN'T WORK. IF WE ARE GOING ON KIND OF 48, 72 HOURS AND STILL NO DELIVERY, IF THERE IS ADEQUATE CERVICAL DILATATION IT CAN BE CONVERTED TO A D&E.

SOMETIMES BLEEDING COULD BE SIGNIFICANT ENOUGH THAT YOU COULD CONVERT TO A D&E TO TRY TO SLOW THE AMOUNT OF BLOOD LOSS THAT IS OCCURRING.

Q. AND ARE THERE ANY CIRCUMSTANCES FOR WHICH INDUCTION IS CONTRAINDICATED?

A. YES. THERE ARE SOME CONDITIONS THAT INDUCTION WOULD BE CONTRAINDICATED. ONE IS PLACENTA PREVIA. THAT IS WHERE THE PLACENTA IS IMPLANTED OVER THE CERVIX AND KIND OF COVERING THE CERVIX. THE FETUS WOULD BE UP HIGHER. THIS -- THE FETUS WOULD HAVE TO DELIVER THROUGH THE PLACENTA, AND IT CAUSES A TREMENDOUS AMOUNT OF BLEEDING WHERE THE PLACENTA PREVIA IS.

SO AN INDUCTION OF LABOR IS CONTRAINDICATED IN THAT SITUATION.

THERE ARE UTERINE CONDITIONS WHERE AN INDUCTION OF LABOR WOULD BE CONTRAINDICATED. THAT COULD BE PREVIOUS UTERINE SURGERY, SOMETHING CALLED A HYSTEROTOMY, OR PREVIOUS CESAREAN SECTION. THERE ARE DIFFERENT TYPES OF CESAREAN SECTIONS.

Q. WHY DON'T WE STOP THERE FOR A MOMENT, BECAUSE I THINK YOU HAVE TALKED ABOUT A COUPLE OF CONDITIONS WE HAVEN'T PREVIOUSLY

MENTIONED.

WHAT IS A HYSTEROTOMY?

A. A HYSTEROTOMY IS AN INCISION THROUGH THE UTERINE WALL INTO THE UTERINE TO OPEN UP THE -- EXPOSE THE UTERINE CAVITY.

Q. WHAT ABOUT A CESAREAN SECTION; WHAT IS THAT?

A. A CESAREAN SECTION IS A HYSTEROTOMY, BUT IT IS DONE TO DELIVER A VIABLE FETUS. NOW, A CESAREAN SECTION, THERE ARE TWO TYPES, REALLY, OF CESAREAN SECTIONS. IT CAN BE WHAT IS COMMONLY KNOWN AND MOST WOMEN WIND UP HAVING SOMETHING CALLED A "LOW TRANSVERSE CESAREAN SECTION."

MAYBE IF I HAVE THE OTHER DIAGRAM IT MIGHT HELP.

MS. PARKER: MAY I GET THAT, YOUR HONOR?

THE COURT: YES.

THE WITNESS: SO MOST WOMEN AT TERM WOULD REQUIRE HAVING A CESAREAN SECTION. THE CESAREAN INCISION IS MADE IN THIS KIND OF LOWER UTERINE SEGMENT. AND WHEN THE UTERUS IS PREGNANT, AND THE TERM FETUS HERE IS -- THE UTERUS IS STRETCHED AND MUCH, MUCH BIGGER.

THIS LOWER SEGMENT STRETCHES OUT AND IS VERY, VERY THIN. IT DOESN'T HAVE A LOT OF MUSCLE WITHIN IT THAT INVOLVES KIND OF CONTRACTED PORTIONS KIND OF LABOR. SO IF YOU MAKE A TRANSVERSE INCISION DOWN HERE (INDICATING), THE RISK IN SUBSEQUENT PREGNANCIES OF THAT RUPTURING OR OPENING UP IS VERY, VERY SMALL.

IT IS APPROXIMATELY HALF A PERCENT. AN UTERINE

RUPTURE CAN BE A CATASTROPHIC EVENT FOR THE FETUS AND FOR THE MOTHER.

AT EARLIER GESTATIONAL AGES, THIS LOWER UTERINE SEGMENT MAY NOT BE DEVELOPED, AND IT IS NOT WIDE ENOUGH TO DO A TRANSVERSE INCISION HERE.

THE UTERINE BLOOD VESSELS ARE KIND OF RIGHT HERE AND KIND OF COMING IN HERE AND HAVE A TREMENDOUS AMOUNT OF BLOOD GOING TO THE UTERUS IN PREGNANCY.

AND IF YOU GET OUT INTO THOSE YOU CAN HAVE QUITE A BAD HEMORRHAGE OCCUR, AND POTENTIALLY A WOMAN CAN DIE FROM THAT.

WE OFTEN HAVE TO MAKE WHAT WE CALL A CLASSICAL UTERINE INCISION. AND THIS IS A VERTICAL INCISION MADE UP HERE (INDICATING) OR EVEN UP AND AROUND WHAT WE CALL "THE FUNDUS," OR TOP OF THE UTERUS.

THIS SORT OF INCISION IS GOING THROUGH A THICKER AREA AND A LOT OF MUSCLE INVOLVED IN CONTRACTING. IT HAS A BIGGER BLOOD LOSS, A LITTLE BIT HARDER REPAIR TO DO. IT HAS A MUCH -- IN SUBSEQUENT PREGNANCIES HAS MANY GREATER RISK FACTORS THAN IF A WOMAN HAD A LOW TRANSVERSE CESAREAN SECTION.

USING THESE MISOPROSTOL AS SUCH A STRONG AGENT TO PROMOTE VERY, VERY STRONG UTERINE CONTRACTIONS WITH AN INDUCTION, THE RISK OF RUPTURING THAT SCAR IS SIGNIFICANT.

BY MS. PARKER:

Q. THAT IS WHY INDUCTION IS CONTRAINDICATED WHERE THERE HAS

BEEN A PRIOR CESAREAN SECTION OR HYSTEROTOMY?

A. CORRECT.

Q. ARE THERE OTHER CONTRAINDICATIONS FOR INDUCTION IN ADDITION TO THOSE TWO?

A. THERE ARE, AGAIN, SOME MEDICAL INDICATIONS THAT THEORETICALLY MISOPROSTOL WOULD BE CONTRAINDICATED.

IT GOES BACK TO THAT PULMONARY HYPERTENSION OR EISENMENGER'S SYNDROME, THAT THE AGENTS THAT -- AND MISOPROSTOL BEING THE PRIMARY ONE NOW THAT CAUSES UTERINE CONTRACTIONS, ALSO CAN CAUSE CONTRACTION OF THE MUSCLE WITHIN THE BLOOD VESSELS IN THE PULMONARY TREE. IT CAN WORSEN THE CONDITIONS THAT WE WERE TALKING ABOUT BEFORE.

Q. SO THAT'S ONE EXAMPLE WHERE THE MEDICATION WOULD MAKE INDUCTION CONTRAINDICATED?

A. CORRECT.

Q. ARE THERE OTHER EXAMPLES?

A. ASTHMA HAS A RELATIVE CONTRAINDICATION. YOU CAN GET THE SPASM OF THE AIR -- THE BRONCHIAL TREE. AND CONSTRICTION OF THAT IS WHAT ASTHMA IS. AND IT COULD WORSEN ASTHMA, POTENTIALLY.

Q. AND WHAT ABOUT CARDIAC CONDITIONS, EVER CONTRAINCIDATED -- IS INDUCTION EVER CONTRAINDICATED FOR CARDIAC CONDITIONS?

A. YES. POTENTIALLY WITH THE PULMONARY HYPERTENSION AND WITH THE EISENMENGER'S SYNDROME COULD BE. FOR THE SAME REASON, AGAIN, OF THE CONSTRICTION OF THE PULMONARY VASCULATURE.

Q. SO IN ADDITION TO THE CONTRAINDICATIONS, ARE THERE ANY JUST RISKS OF AN INDUCTION ABORTION?
A. CERTAINLY THERE ARE RISKS OF INDUCTION ABORTION. AND THE BIGGEST ONES ARE INFECTION, BLEEDING, AND A RETAINED PLACENTA WHERE THE PLACENTA DOESN'T DELIVER AFTER THE FETUS DELIVERS. AND YOU SUBSEQUENTLY NEED A SURGICAL PROCEDURE, LIKE A D&E, TO GO IN AND REMOVE THE PLACENTAL TISSUE.
Q. AND DO YOU HAVE AN OPINION ABOUT THE SAFETY OF INDUCTIONS?
A. IN MY EXPERIENCE, I HAVE HAD MORE COMPLICATIONS WITH INDUCTIONS OF LABOR RATHER THAN D&E'S. BOTH HAVE BEEN SAFE, BUT I HAVE HAD MORE BLEEDING COMPLICATIONS AND HAVING AN INDUCTION KIND OF FAIL OR PLACENTA NOT COME OUT, HAD TO TAKE THEM TO THE OR. I HAVE BASICALLY DONE BOTH PROCEDURES ON THE PATIENT THEN.
Q. AND COULD YOU EVER DO A HYSTEROTOMY IF AN INDUCTION WAS CONTRAINDICATED?
A. YOU COULD DO A HYSTEROTOMY IF AN INDUCTION WAS CONTRAINDICATED, BUT HYSTEROTOMIES HAVE THE BIGGEST RISK OF ANY OF THE PROCEDURES TO END THE PREGNANCY. AND, AGAIN, THIS WOULD BE TYPICAL TO WHAT A CLASSICAL CESAREAN SECTION IS WHERE YOU MAKE YOUR INCISION THROUGH THE THICK PORTIONS AND MUSCULAR PORTIONS OF THE UTERUS. AND NOT ONLY DOES IT HAVE A MUCH GREATER BLOOD LOSS POTENTIAL AND IT'S AN ABDOMINAL SURGERY WHICH HAS RISKS OF POTENTIALLY INJURING OTHER ORGANS AT THE TIME, SUBSEQUENT PREGNANCIES ARE GREATLY AT MUCH HIGHER RISK

THAN IF THE PATIENT HAD A D&E.
Q. AND WHY IS THAT? WHAT ARE THOSE LONG TERM RISKS?
A. THOSE LONG TERM RISKS IS WHEN YOU HAVE HAD A HYSTEROTOMY AND THIS BIG INCISION COMING DOWN HERE (INDICATING), THE BIGGEST RISK IS PROBABLY UTERINE RUPTURE IN A SUBSEQUENT PREGNANCY. AND THAT CAN BE ANYWHERE FROM ABOUT TEN TO TWELVE PERCENT RISK OF A UTERINE RUPTURE.

ADDITIONALLY, IN WOMEN INCISIONS SUCH AS THAT, THE UTERUS REALLY DOESN'T HEAL COMPLETELY NORMAL. AND IF A PLACENTA IMPLANTS UPON THAT AREA, YOU CAN GET SOMETHING CALLED A "PLACENTA ACCRETA."

AND A PLACENTA ACCRETA IS A CONDITION WHERE THE PLACENTA GROWS INTO THE MYOMETRIUM, OR THE MUSCLE OF THE UTERUS. AND IT CAN SOMETIMES BECOME AN INCRETA, IN WHICH IT GOES ALL THE WAY THROUGH THE MUSCLE. OR SOMETIMES EVEN SOMETHING CALLED A PERCRETA, WHICH IT GROWS OUTSIDE OF THE UTERUS, AND POTENTIALLY INTO THE FALLOPIAN TUBE, INTO THE OVARY, INTO THE BLADDER, INTO THE VAGINA, AND ALL SORTS OF THINGS. PARTICULARLY, PARTICULARLY MORBID CONDITION, AND THE TREATMENT IS A HYSTERECTOMY AT THE TIME OF THE SUBSEQUENT DELIVERY.
Q. AND WHAT IS A HYSTERECTOMY?
A. A HYSTERECTOMY IS WHERE THE UTERUS IS REMOVED.
Q. SO WHEN YOU ARE MEETING WITH YOUR PATIENTS AND DISCUSSING THE DIFFERENT ABORTION METHODS THAT THEY HAVE AN OPTION FOR, DO

YOU TALK TO THEM ABOUT THE RELATIVE SAFETY OF THE METHODS?
A. YES. I TALK TO THEM ABOUT THE RELATIVE SAFETY OF THE METHODS, THE POTENTIAL BENEFITS TO THE METHODS. AND SOMETIMES I WON'T HAVE MUCH OF AN OPINION OF WHICH WAY THEY SHOULD GO. SOMETIMES I WILL STEER THEM A LITTLE BIT. AND MAINLY, IN WHETHER OR NOT WE NEED AN AUTOPSY OR NOT TO GIVE THEM RECURRENCE INFORMATION.
Q. AND WHAT DO YOU TELL THEM ABOUT THE RISKS OF THE DIFFERENT TYPES?
A. I SAY THAT THEY ARE CLOSE TO BEING ESSENTIALLY EQUAL, HOWEVER I HAVE HAD MORE BLEEDING COMPLICATIONS AND NEEDING TO GO BACK TO THE OR TO DO -- TO REMOVE A RETAINED PLACENTA WITH INDUCTION.
Q. NOW, I THINK I ASKED YOU A FEW MINUTES AGO -- I DON'T KNOW IF YOU WANT TO SIT DOWN. WE WILL MOVE INTO A DIFFERENT TOPIC. I ASKED YOU WHETHER YOU EVER USED DIGOXIN TO CAUSE FETAL DEMISE WHEN YOU WERE DOING A SECOND-TRIMESTER PROCEDURE. YOU INDICATED YOU DO NOT?
A. CORRECT. I DO NOT USE DIGOXIN.
Q. DO YOU EVER USE KCL, POTASSIUM CHLORIDE, TO CAUSE FETAL DEMISE?
A. I CAN THINK OF ONE OR TWO CASES WHERE I HAVE HAD TO USE POTASSIUM CHLORIDE TO TERMINATE THE FETUS PRIOR TO A PROCEDURE.
Q. BUT THAT IS NOT GENERALLY PART OF YOUR PRACTICE?
A. NO.

Q. AND WHY DO YOU NOT USE EITHER OF THOSE CHEMICALS TO CAUSE FETAL DEMISE?

A. I DON'T THINK EITHER REALLY ADD TO THE SAFETY OF THE PROCEDURE OF DOING THE D&E OR DOING AN DEDUCTION OF LABOR. AND THEY DO HAVE SOME RISKS ASSOCIATED WITH THEM.

Q. WHAT ARE THE RISKS OF DIGOXIN, IN YOUR OPINION?

A. AND MY OPINION IS, WELL, YOU HAVE TO DO AN AMNIOCENTESIS TO DO DIGOXIN. AND AN AMNIOCENTESIS IS NOT WITHOUT RISK. THE RISK IS SMALL, BUT IT IS NOT WITHOUT RISKS. MAIN RISKS ARE BLEEDING AND INFECTION, WITH INFECTION BEING THE PRIMARY RISK.

Q. ARE THERE ANY OTHER RISKS ASSOCIATED WITH THE DIGOXIN INJECTION OTHER THAN JUST BECAUSE YOU HAVE TO DO AN AMNIOCENTESIS?

A. I MEAN, THEORETICALLY, IF YOU DON'T HAVE THE NEEDLE IN THE RIGHT PLACE AND YOU HAVE IT IN THE UTERINE WALL YOU COULD GET ABSORPTION OF THE DIGOXIN INTO THE MATERNAL BLOODSTREAM. AND THAT COULD POTENTIALLY BE DANGEROUS TO THE WOMAN.

IN THE STUDY BY DR. DREY, IT DID NOT HAVE ENOUGH PATIENTS TO BE ABLE TO TELL WHETHER -- THE FREQUENCY THAT THIS WOULD OCCUR, IF REALLY THE DOSE IS SIGNIFICANT ENOUGH TO BE DANGEROUS.

BUT, THEORETICALLY, YES, IT IS A RISK FOR THE PATIENT.

Q. AND YOU ALSO INDICATED THERE WERE RISKS FROM INFECTION IN PROVIDING DIGOXIN?

A. ONLY IN THAT OF THE AMNIOCENTESIS.
Q. AND DO YOU EVER -- DO PATIENTS EVER ASK YOU WHETHER THERE IS SOMETHING THEY COULD USE TO CAUSE FETAL DEMISE?
A. YES. I WOULD -- I DON'T KNOW WHAT PERCENTAGE OF MY PATIENTS, BUT A CERTAINLY SMALL NUMBER OF PATIENTS ASK COULD THERE BE FETAL DEMISE PRIOR TO THE PROCEDURE. WHEN I TALK TO THEM ABOUT WHAT IT WOULD ENTAIL TO DO, MOST OF THEM DO NOT WANT TO PROCEED WITH THAT. AND I DON'T THINK THEY ARE PARTICULARLY WORRIED ABOUT THE EFFECTS. THEY DON'T THINK -- I THINK ABOUT THE INFECTION RISK.

THEY DON'T THINK ABOUT THE INFECTION RISK. THEY JUST DON'T WANT TO GO THROUGH THAT PROCEDURE, TO HAVE A NEEDLE PLACED, AND UNDER ULTRASOUND GUIDANCE MAYBE SEE THE ULTRASOUND AND SEE THE FETUS AGAIN. THE VAST MAJORITY OF THE PATIENTS DON'T WANT TO HAVE THAT DONE.

Q. ARE YOU ABLE TO -- WOULD YOU BE ABLE TO GIVE ANY PATIENTS DIGOXIN IF THEY WANTED IT?
A. IT DEPENDS IF I COULD DO AN AMNIOCENTESIS ON THEM, BECAUSE THAT WOULD BE THE METHOD OF ADMINISTERING THEM. AND IN SOME PATIENTS, AMNIOCENTESIS COULD BE VERY, VERY DIFFICULT TO POTENTIALLY IMPOSSIBLE.

IF THERE IS A FETAL CONDITION WHERE THERE IS NO AMNIOTIC FLUID OR THE AMNIOTIC -- THERE IS PREMATURE RUPTURE OF MEMBRANE, AND THAT IS WHY WE ARE DOING IT, IT WOULD BE VERY, VERY DIFFICULT TO INJECT THE DIGOXIN INTO THE AMNIOTIC SPACE IF

THE AMNIOTIC SPACE IS BASICALLY OBLITERATED AND THE ONLY THING THERE IS THE FETUS.

ADDITIONALLY, SOME PATIENTS ARE QUITE OBESE, AND IT WOULD BE VERY, VERY DIFFICULT TO DO AMNIOCENTESIS ON.

Q. AND WHY IS THAT?

A. BECAUSE VISUALIZATION OF WHERE YOU HAVE TO BE WITH ULTRASOUND IS VERY DIFFICULT BECAUSE YOU HAVE TO LOOK THROUGH A LARGE ADIPOSE LAYER, THROUGH THE SKIN, THEN THE UTERINE WALL, AND THEN THE UTERINE CAVITY.

Q. SO THERE ARE SOME WOMEN FOR WHOM YOU COULD NOT DO DIGOXIN?

A. YES.

Q. AND ARE THERE -- IS THERE ANYBODY ELSE FOR WHOM THE INJECTION IS TECHNICALLY DIFFICULT TO DO?

A. SOME WOMEN IT IS REALLY HARD TO PREDICT, BUT DO NOT IMAGE WELL WITH ULTRASOUND. AND BEING ABLE TO SEE WHERE YOU NEED TO GO COULD BE VERY, VERY DIFFICULT.

AND I THINK IT IS MORE DANGEROUS TO POTENTIALLY INJECT SOMETHING WHERE YOU DON'T KNOW WHERE IT IS IF YOU ARE NOT IN THE CORRECT SPACE.

Q. DO ANY OF YOUR PATIENTS EVER ASK IF THE FETUS EXPERIENCES PAIN DURING THE ABORTION PROCEDURE?

A. YES, SOME PATIENTS ASK THAT.

Q. AND WHAT DO YOU TELL THEM?

A. I TELL THEM I DON'T KNOW. I DON'T THINK -- I DON'T KNOW HOW ANYBODY CAN KNOW WHETHER THERE IS CONSCIOUSNESS TO THE

POINT WE HAVE A REALIZATION OF WHAT PAIN IS.

I TELL THEM THAT I THINK IT IS UNLIKELY THAT THE FETUS FEELS PAIN OR HAS THE ABILITY TO INTERPRET PAINFUL STIMULI AS PAIN.

MS. PARKER: MAY I APPROACH THE WITNESS, AGAIN, YOUR HONOR, TO PUT UP ANOTHER BLOWUP?

THE COURT: YES.

BY MS. PARKER:

Q. DR. DOE, I WOULD LIKE YOU TO TAKE A LOOK AT THIS BLOWUP, WHICH IS THE OPERATIVE PORTION OF THE PARTIAL-BIRTH ABORTION BAN ACT WHICH IS AT ISSUE IN THIS CASE.

HAVE YOU SEEN THAT BEFORE?

A. YES.

Q. AND CAN YOU JUST READ IT TO YOURSELF FOR A MOMENT?

ARE YOU CONCERNED ABOUT THE POTENTIAL IMPACT OF THIS LAW ON YOUR PRACTICE?

A. YES.

Q. AND WHAT ARE YOUR CONCERNS?

A. MY CONCERNS ARE THAT IT IS UNPREDICTABLE OF WHETHER I WOULD SOMETIMES DELIVER A FETUS INTACT TO THE POINT THAT IT'S OUTSIDE OF THE BODY OF THE MOTHER, AND THAT IT MIGHT STILL BE ALIVE WHEN I AM DOING KIND OF A STANDARD D&E THAT I DO.

Q. DOES THE TERM "PARTIAL-BIRTH ABORTION" HAVE A COMMONLY UNDERSTOOD MEANING IN THE MEDICAL COMMUNITY?

A. I DON'T THINK SO, BECAUSE I HAVE TALKED TO MANY OF MY

COLLEAGUES AND THEY'RE ALWAYS LIKE:

"I AM NOT SURE WHAT THIS PROCEDURE IS."

MR. QUINLIVAN: OBJECTION, HEARSAY.

THE COURT: OVERRULED.

BY MS. PARKER:

Q. DOES THE TERM "VAGINALLY DELIVERS," DOES THAT HAVE A COMMONLY UNDERSTOOD MEANING IN THE MEDICAL COMMUNITY?

A. YES.

Q. AND WHAT IS THAT MEANING?

A. THAT THE FETUS DELIVERS SPONTANEOUSLY THROUGH THE CERVIX INTO THE VAGINA AND THEN OUT OF THE BODY.

Q. AND DOES THE TERM "A LIVING FETUS" HAVE A COMMONLY UNDERSTOOD MEANING?

A. YES.

Q. AND WHAT IS THAT MEANING?

A. THAT THE FETUS HAS A BEATING HEART.

Q. IS THAT THE SAME THING AS THE FETUS BEING VIABLE?

A. NO.

Q. WHAT ABOUT THE TERM -- LET'S SEE:

"IN THE CASE OF BREECH PRESENTATION ANY PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE MOTHER"?

WHAT DOES THAT MEAN TO YOU?

A. THAT WOULD MEAN THAT THE FETUS IS KIND OF DELIVERED SUCH THAT THE MAJORITY OF ITS BODY UP TO ITS UMBILICUS OR NAVEL IS

OUTSIDE OF THE VAGINA WITH THE HEAD POTENTIALLY BEING STILL IN THE VAGINA OR IN THE UTERUS.

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

A. YES.

Q. AND THAT YOU WOULD -- WHERE YOU WOULD DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVER A LIVING FETUS UNTIL, IN THE CASE OF BREECH PRESENTATION, ANY PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE THE BODY OF THE MOTHER, FOR THE PURPOSE OF PERFORMING AN OVERT ACT THAT THE PERSON KNOWS WILL KILL THE PARTIALLY-DELIVERED LIVING FETUS?

A. YES.

Q. AND DO YOU HAVE CONCERNS THAT YOU WILL VIOLATE THE ACT -- WHAT ARE YOUR CONCERNS THAT YOU WILL BE VIOLATING THE ACT?

A. WELL, AGAIN, SOME OF MY PROCEDURES OF DELIVERING THE FETUS WIND UP DELIVERING INTACT TO THAT POINT. I DO NOT KNOW IF IT IS ALIVE OR NOT, BUT I MIGHT DO MANEUVERS THEN TO DELIVER THE REST OF THE FETUS, THAT IF IT WERE ALIVE IT CERTAINLY WOULD THEN KILL THE FETUS.

Q. AND DO YOU USE YOUR D&E PROCEDURES SUCH THAT THIS COULD HAPPEN WHEN YOU ARE HANDLING A PREGNANCY TERMINATION WHICH THE PATIENT HAD DECIDED TO DO BECAUSE OF A MATERNAL HEALTH CONDITION?

A. YES.

Q. AND IS THAT BECAUSE MOST OF YOUR PROCEDURES ARE UNDER THOSE

CIRCUMSTANCES?
A. ALMOST ALL OF MY PROCEDURES ARE OF MATERNAL HEALTH CONDITION OR A FETAL ABNORMALITY.
Q. AND COULDN'T YOU CHOOSE TO DO AN INDUCTION TO AVOID VIOLATING THE ACT?
A. I THINK YOU CAN VIOLATE THIS ACT WITH AN INDUCTION, AS WELL. OCCASIONALLY, THE FETUS WOULD DELIVER FROM A BREECH PRESENTATION --
MR. QUINLIVAN: OBJECTION, YOUR HONOR. OBJECTION. THIS ISSUE WAS NOT RAISED IN THE DOCTOR'S EXPERT REPORT. HIS EXPERT REPORT WAS LIMITED TO EXPLAINING HOW IN A D&E THERE COULD BE A VIOLATION OF THE ACT. THERE IS NO MENTION MADE WHATSOEVER THAT THE ACT COULD BE VIOLATED IN TERMS OF AN INDUCTION, AND I DIDN'T RAISE THAT DURING HIS DEPOSITION FOR THAT VERY REASON.
SO I OBJECT TO THIS LINE OF QUESTIONING.
THE COURT: OKAY. UNLESS YOU CAN SHOW ME IN A REPORT OR DEPOSITION TRANSCRIPT THAT THIS ISSUE WAS COVERED, I WILL SUSTAIN THE OBJECTION.
MS. PARKER: WHY DON'T WE MOVE ON WHILE WE ARE CHECKING ON THAT?
BY MS. PARKER:
Q. LET ME ALSO SHOW YOU ANOTHER SECTION OF THE ACT WHILE WE ARE DOING THAT.
THIS IS ANOTHER SECTION OF THE PARTIAL-BIRTH

ABORTION BAN ACT. DO YOU SEE THE SENTENCE:

"THE SUBSECTION DOES NOT APPLY TO A PARTIAL-BIRTH ABORTION THAT IS NECESSARY TO SAVE THE LIFE OF A MOTHER WHOSE LIFE IS ENDANGERED BY A PHYSICAL DISORDER, PHYSICAL ILLNESS OR PHYSICAL INJURY, INCLUDING A LIFE-ENDANGERING PHYSICAL CONDITION CAUSED BY OR ARISING FROM THE PREGNANCY ITSELF"?

MR. QUINLIVAN: YOUR HONOR, I HAVE THE SAME OBJECTION HERE. THE LIFE EXCEPTION WAS NOT RAISED IN THE DOCTOR'S EXPERT REPORT, AND, THEREFORE, I OBJECT TO THIS LINE OF QUESTIONING, AS WELL.

THE COURT: ALL RIGHT. YOU ALL ARE GOING TO HAVE TO SHOW ME THE RELEVANT EXCERPTS.

MS. PARKER: WHAT? I AM SORRY?

THE COURT: YES. YOU ARE GOING TO HAVE TO SHOW ME THE EXCERPTS FROM THE TRANSCRIPT OF THE DEPOSITION OR THE EXPERT REPORT IN VIEW OF THE OBJECTION.

MS. PARKER: OKAY. WE WILL CHECK ON THAT.

YOUR HONOR, DURING THE DEPOSITION MR. QUINLIVAN THEN ASKED DR. DOE WHETHER HE EVER KNEW AT THE OUTSET OF A PROCEDURE WHETHER OR NOT IT IS GOING TO RESULT IN AN INTACT DELIVERY.

AND HE FURTHER ASKED HIM:

"IN THOSE INSTANCES WHERE YOU WERE PERFORMING A D&E OR A LABOR INDUCTION," AND THEN THERE WAS A DISCUSSION OF BOTH THE D&E AND THE LABOR INDUCTION AFTER THAT.

MR. QUINLIVAN: WHICH PAGES?

MS. PARKER: IT BEGAN ON PAGE 66.

MR. QUINLIVAN: AT LEAST ON THOSE PAGES, YOUR HONOR, I DID ASK SEVERAL QUESTIONS ABOUT THE COMPARISON OF A D&E VERSUS INDUCTION, BUT NOT AS IT RELATES TO WHETHER THIS ACT WOULD BE VIOLATED.

THAT WAS A -- MY QUESTIONING ABOUT THAT WAS AN ENTIRELY DIFFERENT SECTION OF THE DEPOSITION.

THE COURT: MAYBE DURING THE BREAK --

MS. PARKER: RIGHT. WE CAN FIND IT.

THE COURT: -- YOU CAN LOOK FURTHER. BUT, ONCE AGAIN, THE TWO SUBJECTS ARE WHETHER OR NOT HE WAS QUESTIONED OR OPINED IN HIS REPORT AT A MINIMUM ON HOW THE ACT WAS -- COULD BE VIOLATED BY AN INDUCTION. OR THIS LAST LINE OF QUESTIONING: THE LIFE EXCEPTION. I DON'T BELIEVE THAT WAS INCLUDED IN THE EXPERT REPORT.

BY MS. PARKER:

Q. SO, DR. DOE, YOU INDICATED THAT THIS WOULD HAVE AN IMPACT ON YOUR PRACTICE; IS THAT CORRECT?

A. YES.

Q. AND WHAT WOULD THAT IMPACT BE ON YOUR CURRENT PRACTICE?

A. AT THIS POINT I AM CURRENTLY GOING TO STOP DOING D&E'S, AND I AM GOING TO DISCUSS WITH COUNSEL AT THE HOSPITAL WHAT WAY I COULD POTENTIALLY BE PROTECTED, WHETHER THAT IS POTENTIALLY JOINING NAFL OR --

THE COURT: THAT IS NAFL?

THE WITNESS: THE NATIONAL ABORTION FEDERATION LEAGUE.

BY MS. PARKER:

Q. AND WHY ARE YOU GOING TO STOP DOING THESE PROCEDURES NOW?

A. BECAUSE I THINK IT WOULD BE UNPREDICTABLE FOR ME TO KNOW WHETHER I VIOLATE THE ACT OR NOT.

Q. ARE YOU CURRENTLY COVERED BY THE INJUNCTION?

A. IN PREPARING FOR THIS CASE I FOUND OUT THAT I AM NOT COVERED BY THE INJUNCTION. I THOUGHT I WAS COVERED BY THE INJUNCTION, BUT I FOUND OUT IN PREPARING FOR THE TESTIMONY FOR THE TRIAL THAT I AM NOT COVERED BY THE INJUNCTION.

Q. AND SO AS A RESULT YOU ARE GOING TO STOP PERFORMING THESE PROCEDURES?

A. YES.

MS. PARKER: I HAVE NO FURTHER QUESTIONS AT THIS TIME.

THE COURT: ALL RIGHT.

PERHAPS WE WILL TAKE OUR BREAK A LITTLE EARLY.

MR. QUINLIVAN: I WAS GOING TO SUGGEST THE SAME THING.

THE COURT: WE WILL BREAK FOR 15 MINUTES.

MR. QUINLIVAN: THANK YOU.

(RECESS TAKEN AT 9:47 A.M.)

(PROCEEDINGS RESUMED AT 10:03 A.M.)

THE COURT: ALL RIGHT. NOW, DID YOU WISH TO CONTINUE OR ARE WE READY FOR CROSS-EXAMINATION?

MS. PARKER: CROSS-EXAMINATION.

THE COURT: MR. QUINLIVAN? CROSS-EXAMINATION.

MR. QUINLIVAN: THANK YOU, YOUR HONOR.

CROSS-EXAMINATION

BY MR. SIMPSON:

Q. GOOD MORNING, DOCTOR.

A. GOOD MORNING.

Q. GOOD TO SEE YOU AGAIN.

WE HAVE MET BEFORE, HAVEN'T WE?

A. YES.

Q. I TOOK YOUR DEPOSITION ABOUT A MONTH AGO?

A. CORRECT.

Q. JUST TO CLEAR UP SOME OF THE POINTS FROM YOUR EARLIER TESTIMONY, ONE OF THE FETAL ANOMALIES YOU MENTIONED WAS TRISOMY 18?

A. TRISOMY 18.

Q. AND TRISOMY 13?

A. CORRECT.

Q. AND YOU SAID THAT BOTH OF THOSE ARE LETHAL ANOMALIES?

A. THEY ARE THE VAST MAJORITY OF OBSTETRICIAN/GYNECOLOGISTS WOULD CONSIDER THEM LETHAL ABNORMALITIES.

Q. AND JUST TO BE CLEAR, LETHAL ABNORMALITIES TO THE FETUS; IS THAT CORRECT?

A. CORRECT.
Q. IT WOULD NOT BE A LETHAL ABNORMALITY TO THE MOTHER?
A. CORRECT.
Q. AND YOU ALSO MENTIONED THAT TRIPLOIDY?
A. TRIPLOIDY.
Q. WITH THE EXCEPTION OF TRIPLOIDY, ARE THERE ANY OF THE FETAL ABNORMALITIES THAT YOU MENTIONED THAT WOULD PROPOSE RISKS TO THE MOTHER?
A. NO.
Q. TAKING THE ISSUE OF TRIPLOIDY, THAT IS A CHROMOSOMAL ABNORMALITY OF THE FETUS, CORRECT?
A. CORRECT.
Q. AND IS IT FAIR TO SAY THAT THAT CAN BE DETECTED AT AN EARLIER GESTATIONAL AGE?
A. EARLIER THAN WHAT?
Q. CAN TRIPLOIDY BE DETECTED DURING THE FIRST-TRIMESTER?
A. POTENTIALLY.

IN ORDER TO DETECT IT, THERE HAS TO BE -- THERE'S SOME ULTRASOUND FINDINGS THAT ARE SUGGESTIVE OF IT, BUT YOU REALLY NEED A CHROMOSOME EVALUATION OR KARYOTYPE IF IT SEEMS -- AND POTENTIALLY A CVS, WHICH WOULD BE DONE AT THE END OF THE FIRST TRIMESTER. HOWEVER, THE NUMBER OF PROVIDERS IN THE UNITED STATES THAT PERFORM CVS IS MUCH, MUCH SMALLER THAN THE NUMBER THAT CAN PROVIDE ULTRASOUND DIAGNOSIS AND AMNIOCENTESIS.

Q. THANK YOU, DOCTOR.

YOU ALSO TESTIFIED ABOUT CERVICAL INCOMPETENCE AND I HAVE ONE QUESTION ABOUT YOUR TESTIMONY.

THE WOMEN'S PREGNANCY ITSELF DOES NOT CAUSE CERVICAL INCOMPETENCE, CORRECT?

A. I GUESS IT DEPENDS ON HOW YOU LOOK AT IT. IF SHE WASN'T PREGNANT, SHE WOULDN'T HAVE CERVICAL INCOMPETENCE.

THE -- BUT IT IS MOST LIKELY A STRUCTURAL ABNORMALITY WITHIN THE PROTEINS AND MOLECULES THAT MAKE UP THE CERVIX THAT THEN LEAD TO CERVICAL INCOMPETENCE.

Q. THANK YOU.

DOCTOR, I AM CORRECT, AM I NOT, THAT ABORTION SERVICES ARE NOT A MAJOR PART OF YOUR CURRENT PRACTICE?

A. CORRECT.

Q. AND AM I CORRECT THAT FROM OCTOBER OF 2003 WHEN YOU TOOK YOUR CURRENT POSITION TO THE FIRST WEEK OF MARCH WHEN I TOOK YOUR DEPOSITION, YOU HAD ONLY PERFORMED TWO ABORTIONS?

A. CORRECT.

Q. DOCTOR, YOU TESTIFIED THAT YOU HANDLE CASES INVOLVING BOTH FETAL ABNORMALITIES AND MATERNAL CONDITIONS?

A. YES.

Q. AND THE VAST MAJORITY OF THOSE CASES INVOLVE SECOND-TRIMESTER PREGNANCIES?

A. WELL, I MEAN, THE CASES -- IT DEPENDS WHEN I AM FIRST SEEING THE PATIENT. SO IT MIGHT BE FIRST TRIMESTER, MIGHT BE SECOND, MIGHT BE THIRD, AND SOMETIMES I AM FOLLOWING THEM ALONG

AND SOMETIMES IT'S ONE VISIT.

SO, MY ENCOUNTERS WITH PATIENTS, THE MAJORITY IS NOT IN THE SECOND TRIMESTER, BUT I SEE A LARGE NUMBER OF PATIENTS IN THE SECOND-TRIMESTER.

Q. IS IT FAIR TO SAY, THOUGH, THAT IN CASES IN WHICH YOU PERFORM ABORTIONS FOR EITHER A FETAL ABNORMALITY OR A MATERNAL CONDITION, YOU PERFORM THEM BY BOTH THE D&E AND THE LABOR INDUCTION METHODS?

A. YES.

Q. AND IS IT FAIR TO SAY YOU BELIEVE THAT BOTH D&E AND INDUCTION ARE SAFE METHODS OF ABORTION?

A. YES.

Q. I THINK YOU TESTIFIED EARLIER, WHEN ASKED, YOU TELL YOUR PATIENTS THEY ARE CLOSE TO BEING ESSENTIALLY EQUAL IN TERMS OF SAFETY?

A. YES.

Q. IN FACT, IS IT FAIR TO SAY THAT YOU BELIEVE THAT BOTH D&E AND LABOR INDUCTION ARE EXTREMELY SAFE METHODS OF ABORTION?

A. YES.

Q. AND YOU TESTIFIED THAT IN SOME CASES OF FETAL ABNORMALITY, IT'S, IMPORTANT TO DO AN AUTOPSY OF THE FETUS AFTER AN ABORTION IS PERFORMED; IS THAT CORRECT?

A. IMPORTANT, YES. IF THE COUPLE IS INTERESTED IN RECURRENCE INFORMATION, AND OFTEN THEY ARE.

Q. CAN YOU -- I AM NOT SURE YOU DESCRIBED THAT IN YOUR DIRECT

TESTIMONY.

CAN YOU TELL THE COURT WHAT RECURRENCE RISK MEANS?

A. RECURRENCE RISK IS A FETUS SAY HAS AN ABNORMALITY AND OFTEN THE COUPLE WANTS TO KNOW IF IT'S GOING TO HAPPEN IN ANOTHER PREGNANCY. AND THE RECURRENCE RISK IS THE ODDS OF THAT HAPPENING AGAIN IN A FUTURE PREGNANCY.

Q. IS IT FAIR TO SAY THAT IF YOU KNOW WHAT THE FETAL -- THE DIAGNOSIS OF THE FETAL ANOMALY IS, YOU HAVE A BETTER CHANCE OF KNOWING WHAT THE RECURRENCE RISK FOR THE PARENTS ARE?

A. YES.

Q. AND IN CASES IN WHICH IT MIGHT BE -- IN CASES IN WHICH YOU WANT THE VERY BEST AUTOPSY POSSIBLE, YOU RECOMMEND AN ABORTION BY A LABOR INDUCTION METHOD; IS THAT CORRECT?

A. YES.

Q. AND IN CASES IN WHICH YOU KNOW OR A PHYSICIAN IS ABLE TO DETERMINE WHAT THE DIAGNOSIS OF THE FETAL ABNORMALITY, YOU OFFER YOUR PATIENTS A CHOICE OF EITHER AN ABORTION BY LABOR INDUCTION OR D&E; IS THAT CORRECT?

A. CAN YOU REPEAT THE QUESTION?

Q. SURE.

IN CASES IN WHICH THE FETAL ABNORMALITY HAS BEEN DIAGNOSED, YOU OFFER YOUR PATIENTS A CHOICE OF EITHER ABORTION BY A D&E OR A LABOR INDUCTION METHOD; IS THAT FAIR TO SAY?

A. YES.

Q. AND IN THOSE SITUATIONS WHICH I HAVE JUST DISCUSSED, YOU

DON'T RECOMMEND A D&E OVER A LABOR INDUCTION, DO YOU?
A. I TEND NOT TO. I TEND TO GO OVER RISK BENEFITS, WHAT THE PROCEDURES ENTAILED, THE TIMING, AND THOSE SORTS OF THINGS AND I HELP THE PATIENT MAKE A DECISION OF WHAT SHE FEELS IS KIND OF BEST FOR HER.
Q. DOCTOR, THERE ARE SOME FETAL ABNORMALITIES WHERE IT'S IMPORTANT TO ANALYZE THE CONTENTS OF THE BRAIN IF YOU ARE DOING A SUBSEQUENT AUTOPSY; IS THAT CORRECT?
A. YES.
Q. AND I THINK YOU TESTIFIED EARLIER THAT IN ABOUT 15 PERCENT OF THE D&E'S YOU PERFORM, THE FETUS IS DELIVERED PARTIALLY INTACT SO THAT THE CALVARIUM GETS STUCK IN THE CERVIX; IS THAT CORRECT?
A. IT WAS -- I THINK MY TESTIMONY, I BELIEVE, IS APPROXIMATELY 15 PERCENT WOULD BE DELIVERED INTACT. NOT ALL OF THOSE THAT THE CALVARIUM WOULD BE STUCK; SOME WOULD DELIVER COMPLETELY INTACT.
Q. DO YOU HAVE A -- CAN YOU GIVE ME AN ESTIMATE OF THAT 15 PERCENT HOW MANY ARE DELIVERED WHERE THE CALVARIUM DOES GET STUCK IN THE CERVIX?
A. I WOULD PROBABLY SAY AT LEAST 80 PERCENT THE CALVARIUM WOULD BE STUCK IN THE CERVIX.
Q. AND JUST TO BE CLEAR, THE CALVARIUM, AGAIN, IS JUST THE FETUS' HEAD, CORRECT?
A. CORRECT.

Q. IN THOSE CASES IN WHICH YOU ARE DOING A D&E AND THE FETUS DELIVERS PARTIALLY INTACT EXCEPT FOR THE CALVARIUM GETTING STUCK IN THE CERVIX, YOU HAVE TO INSERT FORCEPS AND CRUSH THE CALVARIUM; IS THAT RIGHT?

A. I WOULD SEPARATE THE CALVARIUM FROM THE FETAL -- HOW I WOULD PERFORM THE PROCEDURE IS, I WOULD SEPARATE THE CALVARIUM FROM THE FETAL BODY, THORAX, AND THEN INSERT THE FORCEPS TO CRUSH THE CALVARIUM TO BE ABLE TO DELIVER IT.

Q. AND IN CRUSHING THE CALVARIUM, WOULD THAT INHIBIT THE ABILITY TO DO A SUBSEQUENT AUTOPSY ON THE CONTENTS OF THE BRAIN?

A. YES, BUT THE CAVEAT ABOUT AUTOPSIES OF BRAINS EVEN ON VERY EARLY FETUSES, ALTHOUGH THERE ARE MANY TIMES WE WANT TO GET THEM THE YIELD IS ALSO PRETTY SMALL EVEN WITH A COMPLETELY INTACT FETUS BECAUSE THE BRAIN WILL START TO DECOMPOSE VERY QUICKLY. AND SOMETIMES EVEN THOUGH THAT'S WHAT WE ARE ATTEMPTING, WE DON'T GET THAT DIAGNOSIS.

Q. I CERTAINLY APPRECIATE THAT DOCTOR, AND I GUESS MY QUESTION, THOUGH, IS, IF YOU ARE ABLE TO GET AN AUTOPSY OF THE BRAIN, AND YOU HAVE CRUSHED THE CALVARIUM, THAT MIGHT INHIBIT THE ABILITY TO DO AN AUTOPSY ON THE CONTENTS OF THE BRAIN?

A. IF THE CALVARIUM HAS BEEN CRUSHED, YOU WOULD NOT BE ABLE TO DO AN AUTOPSY ON THE BRAIN.

Q. AND BY CONTRAST, IF YOU HAVE AN ABORTION BY THE LABOR INDUCTION METHOD, WITH THE EXCEPTION OF THE CIRCUMSTANCES YOU

JUST MENTIONED, YOU WOULD BE ABLE TO DO AN AUTOPSY ON THE BRAIN?

A. YES. YOU WOULD ALWAYS BE ABLE TO DO AN AUTOPSY ON THE BRAIN; WHETHER YOU HAVE ANY MEANINGFUL RESULTS OUT OF IT IS UNCERTAIN BECAUSE OF THE RAPID DECOMPOSITION OF THE FETAL BRAIN.

Q. DOCTOR, I THINK YOU MENTIONED THAT THERE ARE SOME CONTRAINDICATIONS TO LABOR INDUCTION?

A. YES.

Q. AND SOME OF THOSE YOU MENTIONED WERE CONTRAINDICATIONS TO MISOPROSTOL; IS THAT RIGHT?

A. YES.

Q. MISOPROSTOL ISN'T THE ONLY METHOD BY WHICH A PHYSICIAN CAN INDUCE LABOR, IS IT?

A. IT IS NOT THE ONLY METHOD, CORRECT. IT'S NOT THE ONLY METHOD THAT CAN BE USED TO INDUCE LABOR.

Q. A PHYSICIAN MIGHT USE OXYTOCIN IN SOME CIRCUMSTANCES TO INDUCE LABOR; IS THAT RIGHT?

A. YES, AND, BUT THE SUCCESS RATES AT THAT EARLY, EARLY GESTATIONAL AGE OF USING OXYTOCIN ARE MUCH LESS THAN MISOPROSTOL OR SOME OF THE OTHER AGENTS.

Q. THOSE COMPLICATIONS THAT YOU MENTIONED WITH RESPECT TO MISOPROSTOL, THOSE WOULDN'T NECESSARILY OCCUR IF OXYTOCIN IS USED; IS THAT CORRECT?

A. CAN YOU REPEAT THAT?

Q. YOU MENTIONED THERE WERE SOME CONTRAINDICATIONS FOR LABOR INDUCTION WHEN MISOPROSTOL IS USED; THOSE CONTRAINDICATIONS WOULDN'T NECESSARILY OCCUR IF OXYTOCIN WAS USED INSTEAD OF MISOPROSTOL; IS THAT CORRECT?

A. WELL, NOT NECESSARILY. IT DEPENDS ON WHAT THE INDICATION FOR THE CONTRAINDICATION IS. IF IT'S FOR THE CARDIAC DISEASE THAT I WAS TALKING ABOUT, NO, OXYTOCIN WOULD NOT BE A CONTRAINDICATION. BUT, HOWEVER, FOR A PREVIOUS HYSTEROTOMY, PLACENTA PREVIA, OXYTOCIN WOULD BE A CONTRAINDICATION FOR LABOR INDUCTION.

Q. THANK YOU, DOCTOR.

LET ME TURN YOUR ATTENTION TO WHEN YOU ARE PERFORMING A D&E ABORTION. IS IT FAIR TO SAY THAT DISARTICULATION OR DISMEMBERMENT ARE COMMON CHARACTERISTICS OF A D&E?

A. YES.

Q. AND IN PERFORMING A D&E PROCEDURE BY DISARTICULATION OR DISMEMBERMENT, YOU GENERALLY USE FORCEPS TO REMOVE THE FETAL PARTS?

A. YES.

Q. YOU TYPICALLY USE WHAT ARE KNOWN AS BIERER FORCEPS?

A. BIERER FORCEPS, YES. AT EARLIER GESTATIONAL AGES I MIGHT USE SOPHER FORCEPS.

Q. AND THERE ARE -- IS IT FAIR TO SAY THAT THERE ARE SOME UNUSUAL CIRCUMSTANCES IN WHICH YOU MIGHT USE HERN OR RING

FORCEPS?
A. I WOULD NEVER USE A RING FORCEP. THERE ARE SOME UNUSUAL CIRCUMSTANCES THAT I WOULD USE A HERN FORCEP.
Q. DO ALL OF THESE FORCEPS HAVE TEETH AT THE END?
A. YES.
Q. AND IT'S FAIR TO SAY GIVEN THE PERCENTAGES THAT YOU MENTIONED THAT IN 85 PERCENT OF THE CASES OR APPROXIMATELY 85 PERCENT OF THE D&E'S YOU PERFORM THEY PROCEED BY DISMEMBERMENT OR DISARTICULATION?
A. YES.
Q. NOW, LET ME TURN YOUR ATTENTION TO THE SITUATIONS IN WHICH YOU'RE PERFORMING A D&E ABORTION AND THE FETUS IS DELIVERED INTACT OR PARTIALLY INTACT.

I THINK YOU TESTIFIED THAT AT THE BEGINNING OF THE PROCEDURE, YOU NEVER KNOW WHETHER A FETUS IS GOING TO BE DELIVERED INTACT OR PARTIALLY INTACT IN A D&E PROCEDURE; IS THAT CORRECT?
A. CORRECT.
Q. SO, IF YOU HAVE A WOMAN SUFFERING FROM A MATERNAL CONDITION OR A FETAL ANOMALY, YOU DON'T TAKE SPECIFIC STEPS --

THE REPORTER: I APOLOGIZE. CAN YOU REPEAT THAT?

BY MR. QUINLIVAN:
Q. IN CASES IN WHICH A WOMAN IS SUFFERING FROM A MATERNAL CONDITION OR A FETAL ANOMALY, YOU DON'T TAKE SPECIFIC STEPS TO ENSURE THAT THE FETUS WILL BE DELIVERED INTACT OR PARTIALLY

INTACT IN PERFORMING A D&E PROCEDURE?
A. NO.
Q. IS IT TRUE THAT WHEN A FETUS IS DELIVERED INTACT OR PARTIALLY INTACT DURING A D&E PROCEDURE, THERE GENERALLY IS MORE CERVICAL DILATION?
A. THERE GENERALLY IS MORE CERVICAL DILATION, YES.
Q. IN YOUR EXPERIENCE, THE USE OF MISOPROSTOL OFTENTIMES RESULTS OR YOU'VE SEEN SOME, SHALL WE SAY, LINK BETWEEN THE USE OF MISOPROSTOL AND SITUATIONS IN WHICH A FETUS IS DELIVERED INTACT OR PARTIALLY INTACT DURING A D&E?
A. I HAD ONE SPECIFIC CASE WHEN I USED MISOPROSTOL IN, PRIOR TO THE PROCEDURE, AND WE WERE DELAYED IN THE OR. IT TOOK A LITTLE BIT MORE TIME. AND WHEN WE GOT HER INTO THE OPERATING ROOM, ADMINISTERED THE ANESTHESIA, THE FETUS WAS KIND OF COMING OUT, KIND OF DELIVERING AT THAT POINT.

FRANKLY, I WAS HAPPY WITH THAT SITUATION BECAUSE I THINK IT WAS THEN SAFER FOR THE PATIENT.
Q. LET'S TURN TO THAT.

YOU TESTIFIED THAT YOU THINK THAT IF YOU ARE ABLE TO DELIVER THE FETUS INTACT OR PARTIALLY INTACT DURING A D&E, YOU THINK THAT'S SAFER BECAUSE THERE ARE LESS PASSES INTO THE UTERUS?
A. YES.
Q. AND YOU, I THINK YOU TESTIFIED THAT THAT'S IN PART IS EXTRAPOLATED FROM STUDIES INDICATING THAT ANY TIME YOU DO

SOMETHING ON MORE OCCASIONS, IT LEADS TO MORE COMPLICATIONS?
A. WELL, IF YOU WERE DOING SOMETHING THAT IS ASSOCIATED WITH A COMPLICATION, THE MORE TIMES YOU DO THAT SOMETHING, THE MORE LIKELIHOOD YOU ARE GOING TO HAVE THAT COMPLICATION.
Q. IS IT FAIR TO SAY, THOUGH, DOCTOR, THAT YOU ARE NOT AWARE OF ANY PUBLISHED PEER-REVIEWED STUDIES THAT HAVE EVALUATED WHETHER MULTIPLE PASSES DURING A D&E POSE GREATER RISKS THAN A D&E THAT RESULTS IN AN INTACT DELIVERY OR A PARTIALLY INTACT DELIVERY?
A. I KNOW OF NO PUBLISHED STUDIES TO THAT EFFECT. I THINK IT IS COMMON SENSE.
Q. LET'S TALK ABOUT COMMON SENSE.
IS IT FAIR TO SAY THAT PART OF WHAT YOU SAY IS YOUR COMMON SENSE, THAT THAT'S AN INTUITIVE ASSESSMENT?
A. PARTIALLY IT IS AN INTUITIVE ASSESSMENT, YES.
Q. WELL, IN ADDITION TO AN INTUITIVE ASSESSMENT, WHAT WOULD THE OTHER COMPONENTS BE, YOUR CLINICAL EXPERIENCE?
A. CLINICAL EXPERIENCE, AND, AGAIN, OTHER STUDIES, AGAIN, THAT SHOW MULTIPLE SORT OF TREATMENTS THAT ARE INVOLVED WITH THE RISK. THE MORE TREATMENTS YOU DO, THE MORE LIKELY YOU ARE GOING TO HAVE THAT COMPLICATION.
Q. BUT, AGAIN, THOSE STUDIES HAVE NOT COMPARED D&E BY DISARTICULATION VERSUS D&E WHERE THE FETUS IS DELIVERED INTACT OR PARTIALLY INTACT?
A. CORRECT.

Q. IS IT -- CAN YOU GIVE ME ANY KIND OF -- ARE YOU ABLE TO QUANTIFY YOU'RE INTUITIVE ASSESSMENT IN ANY WAY IN TERMS OF HOW MUCH SAFER YOU THINK AN INTACT OR PARTIALLY INTACT D&E IS AS COMPARED TO DISARTICULATION D&E?

A. I MEAN, IT'S A LITTLE DIFFICULT, BUT ALL I KNOW IS IF I AM HAVING TO MAKE THE FEWER NUMBER OF PASSES THAT I CAN MAKE, THE MORE I AM ASSURED THAT MY CHANCE OF INJURING THE UTERUS OR CAUSING AN INFECTION IS LESS.

Q. AND I APPRECIATE THAT.

YOU HAVE TESTIFIED THAT YOU THINK THAT D&E BY DISARTICULATION IS EXTREMELY SAFE?

A. YES.

Q. AND THAT'S WHAT I AM TRYING TO GET.

IS IT FAIR TO SAY THAT YOU ARE NOT ABLE TO QUANTIFY HOW MUCH SAFER YOU PERCEIVE A D&E BY -- THAT RESULTS IN AN INTACT OR PARTIALLY INTACT DELIVERY IS?

A. I CAN'T QUANTIFY THAT.

Q. DOCTOR, IS IT FAIR TO SAY THAT ONE OF THE REASONS THAT PHYSICIANS OR SCIENTISTS MIGHT CONDUCT A STUDY ON A PARTICULAR MEDICAL OR SURGICAL PROCEDURE IS TO TEST INTUITIVE JUDGMENTS?

A. YES.

Q. AND IS IT FAIR TO SAY THAT SOMETIMES THE INTUITIVE JUDGMENT OF A PHYSICIAN THAT A PARTICULAR MEDICAL OR SURGICAL PROCEDURE IS SAFE IS PROVEN WRONG WHEN SUBJECTED TO STUDY?

A. YES.

Q. CAN YOU GIVE ME SOME EXAMPLES?

MS. PARKER: I WILL OBJECT, YOUR HONOR. I BELIEVE THIS IS OUTSIDE THE SCOPE OF THE DIRECT.

THE COURT: I THINK IT'S PERMISSIBLE.

OVERRULED.

THE WITNESS: I CAN THINK OF A PARTICULAR INSTITUTION OF A TECHNOLOGY IN OBSTETRICS AND GYNECOLOGY THAT WAS INTUITIVELY THOUGHT TO PROVIDE BENEFIT THAT HAS SUBSEQUENTLY PROBABLY PROVIDED NO BENEFIT AND PROBABLY INCREASED HARM.

BY MR. QUINLIVAN:

Q. WHAT IS -- I AM SORRY, I MISSED WHAT YOUR --

A. THE TECHNOLOGY THAT WAS INSTITUTED IN OBSTETRICS AND GYNECOLOGY THAT I AM REFERRING TO IS ELECTRONIC FETAL HEART RATE MONITORING.

Q. IT WAS THOUGHT THAT ELECTRONIC FETAL HEART RATE MONITORING WOULD HAVE SOME BENEFITS FOR THE FETUS?

A. YES.

Q. AND WHEN IT WAS SUBJECTED TO STUDY, WHAT HAPPENED?

A. IT'S REALLY SHOWN THAT IT HAS NO EXTRA BENEFIT THAN KIND OF INTERMITTENT MONITORING OF THE FETAL HEART RATE BY AUSCULTATION, WHICH IS IN THE OLD DAYS OF FETALSCOPE OR POTENTIALLY A DOPPLER TO LISTEN TO THE HEARTBEAT, THAT THE STUDIES DON'T PARTICULARLY SHOW ANY EXTRA HARM TO THE FETUS AT ALL, BUT THERE HAVE BEEN -- DIDN'T REALLY SHOW A SIGNIFICANT

BENEFIT.

Q. THANK YOU, DOCTOR.

IS THE ABSENCE OF A STUDY ESTABLISHING THE SAFETY OF A PARTICULAR MEDICAL OR SURGICAL PROCEDURE SOMETHING YOU MIGHT TAKE INTO ACCOUNT IN ASSESSING WHETHER YOU WERE GOING TO USE THAT PROCEDURE?

A. IT MAY. BUT, PART OF, IT MIGHT BE WHETHER SOME STUDIES ARE JUST NOT POTENTIALLY FEASIBLE. THEY CAN'T BE DONE.

Q. WELL, I APPRECIATE THAT.

LET ME ASK YOU, AM I CORRECT THAT IN YOUR REBUTTAL EXPERT REPORT WHEN YOU DISCUSS WHY YOU DON'T GENERALLY GIVE INJECTIONS OF DIGOXIN OR POTASSIUM CHLORIDE, THE VERY FIRST REASON YOU GAVE IS THAT THERE ARE NO STUDIES SHOWING THAT IT WAS EASIER OR SAFER; IS THAT RIGHT?

A. YES.

Q. GOING BACK TO YOUR TESTIMONY JUST A MOMENT AGO, YOU SAID THERE ARE SOME CIRCUMSTANCES WHERE IT WOULD BE INFEASIBLE TO DO A STUDY.

DO YOU THINK IT WOULD BE INFEASIBLE TO TEST WHETHER AN INTACT OR A D&E THAT PROCEEDS BY DISARTICULATION IS RELATIVE -- STRIKE THAT. LET ME BEGIN AGAIN.

DO YOU THINK IT WOULD BE INFEASIBLE TO CONDUCT A STUDY TESTING THE COMPARATIVE SAFETY OF A D&E THAT PROCEEDS BY DISARTICULATION AS OPPOSED TO A D&E THAT RESULTS IN AN INTACT OR PARTIALLY INTACT DELIVERY?

A. I DON'T THINK THAT STUDY COULD BE FEASIBLE.
Q. WHY NOT?
A. ONE, BECAUSE OF THE -- IF YOU WANT TO DO A PROPER STUDY, YOU NEED TO DO IT THAT IT WOULD BE PROSPECTIVE AND YOU WOULD RANDOMIZE PATIENTS TO IT, TO THE TWO TREATMENTS.

WHEN A LOT OF TIMES YOU CAN'T PREDICT WHETHER OR NOT THE FETUS IS GOING TO COME OUT INTACT, HOW CAN YOU RANDOMIZE PATIENTS TO TWO GROUPS WITH THE INTENT OF TREATING ONE. THAT CAN'T BE DONE.

Q. IS IT FAIR TO SAY, AM I CORRECT, THOUGH, THAT PROSPECTIVE RANDOMIZED TRIALS ARE NOT THE ONLY FORM OF STUDY THAT ARE ACCEPTED IN THE MEDICAL LITERATURE?
A. CORRECT.
Q. THERE ARE RETROSPECTIVE COHORT STUDIES WHERE YOU GO BACK AND COMPARE ONE PROCEDURE AS TO ANOTHER PROCEDURE?
A. CORRECT.
Q. AND THERE IS NO REASON WHY IF ON THE MEDICAL CHARTS IT WAS LISTED WHETHER A D&E RESULTED IN AN INTACT OR PARTIALLY INTACT DELIVERY AND ANOTHER CHART SAID IT WAS DISARTICULATION, THERE IS NO REASON WHY YOU COULDN'T GO BACK AND CONDUCT SUCH A RETROSPECTIVE COHORT STUDY; ISN'T THAT RIGHT?
A. YOU COULD, BUT THE POTENTIAL FOR HUGE BIAS OR UNTHOUGHT OF THINGS THAT WOULD BE DIFFERENCES IN THOSE CASES, I THINK IS HUGE. AND I THINK THAT IF THAT STUDY WERE DONE, IT WOULD BE -- VALIDITY OF IT COULD BE IN QUESTION.

Q. AND JUST ON THAT POINT, WHEN WE TALKED A LITTLE BIT EARLIER ABOUT THE ABSENCE OF STUDIES, WE WEREN'T -- LET'S CLARIFY THAT.

YOU ARE NOT AWARE OF ANY PROSPECTIVE RANDOMIZED TRIALS OR CLINICAL STUDIES THAT HAVE COMPARED AN INTACT D&E VERSUS A DISARTICULATION D&E?

A. CORRECT.

Q. YOU ARE NOT AWARE OF ANY RETROSPECTIVE COHORT STUDIES THAT HAVE COMPARED A DISARTICULATION D&E VERSUS AN INTACT D&E?

A. CORRECT.

Q. DOCTOR, GOING BACK TO THE CASES IN WHICH YOU ARE DOING A D&E AND IT PROCEEDS WITH A PARTIALLY INTACT DELIVERY SO THE CALVARIUM IS STUCK IN THE CERVIX, I THINK YOU TESTIFIED THAT YOU SLIDE, YOU USE THE FORCEPS TO CRUSH THE CALVARIUM, RIGHT?

A. YES.

Q. IS IT FAIR THAT YOU GENERALLY SLIDE THE BIERER FORCEPS, IF YOU ARE USING THOSE, OR ANY FORM OF FORCEPS, UNDER THE CERVIX BETWEEN THE FETUS AND THE UTERINE CAVITY; IS THAT CORRECT?

A. I AM SORRY, CAN YOU REPEAT THAT PART?

Q. LET ME JUST ASK YOU.

CAN YOU DESCRIBE FOR US HOW YOU GET THE FORCEPS AROUND THE CALVARIUM BEFORE CRUSHING IT?

A. IN A SITUATION WHERE THE FETUS IS DELIVERED UP UNTIL THE CALVARIUM?

Q. THAT'S RIGHT.

A. AGAIN, AS I TESTIFIED, I WOULD SEPARATE THE CALVARIUM FROM

THE FETUS, SO --

Q. LET ME STOP YOU RIGHT THERE.

HOW WOULD YOU SEPARATE THE CALVARIUM FROM THE FETUS?

A. UNDER DIRECT VISUALIZATION, I WOULD USE, SEEING OUTSIDE OF THE CERVIX WITHIN THE VAGINA THAT I CAN SEE DIRECTLY, I WOULD USE SCISSORS TO CUT THE NECK AND SEPARATE THE -- I AM NOT IN THE UTERUS, I AM IN THE VAGINA, SEPARATING THE FETAL CALVARIUM FROM THE FETAL BODY.

Q. AND AFTER YOU'VE DONE THAT, THE CALVARIUM IS STILL IN THE CERVIX?

A. OR IN THE LOWER UTERINE SEGMENT.

Q. OKAY.

THEN WHAT IS THE NEXT STEP THAT YOU DO?

A. THE NEXT STEP I WOULD USE IS TO PUT THE BIERER FORCEPS -- IS WHAT I MOST LIKELY WOULD BE USING IN THE SITUATION -- INTO THE UTERUS, GET AROUND, OPEN THEM WIDE, GET AROUND THE CALVARIUM, AND CRUSH THE CALVARIUM. JUST AS IF IT WERE HIGHER UP AND NOT STUCK IN THE CERVIX, I WOULD BE DOING IT JUST THE SAME WAY.

Q. AND IS IT FAIR TO SAY THAT THE CALVARIUM IS ONE OF THE LARGEST PARTS OF THE FETUS?

A. YES.

Q. IT IS ALSO ONE OF THE WIDEST PARTS OF THE FETUS?

A. YES.

Q. IS IT FAIR TO SAY THAT WHEN YOU ARE OPENING THE FORCEPS TO

GET AROUND THE CALVARIUM, YOU ARE OPENING THEM WIDER THAN YOU WOULD IF YOU WERE ATTEMPTING TO GRASP A FETAL LIMB?

A. YES.

Q. COULD THERE POTENTIALLY BE RISKS TO THE CERVIX WHEN YOU ARE OPENING THE FORCEPS WIDE ENOUGH TO GET AROUND THE CALVARIUM?

A. YES.

Q. IN FACT, ONE OF THOSE RISKS MIGHT BE A PERFORATION OR A LACERATION OF THE CERVIX, RIGHT?

A. YES.

Q. AND ANOTHER RISK MIGHT BE A PERFORATION OR A LACERATION OF THE LOWER UTERINE SEGMENT?

A. YES.

Q. NOW, LET'S GO --

A. MAY I CLARIFY?

Q. PLEASE DO.

A. AT LEAST OFTEN IF THAT CALVARIUM IS STILL STUCK IN THE CERVIX OR LOWER UTERINE SEGMENT, IN THE ATTEMPT OF GETTING THE FORCEPS IN, IT PUSHES THE CALVARIUM UP HIGHER, SO YOU ARE NOT IN THE CERVIX TRYING TO CRUSH IT; IT'S YOU'RE HIGHER UP INTO THE BODY OF THE UTERUS.

Q. SO, IN ADDITION, IS IT FAIR TO SAY THAT THE RISK IN THAT SITUATION WOULD BE, THE ONLY DIFFERENCE WOULD BE THE RISK WOULD BE A PERFORATION OR LACERATION OF THE UTERUS AS OPPOSED TO THE CERVIX?

A. YES.

BUT IT IS NO DIFFERENT THAN THE BASELINE RISK OF THE PROCEDURE IF IT HADN'T COME OUT INTACT BECAUSE THIS IS WHAT WE DO DOING A DISARTICULATION OF THE -- AS YOU HAVE TALKED ABOUT, THE DISARTICULATION D&E. THAT'S WHAT WE DO IN THAT PROCEDURE. SO IT'S NOT REALLY -- THAT PART IS NOT ANY DIFFERENT.

Q. AND LET'S TALK ABOUT THAT A LITTLE BIT.

ARE THE -- CAN THE BONES OF THE CALVARIUM, CAN THEY BE SHARP?

A. YES.

Q. ARE THEY IN ANY -- ARE THEY SHARPER SAY THAN THE BONES OF THE FETAL LEG OR ARE THEY ROUGHLY COMPARABLE?

A. IT DEPENDS ON HOW -- IF IT'S A DISARTICULATION OF HOW IT WENT. A CALVARIUM COULD BE CRUSHED AND THERE ARE NOT SHARP EDGES AND THE FEMUR, WHICH IS A LEG BONE, COULD BE BROKEN AND BE SHARPER. I THINK YOU CAN'T PREDICT THAT.

BUT I THINK ANY OF THE MAJOR LONG BONES, CERTAINLY NOT RIBS, BUT FEMUR, HUMOROUS COULD BE SHARPER THAN A CALVARIUM THAT HAS BEEN CRUSHED.

Q. AND WHEN YOU ARE CRUSHING THE CALVARIUM, THERE IS THE SAME RISKS THAT WE TALKED ABOUT EARLIER, POSSIBLE PERFORATION OR LACERATION OF THE CERVIX, THE LOWER UTERINE SEGMENT, OR THE UTERUS; IS THAT RIGHT?

A. YES.

Q. AND A CERVICAL OR UTERINE LACERATION, IT CAN BE RELATIVELY MINOR OR IT COULD BE RELATIVELY SEVERE; IS THAT RIGHT?

A. YES.
Q. IF IT'S SEVERE ENOUGH, THERE ARE SOME CASES WHERE A WOMAN MIGHT EXSANGUINATE AND DIE, RIGHT?
A. YES.
Q. CAN YOU TELL US WHAT EXSANGUINATE MEANS?
A. TO BLEED TO DEATH.
Q. DOCTOR, YOU GAVE US SOME TESTIMONY THIS MORNING ABOUT WHY YOU DON'T USE AN INJECTION OF DIGOXIN OR POTASSIUM CHLORIDE, AND I THINK YOU SAID THAT THERE ARE SOME RISKS TO THOSE PROCEDURES; IS THAT RIGHT?
A. CORRECT.
Q. ONE OF THE THINGS YOU ALSO MENTIONED IS THAT IT WAS DIFFICULT TO GIVE AN INJECTION OF DIGOXIN BECAUSE THERE ARE SOME SITUATIONS IN WHICH THERE IS A LACK OR EVEN AN ABSENCE OF ENOUGH AMNIOTIC FLUID, RIGHT?
A. YES.
Q. AND THAT EXAMPLE YOU GAVE, THAT'S LIMITED TO WHAT WOULD BE AN INTRA-AMNIOTIC INJECTION OF DIGOXIN; IS THAT RIGHT?
A. YES. HOWEVER, IN THOSE SITUATIONS WHERE THERE IS VERY LITTLE AMNIOTIC FLUID, VISUALIZATION WITH ULTRASOUND IS USUALLY MUCH MORE DIFFICULT.

SO EVEN IF YOU WERE ATTEMPTING TO DO AN INTRACARDIAC INJECTION OF EITHER DIGOXIN OR POTASSIUM CHLORIDE OR KCL WITH THAT LOW AMOUNT OF AMNIOTIC FLUID, IT IS TECHNICALLY MORE DIFFICULT.

Q. I THINK YOU TALKED A LITTLE BIT EARLIER ABOUT AMNIOCENTESIS.

YOU'VE HAD A GOOD AMOUNT OF EXPERIENCE DOING AMNIOCENTESIS; IS THAT RIGHT?

A. YES.

Q. AND WITH RESPECT TO THE RISKS OF AN AMNIOCENTESIS, ARE THOSE RISKS GREATER TO THE FETUS OR TO THE MOTHER?

A. TO THE FETUS.

IN AN -- I GUESS IN A SITUATION OF PRE-ABORTION, IT IS NOT INCREASED RISK TO THE FETUS, BUT IN A PREGNANCY THAT IS MEANT OR WANTED TO BE CONTINUED, YES, THE GREATEST RISK IS TO THE FETUS.

Q. I THINK YOU ALSO TESTIFIED THAT THE RISKS OF AN INJECTION OF DIGOXIN OR POTASSIUM CHLORIDE ARE RELATIVELY SIMILAR TO THE RISKS OF AN AMNIOCENTESIS; IS THAT CORRECT?

A. YES BECAUSE THE RISKS ARE ALL OR THE BULK OF THE RISKS IS THE AMNIOCENTESIS PORTION OF IT. THERE ARE, AGAIN, THE SMALL RISKS OF IT GETTING INTO THE MATERNAL SERUM THAT I TALKED ABOUT.

Q. GOING BACK TO THOSE RISKS, I THINK YOU MENTIONED THE DREY ARTICLE. IS THAT AN ARTICLE BY DOCTOR ELEANOR DREY ENTITLED "SAFETY OF INTRA-AMNIOTIC DIGOXIN ADMINISTRATION BEFORE LATE SECOND-TRIMESTER ABORTION BY DILATION AND EVACUATION" THAT WAS PUBLISHED IN THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY?

A. YES.

Q. AND IF YOU CAN RECALL TODAY, THERE WERE NO MATERNAL HEALTH COMPLICATIONS THAT THE AUTHORS OF THAT STUDY FOUND; IS THAT CORRECT?

A. CORRECT. HOWEVER, THE INCIDENTS OF SOME OF THE COMPLICATIONS THAT YOU WOULD LOOK FOR, THEY DID NOT HAVE ENOUGH PATIENTS TO WIND UP POTENTIALLY SEEING SOME OF THOSE COMPLICATIONS.

Q. I APPRECIATE THAT, DOCTOR.

MY QUESTION WAS SIMPLY WHETHER IN THE CASES THAT THEY HAD STUDIED, WHETHER OR NOT THERE WERE ANY MATERNAL HEALTH COMPLICATIONS.

A. IN THE CASES THAT THEY HAD STUDIED AND REPORTED ON, THERE WERE NOT ANY MATERNAL HEALTH COMPLICATIONS.

Q. AND I THINK WHEN WE SPOKE DURING YOUR DEPOSITION, YOU ALSO MENTIONED THAT YOU HAD REVIEWED AN ARTICLE BY DR. ISADA, ET AL., WHICH WAS PUBLISHED IN THE OBSTETRICS AND GYNECOLOGY, AND TALKED ABOUT INJECTIONS OF POTASSIUM CHLORIDE?

A. CORRECT.

Q. YOU REVIEWED THAT STUDY IN PREPARATION FOR YOUR DEPOSITION, CORRECT?

A. CORRECT.

Q. AM I CORRECT THAT IN THAT STUDY, IN THE GROUP THAT THE AUTHORS HAD LOOKED AT, THERE WAS NO MATERNAL COMPLICATIONS THAT RESULTED OR WERE ATTRIBUTABLE TO THE INJECTIONS OF POTASSIUM CHLORIDE?

A. CORRECT.
Q. I THINK YOU TESTIFIED BRIEFLY THAT THERE WERE SOME PATIENTS FOR WHOM AN INJECTION OF DIGOXIN OR POTASSIUM CHLORIDE MIGHT BE DIFFICULT. I THINK ONE OF THE EXAMPLES YOU GAVE IS A WOMAN WHO IS OBESE; IS THAT RIGHT?
A. CORRECT.
Q. IS IT FAIR TO SAY THAT DOING A D&E PROCEDURE FOR A WOMAN WHO'S OBESE MIGHT ALSO BE TECHNICALLY DIFFICULT?
A. IT MAY BE TECHNICALLY DIFFICULT, YES.
Q. IN FACT, YOU HAD ONE CASE IN WHICH YOU WERE -- YOU HAD A PATIENT WHO WAS EXTREMELY OBESE AND YOU ENDED UP DOING A HYSTEROTOMY; IS THAT CORRECT?
A. YES. I HAD TO DO A HYSTEROTOMY, BUT AS I BELIEVE IN MY DEPOSITION WE DISCUSSED THAT IT WASN'T DUE TO HER OBESITY THAT LED TO THE HYSTEROTOMY.
Q. WELL, LET'S GO BACK TO THAT FOR A QUICK SECOND.
AM I CORRECT THAT IN YOUR DEPOSITION YOU SAID THAT ONE OF THE REASONS YOU COULD NOT DO A D&E WAS BECAUSE YOU DIDN'T HAVE FORCEPS LONG ENOUGH TO REACH THE FETAL PARTS?
A. YES.
PART OF THE REASON I COULDN'T REACH IT WAS SIZE, OBESITY OF THE WOMAN, BUT ALSO WAS THAT THE LARGE FIBROIDS IN THE LOWER PART OF THE UTERUS MADE THE FETUS UP, MUCH HIGHER UP IN THE UTERINE CAVITY AND WAS DIFFICULT, IN FACT, IT TURNED OUT TO BE IMPOSSIBLE TO REACH.

Q. SO, IS IT FAIR TO SAY AT LEAST PART OF THE REASON THAT YOU WERE NOT, THAT YOU HAD TO DO A HYSTEROTOMY WAS RESULTED FROM THE SIZE OR THE OBESITY OF THAT PARTICULAR PATIENT?
A. WELL, ACTUALLY NO BECAUSE THE HYSTEROTOMY WASN'T DONE UNTIL THE INDUCTION FAILED AND HER OBESITY HAD NO REASON -- HAD NO BEARING ON WHY THE INDUCTION THEN FAILED.
Q. I UNDERSTAND. SO, LET ME REPHRASE THAT.
IS IT FAIR TO SAY THAT THE REASON YOU WERE NOT ABLE TO PERFORM THE D&E WAS AS A RESULT OF THE SIZE OF THE WOMAN?
A. PART OF THE TECHNICAL DIFFICULTY OF THE D&E WAS DUE TO HER SIZE.
Q. DOCTOR, I THINK YOU TESTIFIED THAT THERE ARE SOME OCCASIONS IN WHICH YOUR PATIENTS ASK FOR AN INJECTION OF POTASSIUM CHLORIDE; IS THAT RIGHT?
A. WELL, THEY TEND NOT TO ASK FOR AN INJECTION FOR POTASSIUM CHLORIDE, THEY ASK IS THERE ANY WAY THERE CAN BE A FETAL DEMISE PRIOR TO THE PROCEDURE.
Q. AND I THINK YOU TESTIFIED THIS MORNING THAT ONE OR TWO OCCASIONS YOU HAVE CONDUCTED OR GIVEN AN INJECTION OF POTASSIUM CHLORIDE IN THOSE SITUATIONS?
A. YES.
Q. DURING YOUR DEPOSITION -- WELL, LET ME ASK YOU THIS WAY: DO YOU BELIEVE THAT THE NUMBER IS, IN FACT, THREE OR FOUR PATIENTS WHO YOU HAVE GIVEN INJECTIONS OF POTASSIUM CHLORIDE TO UNDER THOSE CIRCUMSTANCES?

A. VERSUS ONE OR TWO?
Q. YES.
A. IT COULD BE. IT'S REALLY HARD FOR ME TO RECALL. I HAVE NOT DONE IT PARTICULARLY OFTEN. AND AS A DENOMINATOR OF NUMBERS OF D&E'S I'VE PERFORMED DURING THAT TIME PERIOD WAS SEVERAL HUNDRED.
MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?
THE COURT: YES.
BY MR. QUINLIVAN:
Q. DOCTOR, IF YOU COULD OPEN -- IS THIS A COPY OF THE DEPOSITION THAT YOU GAVE IN THIS CASE?
THE COURT: DO YOU HAVE A COPY FOR THE COURT?
MR. QUINLIVAN: OH, I AM SORRY, YOUR HONOR. I DO.
THE WITNESS: YES.
BY MR. QUINLIVAN:
Q. AND IF YOU LOOK AT THE VERY LAST PAGE, IS THAT YOUR SIGNATURE?
A. YES.
Q. IF YOU COULD TURN TO PAGE 116, BEGINNING LINE TWO AND CONTINUING ON TO LINE 11. AND IF YOU COULD JUST READ THAT.
A. YES.
Q. DOES THAT REFRESH YOUR RECOLLECTION THAT THERE MAY HAVE BEEN THREE OR FOUR PATIENTS IN WHICH -- OR FOR WHOM YOU GAVE INJECTIONS OF POTASSIUM CHLORIDE?

A. YES, THERE MAY HAVE BEEN THREE OR FOUR PATIENTS.
Q. AND IN THOSE THREE OR FOUR OCCASIONS, YOU ACTUALLY GAVE THE INJECTION OF POTASSIUM CHLORIDE, RIGHT?
A. CORRECT.
Q. AND YOU WOULD NOT HAVE GIVEN AN INJECTION OF POTASSIUM CHLORIDE TO THOSE PATIENTS IF YOU THOUGHT THAT IT WAS UNSAFE, WOULD YOU?
A. CORRECT.
Q. DOCTOR, IF A PHYSICIAN ENSURED FETAL DEMISE PRIOR TO A D&E THAT RESULTS IN AN INTACT OR PARTIALLY INTACT FETUS BY EITHER AN INJECTION OF DIGOXIN OR POTASSIUM CHLORIDE, DO YOU THINK THAT PHYSICIAN WOULD BE IN VIOLATION OF THE ACT PASSED BY CONGRESS?
A. NO.
Q. DOCTOR, I BELIEVE YOU TESTIFIED THAT WHEN YOUR PATIENTS ASK YOU WHETHER THE FETUS EXPERIENCES PAIN, YOU TELL THEM THAT THERE IS NO WAY TO KNOW; IS THAT RIGHT?
A. TO A MEDICALLY CERTAINTY, YES. I TELL THEM THERE IS NO WAY TO KNOW.
Q. AND WHAT IS THAT JUDGMENT BASED ON?
A. BASED ON INFORMATION AND STUDIES AND TEACHING I HAD DURING RESIDENCY AND FELLOWSHIP.
Q. AND IS IT FAIR TO SAY THAT YOUR RESIDENCY AND FELLOWSHIP OCCURRED IN THE MID 1990'S?
A. YES.

Q. AND IS IT FAIR TO SAY THAT THE LAST TIME YOU LOOKED AT THE MEDICAL LITERATURE REGARDING FETAL PAIN WAS DURING YOUR RESIDENCY AND YOUR FELLOWSHIP?

A. YES.

Q. SO THE LAST TIME YOU LOOKED AT THE MEDICAL LITERATURE REGARDING FETAL PAIN WAS ROUGHLY 10 YEARS AGO, GIVE OR TAKE A FEW YEARS?

A. YES.

Q. DOCTOR, WHEN YOU ARE PERFORMING A D&E THAT RESULTS IN A PARTIALLY INTACT DELIVERY, AND YOU HAVE -- AND PRIOR TO, AS YOU SAY, SEPARATING THE BODY OR THE THORAX FROM THE CALVARIUM, WHO IS HOLDING THE BODY OF THE FETUS?

A. NO ONE.

THE VAGINA IS KIND OF TENDS TO BE SUPPORTING IT, AND THE PORTIONS THAT ARE OUT OF THE VAGINA KIND OF JUST HANG DOWN.

Q. IN THOSE SITUATIONS, HAVE YOU EVER -- PRIOR TO SEPARATING THE CALVARIUM FROM THE THORAX, HAVE YOU EVER NOTICED ANY MOVEMENT OR TWITCHING OR JERKING OF ANY FORM IN THE FETUS?

A. NO, BUT I GUESS I WOULDN'T BE PARTICULARLY PAYING ATTENTION TO THAT. I AM FOCUSING ON TRYING TO COMPLETE THE PROCEDURE AS SAFELY AS POSSIBLE.

Q. HOW ABOUT WHEN YOU TAKE THE SCISSORS TO CUT AND SEPARATE THE FETUS' HEAD FROM THE BODY, HAVE YOU EVER NOTICED ANY MOVEMENTS OR JERKS OR ANYTHING OF THAT FORM ON THE FETUS?

A. NO.

MR. QUINLIVAN: NOTHING FURTHER, YOUR HONOR.

THE COURT: ALL RIGHT. ANY REDIRECT?

MS. PARKER: YES, YOUR HONOR.

REDIRECT EXAMINATION

BY MS. PARKER:

Q. I BELIEVE IN RESPONSE TO A QUESTION BY MR. QUINLIVAN, YOU INDICATE THAT YOU WILL RECOMMEND AN INDUCTION ABORTION WHEN YOU NEED AN INTACT FETUS FOR PATHOLOGICAL REASONS; IS THAT RIGHT?

A. YES.

Q. AND WHY DO YOU MAKE THAT RECOMMENDATION?

A. IN ORDER, AGAIN, TO HAVE AN INTACT FETUS TO DO AS BEST AN AUTOPSY AS POSSIBLE FOR THE BEST CHANCE OF FINDING OUT DIAGNOSIS. AGAIN, THIS IS AN UNCLEAR DIAGNOSIS, BUT KNOWN TO BE A SEVERE FETAL ABNORMALITY SO WE CAN THEN COUNSEL THE COUPLE REGARDING RECURRENCE RISKS.

Q. AND WHY DO YOU NOT RECOMMEND DOING A D&E PROCEDURE WHERE YOU CAN GET AN INTACT FETUS?

A. BECAUSE IN MY PRACTICE I AM IN MY HANDS DOING IT. IF I AM TAKING CARE OF THE PATIENT, I THINK IT IS UNPREDICTABLE WHETHER I CAN GET AN INTACT FETUS OR NOT.

Q. YOU CAN'T GUARANTEE IT?

A. I CERTAINLY BY NO MEANS CAN GUARANTEE IT.

Q. AND YOU INDICATE THAT YOU OFFER YOUR PATIENTS THE CHOICE OF INDUCTION OR A D&E ABORTION; IS THAT RIGHT?

A. YES.

Q. AND THAT 75 PERCENT OF THE TIME THEY CHOOSE A D&E ABORTION?
A. ROUGHLY, YES.
Q. AND WHY THE LARGER PERCENTAGE OF TIMES DO PATIENTS CHOOSE A D&E PROCEDURE?
A. I THINK THERE ARE A NUMBER OF REASONS.
MR. QUINLIVAN: OBJECTION, FOUNDATION. I DON'T BELIEVE THE WITNESS TESTIFIED TO THIS.
THE COURT: WELL, THE -- I AM NOT SURE THAT IS THE RIGHT OBJECTION. IT IS SPECULATIVE UNLESS YOU CAN ESTABLISH A FOUNDATION FOR HIS KNOWLEDGE. HE DID TESTIFY AS TO THE PERCENTAGE, HOWEVER, COUNSEL.
MR. QUINLIVAN: HE TESTIFIED AS TO THE PERCENTAGE OF THOSE THAT OCCURRED BY AN INTACT OR PARTIALLY INTACT DELIVERY, NOT THE PERCENTAGE OF HIS PATIENTS WHO CHOOSE ONE, EITHER A D&E VERSUS INDUCTION --
MS. PARKER: I BELIEVE I DID DURING THE OPENING QUESTIONS. I ASKED HIM WHAT PERCENTAGE OF HIS PATIENTS DOES HE DO A D&E ABORTION VERSUS WHAT PERCENTAGE DOES HE DO INDUCTION.
THE COURT: I BELIEVE THAT WAS 85 PERCENT; IS THAT CORRECT? DO YOU RECALL THAT?
I AM GOING TO ALLOW IT. I WILL ALLOW YOU TO ANSWER THE QUESTION.
WHY DON'T YOU START OVER AGAIN?
MS. PARKER: SURE, YOUR HONOR.
BY MS. PARKER:

Q. WELL, YOU OFFER YOUR PATIENTS A CHOICE OF TWO METHODS OF ABORTION DURING SECOND-TRIMESTER; IS THAT RIGHT?
A. YES.
Q. AND THAT IS INDUCTION OR A D&E ABORTION; IS THAT RIGHT?
A. CORRECT.
Q. AND APPROXIMATELY WHAT PERCENTAGE OF PATIENTS CHOOSE TO HAVE A D&E PROCEDURE?
A. APPROXIMATELY 75 PERCENT OF THE PATIENTS CHOOSE TO HAVE A D&E PROCEDURE WITH THE REMAINDER 25 PERCENT HAVE AN INDUCTION OF LABOR.
Q. WHY DO THE LARGER NUMBER OF PATIENTS WANT TO HAVE A D&E PROCEDURE?
MR. QUINLIVAN: OBJECTION, YOUR HONOR. THAT'S SPECULATION AS TO WHY --
THE COURT: YES, UNLESS HE KNOWS. IF HE KNOWS, HE MAY ANSWER.
BY MS. PARKER:
Q. DO YOU KNOW WHY MORE PATIENTS CHOOSE TO HAVE A D&E?
A. IN MANY OF THE PATIENTS SINCE I AM THE ONE COUNSELING REGARDING THE PROCEDURE AND OFFERING THE OPTIONS, THEY OFTEN TELL ME WHY THEY WANT TO HAVE ONE PROCEDURE OR THE OTHER. I CAN'T SAY IN A HUNDRED OF THE CASES, BUT IN MANY OF THE CASES OUR INTERACTION IS SUCH THAT:
"NO, I WANT THIS PROCEDURE BECAUSE."
AND OFTEN THEY CHOOSE A D&E -- AGAIN, THE MAJORITY

OF PATIENTS CHOOSING D&E IS BECAUSE, ONE: THEY DON'T WANT TO GO THROUGH LABOR. IT IS SOMETHING THAT WHEN THEY HAVE BEEN DIAGNOSED WITH ONE OF THESE PROBLEMS IT IS NOT SOMETHING THAT THEY WANT TO GO THROUGH.

TWO: OFTEN MANY OF THEM ARE VERY WORRIED ABOUT SEEING THE FETUS, AND THEY FEEL THAT THEY WOULD DO BETTER WITHOUT SEEING THE FETUS.

THREE, MANY OF THEM DON'T WANT TO SPEND THE TIME IN THE HOSPITAL THAT IT WOULD TAKE TO HAVE AN INDUCTION OF LABOR.

THOSE ARE THE MAJORITY OF THE REASONS.

Q. NOW, MR. QUINLIVAN HAD ALSO ASKED YOU A SERIES OF QUESTIONS ABOUT A DISARTICULATION D&E VERSUS AN INTACT D&E. DO YOU RECALL THOSE QUESTIONS?

A. YES.

Q. AND THE WAY YOU DO THE PROCEDURE, DO YOU CONSIDER THOSE TWO SEPARATE TYPES OF PROCEDURES?

A. THE WAY I DO THE PROCEDURE, NO, I DO NOT. I THINK IT IS A VARIATION OF ONE. AND IT HAPPENS AT AN UNPREDICTABLE RATE, WHETHER THE FETUS IS INTACT OR WHETHER IT IS COMPLETELY DISARTICULATED.

Q. AND WHEN THE FETUS IS ABLE TO EMERGE INTACT, YOU PREFER THAT; ISN'T THAT RIGHT?

A. YES.

Q. AND WHY DO YOU PREFER IT?

A. BECAUSE I THINK THE RISK OF INJURY TO THE PATIENT IS LESS

BECAUSE THERE ARE LESS PASSES OF INSTRUMENTS INTO THE UTERINE CAVITY IN THAT SITUATION.

Q. AND LESS PASSES RESULTS IN WHAT?

A. IN MY CLINICAL EXPERIENCE -- AND, AGAIN, IF YOU EXTRAPOLATE FROM OTHER SUDDEN STUDIES, WHICH MAY OR MAY NOT BE APPROPRIATE, BUT THE FEWER TIMES YOU DO SOMETHING THAT HAS A POTENTIAL RISK, THE LOWER LIKELIHOOD OF THAT RISK.

Q. NOW, MR. QUINLIVAN ALSO ASKED YOU A SERIES OF QUESTIONS ABOUT DIGOXIN; IS THAT RIGHT?

A. YES.

Q. AND I BELIEVE YOU SAID IN RESPONSE THAT HE HAD YOU SAY THAT THERE WERE NO STUDIES SHOWING THAT DIGOXIN WAS SAFER OR EFFICACIOUS?

A. I THINK THERE IS A STUDY THAT SHOW THERE WAS NO DIFFERENCE IN REGARDS TO SAFETY TO THE PATIENT.

Q. BUT THERE HAVE BEEN STUDIES ABOUT DIGOXIN; ISN'T THAT RIGHT?

A. YES.

Q. AND THEY ARE THE TWO STUDIES PUBLISHED OUT OF UCSF?

A. YES.

Q. ONE OF WHICH WAS AUTHORED BY DR. DREY?

A. YES.

Q. AND WHAT DID THOSE STUDIES SHOW?

A. ONE STUDY WAS, I GUESS, SOMEWHAT KIND OF A PHARMAKINETIC TYPE STUDY OR A POTENTIAL SMALL NUMBER OF PATIENTS TO SEE IF

THERE WAS A RISK TO PATIENTS WITH THAT. AND A KIND OF FEASIBILITY: IS THIS SOMETHING THAT CAN BE KIND OF DONE AND ACHIEVE FETAL DEATH?

THE OTHER STUDY WAS RANDOMIZING PATIENTS TO HAVE THE DIGOXIN INJECTION VERSUS NOT HAVING THE DIGOXIN INJECTION. AND THE PRIMARY OUTCOME VARIABLE IN THAT STUDY WAS THE EASE AND SPEED OF PROCEDURE. AND THERE WAS NO SIGNIFICANT DIFFERENCE BETWEEN THE TWO GROUPS AS FAR AS EASE AND SPEED OF THE PROCEDURE.

Q. SO WHAT DID THE STUDY SHOW IN TERMS OF THE EFFICACY OF THE USE OF DIGOXIN?

MR. QUINLIVAN: YOUR HONOR, I WILL OBJECT. THAT IS BEYOND THE SCOPE. I WASN'T QUESTION ABOUT THE EFFICACY OF IT. I WAS ONLY QUESTIONING ABOUT THE SAFETY.

THE COURT: SUSTAINED.

MS. PARKER: HE ACTUALLY ASKED HIM WHETHER THERE WERE STUDIES THAT SHOWED WHETHER IT WAS SAFE OR EFFICACIOUS TO USE. THOSE WERE THE PRECISE WORDS.

THE COURT: WELL, WE ARE NOT GOING TO GO BACK AND HAVE THE COURT REPORTER LOOK FOR THE WORD. I WILL PERMIT IT.

THE WITNESS: CAN YOU REPEAT THE QUESTION?

BY MS. PARKER:

Q. WHAT DID THE STUDY CONCLUDE IN TERMS OF THE -- WHETHER OR NOT DIGOXIN WAS EFFICACIOUS?

A. IT WAS EFFICACIOUS IN CREATING FETAL DEMISE, BUT WHETHER --

IT WAS NOT EFFICACIOUS IN CHANGING THE EASE OF THE PROCEDURE.
Q. YOU ALSO TESTIFIED THAT THERE WERE THREE TO FOUR PATIENTS TO WHOM YOU GAVE KCL?
A. YES.
Q. DO YOU REMEMBER THAT? DO YOU RECALL WHEN THEIR TERMINATIONS OCCURRED, WHAT GESTATIONAL AGE RANGE?
A. ONE PATIENT IN PARTICULAR I RECOMMEND -- I MEAN, I REMEMBER. AND THAT WAS -- SHE WAS PROBABLY IN THE 22, 23 WEEK RANGE.
Q. SO IT WAS FAIRLY LATE IN THE SECOND-TRIMESTER?
A. YES.
Q. AND WOULD YOU RECOMMEND KCL OR DIGOXIN IN THE EARLIER PORTION OF THE SECOND-TRIMESTER?
A. NO.
Q. WHY IS THAT?
A. WELL, AS I THINK I DISCUSSED BEFORE, I DON'T THINK IT HAS ANY ADVANTAGES, AND IT HAS SOME RISKS.
Q. YOU ALSO TESTIFIED IN THE CROSS ABOUT THE ISADA STUDY; IS THAT RIGHT?
A. YES.
Q. IN THAT STUDY, ISN'T IT CORRECT THAT ONLY 21 PATIENTS WERE STUDIED?
A. YES.
Q. AND IS IT ALSO CORRECT THAT THE KCL INJECTION WAS SUCCESSFUL IN ONLY 20 OF THE 21 CASES OF THAT STUDY?

A. YES.
Q. MR. QUINLIVAN ALSO ASKED YOU SOME QUESTIONS ABOUT THE EXAMPLE OF THE ELECTRONIC FETAL HEART MONITORING; DO YOU REMEMBER THAT?
A. YES.
Q. ARE THERE SITUATIONS WHERE ELECTRONIC FETAL HEART MONITORING IS STILL USED?
A. YEAH, IN EVERY LABOR AND DELIVERY UNIT IN THE UNITED STATES, PROBABLY.
Q. AND, IN YOUR OPINION, WOULD IT BE GOOD HEALTH POLICY TO BAN THE USE OF ELECTRONIC FETAL HEART MONITORING?
A. NO.

MS. PARKER: I DON'T HAVE ANY FURTHER QUESTIONS.

THE COURT: ANY RECROSS?

MR. QUINLIVAN: JUST A FEW BRIEF QUESTIONS, YOUR HONOR.

RECROSS-EXAMINATION

BY MR. QUINLIVAN:
Q. DOCTOR, I BELIEVE THAT MS. PARKER ASKED YOU A QUESTION ABOUT WHEN YOU DON'T KNOW THE DIAGNOSIS OF THE FETAL ABNORMALITY WHY YOU DON'T RECOMMEND A D&E THAT RESULTS IN AN INTACT OR PARTIALLY INTACT DELIVERY. AND YOU SAID THAT YOU CAN NEVER KNOW WHETHER OR NOT A D&E IS GOING TO RESULT IN AN INTACT DELIVERY; IS THAT RIGHT?
A. IN MY HANDS.

Q. IN YOUR HANDS?
A. YES.
Q. WOULDN'T ONE OF THE OTHER REASONS WHY YOU WOULDN'T RECOMMEND A D&E WITH AN INTACT OR PARTIALLY INTACT DELIVERY IS THAT IF YOU DON'T HAVE A DIAGNOSIS, YOU MIGHT WANT TO ANALYZE THE CONTENTS OF THE BRAIN?
A. YES. BUT I THOUGHT THAT'S PART OF WANTING -- I THOUGHT THAT WAS -- YES. THAT WAS EVIDENT.
Q. AND MS. PARKER ASKED YOU A QUESTION ABOUT WHY SOME OF YOUR PATIENTS DON'T PREFER A LABOR INDUCTION ABORTION. I THINK ONE OF THE REASONS YOU GAVE WAS THAT YOUR -- THE WOMAN MAY NOT WANT TO SEE THE FETUS; IS THAT RIGHT?
A. YES.
Q. NOW, IN A LABOR INDUCTION ABORTION YOU ARE NOT SHOWING THE FETUS TO THE MOTHER IN EVERY CASE, ARE YOU?
A. NO, WE ARE NOT. BUT WITH A LABOR INDUCTION, IT IS OFTEN KIND OF UNPREDICTABLE WHEN THE FETUS DELIVERS. AND IT IS PROBABLY A MINORITY OF TIMES THE PHYSICIAN IS ACTUALLY THERE AT THE TIME TO DELIVER THE FETUS. OFTEN YOU DON'T HAVE THE NORMAL KIND OF CERVICAL DILATION THAT YOU MIGHT HAVE IN A TERM LABOR.
YOU HAVE NOTHING, NOTHING, NOTHING. AND THEN, ALL OF A SUDDEN, SHE GOES:
"I HAVE GOT TO PUSH," AND THE FETUS KIND OF POPS INTO THE BED.
Q. AND I BELIEVE MS. PARKER ASKED YOU ABOUT WHY YOU -- FOR

PATIENTS UNDER 22 WEEKS YOU WOULD NOT RECOMMEND AN INJECTION OF POTASSIUM CHLORIDE; IS THAT RIGHT?

A. SHE DID ASK ME THAT QUESTION, YES.

Q. NOW, IF A PATIENT PREFERRED OR DESIRED AN INJECTION OF POTASSIUM CHLORIDE TO ENSURE FETAL DEMISE PRIOR TO A PROCEDURE, YOU WOULD GIVE THAT TO HER, WOULDN'T YOU?

A. YES.

MR. QUINLIVAN: THANK YOU. NOTHING FURTHER.

THE COURT: ALL RIGHT. ANYTHING ELSE?

MS. PARKER: NO, YOUR HONOR.

THE COURT: THANK YOU, DOCTOR. YOU ARE EXCUSED.

THE WITNESS: THANK YOU.

THE COURT: ALL RIGHT. WERE THERE ANY OTHER WITNESSES FOR THE PLAINTIFFS TODAY?

MS. PARKER: NO, YOUR HONOR. OUR NEXT WITNESS WON'T BE AVAILABLE UNTIL MONDAY.

THE COURT: ALL RIGHT. AND ON MONDAY WE HAVE DOCTORS BROEKHUIZEN AND CREININ?

MS. PARKER: YES.

THE COURT: AND THEN HOW LONG DO YOU THINK -- IN ADDITION TO THE REGULAR TRIAL DAY, HOW MUCH ADDITIONAL TIME DO YOU ANTICIPATE WE WOULD NEED TO GET THROUGH BOTH OF THEM ON MONDAY?

MS. GARTNER: YOUR HONOR, I THINK IT'S HARD TO KNOW UNTIL WE ACTUALLY MEET WITH THEM OVER THE WEEKEND TO DO THE

PREPARATION. I THINK THE MAXIMUM ADDITIONAL TIME THAT WE WOULD ASK FOR WOULD BE TWO HOURS. AND I DON'T THINK WE WOULD NEED THAT MUCH MORE TIME.

THE COURT: OKAY. THE LONGER THE DAY IS, THE -- WE ARE GOING TO HAVE TO TAKE A LUNCH BREAK IN THE MIDDLE OF THE DAY. WE CAN'T JUST ADD TWO HOURS ON TO AN ALREADY LONG DAY.

SO ESSENTIALLY YOU ARE ASKING US TO BE AVAILABLE UNTIL 3:30 OR 4:00 O'CLOCK ON MONDAY WITH A LUNCH BREAK.

ALL RIGHT. THAT WILL BE ACCEPTABLE TO THE COURT.

AND YOU ALL WILL HAVE YOUR FIRST WITNESS HERE ON THURSDAY. I WOULD ASSUME THAT YOU WILL HAVE NO DIFFICULTY IN GETTING ALL OF YOUR WITNESSES IN FROM THURSDAY TO THE FOLLOWING THURSDAY?

MR. QUINLIVAN: THAT'S RIGHT, YOUR HONOR. WE HAVE CURRENTLY SCHEDULED -- WE HAVE A WITNESS FOR EVERY ONE OF THOSE DAYS. AND WE WILL ENSURE THAT THEY ARE COMPLETED BY THE LAST THURSDAY, WHICH IS APRIL 15TH.

THE COURT: ALL RIGHT. THAT SEEMS FINE.

ALL RIGHT, THEN. WE ARE ADJOURNED FOR NOW, AND YOU ALL, I WILL SEE YOU ON MONDAY MORNING.

MR. SIMPSON: YOUR HONOR, IF I COULD, THERE IS ONE OTHER THING THAT WE NEED TO BRING UP. AND I BELIEVE PLAINTIFFS' COUNSEL KNOWS WE ARE GOING TO BRING THIS UP. IN OUR CONFERENCE CALL LAST FRIDAY WE DISCUSSED THE CHASEN STUDY. SOME OF THE EXHIBITS THAT PLAINTIFFS INDICATED ON THE EXHIBIT

WITNESS ARE SUBJECT TO A CONFIDENTIALITY ORDER OUT OF THE SOUTHERN DISTRICT OF NEW YORK.

THE COURT: RIGHT.

MR. SIMPSON: I UNDERSTAND THERE HAS BEEN SOME PROGRESS FROM PLAINTIFFS' COUNSEL IN ALLOWING US TO USE THAT STUDY WITH OUR WITNESSES STARTING NEXT THURSDAY. MY UNDERSTANDING IS THAT THAT IS NOT YET RESOLVED. I BELIEVE WE SAID LAST WEEK DURING THE CONFERENCE CALL THAT WE WOULD AIM TO RESOLVE IT BY THE END OF THIS WEEK.

THE COURT: RIGHT. I MEAN, THE IMPORTANT THING IS THAT IT BE RESOLVED BEFORE THE DEFENDANTS START CALLING THEIR WITNESSES SO THAT THEY CAN BE GIVEN AN OPPORTUNITY TO QUESTION THEIR WITNESSES ON THE STUDY IF IT IS GOING TO BE USED BY DR. CHASEN.

MS. GARTNER: YES, YOUR HONOR. I ADVISED MR. SIMPSON ACTUALLY MONDAY MORNING BEFORE WE STARTED OUR TESTIMONY THAT THE PUBLISHER HAD GRANTED PERMISSION TO COUNSEL IN THE NEW YORK CASE TO USE THIS STUDY IN EVIDENCE IN THE NEW YORK CASE PROVIDED THERE WAS SOME ACKNOWLEDGMENT THAT IT WAS TO BE PUBLISHED IN THAT PARTICULAR JOURNAL.

AND I HAVE BEEN ATTEMPTING -- IT IS HARD WITH OUR TRIAL SCHEDULE AND THE FACT THE TIME CHANGE WITH NEW YORK WHERE THE PUBLISHER IS LOCATED -- TO REACH THE PUBLISHER TO WORK OUT THE SAME SITUATION IN OUR CASE.

I CAN'T IMAGINE WHY THEY WOULD PERMIT IT IN NEW YORK

BUT NOT IN SAN FRANCISCO, SO I AM ASSUMING THAT THAT IS GOING TO WORK OUT FINE. I JUST HAVEN'T REACHED HIM TO CONFIRM THAT.

BUT I WOULD ALSO NOTE, YOUR HONOR, THAT OBVIOUSLY AS WE HAVE ALWAYS SAID WHATEVER ACCOMMODATION IS WORKED OUT FOR PLAINTIFFS TO USE THE ARTICLE, WOULD CLEARLY APPLY TO DEFENDANTS.

BUT I WOULD ALSO NOTE THAT NONE OF THE DEFENDANT'S EXPERTS STATED IN THEIR EXPERT REPORTS THAT THEY WOULD OFFER ANY OPINIONS ABOUT THE DR. CHASEN ARTICLE, NOR DID ANY OF THEM REFER TO DR. CHASEN'S STUDY IN THE DEPOSITIONS, NOR DID THEY INDICATE THAT THEY WOULD BE OPINING ABOUT DR. CHASEN'S STUDY.

THE COURT: WERE THEY AVAILABLE TO THE EXPERTS AT THE TIME OF THE DEPOSITIONS IN PREPARATION OF THE REPORTS?

MS. GARTNER: YES, YOUR HONOR. BUT DR. CHASEN'S STUDY --

THE COURT: I AM SORRY. I HAVE PEOPLE AT THIS TABLE SHAKING THEIR HEAD "YES" AND PEOPLE AT THIS TABLE SHAKING THEIR HEAD "NO."

MS. GARTNER: WELL, I CAN LET YOU KNOW, YOUR HONOR, THAT DR. CHASEN'S STUDY WAS PRODUCED TO THE DEFENDANT ON JANUARY 29TH. DR. CHASEN WAS DEPOSED ON FEBRUARY 16TH. AND I WOULD SAY THAT THE BULK OF HIS DEPOSITION WAS ABOUT HIS STUDY.

NONE OF -- DR. CHASEN'S STUDY WAS PRODUCED ON THE 29TH. THE EXPERT REPORTS HAD ALREADY BEEN SUBMITTED PREVIOUSLY, SO IT IS CORRECT THAT AT THE TIME THE EXPERT

REPORTS WERE DRAFTED DEFENDANT'S EXPERTS DIDN'T HAVE THE STUDY AVAILABLE TO THEM.

BUT THE FIRST DEPOSITION OF ONE OF DEFENDANT'S EXPERTS DIDN'T TAKE PLACE UNTIL FEBRUARY 11TH, AND THEN THEY PROCEEDED FOR THE NEXT FEW WEEKS. SO AT THE TIME OF THE FIRST DEPOSITION THE DEFENDANT HAD THE STUDY FOR SEVERAL WEEKS, AND THEN CONTINUED. AND EVEN, OBVIOUSLY, I THINK WE HAVE ALL ADVISED EACH OTHER EVEN AFTER THE DEPOSITIONS OF ADDITIONAL MATERIALS THAT WOULD BE CONSIDERED.

AND, YOU KNOW, I THINK THAT THAT IS FINE. BUT IT WASN'T ACTUALLY UNTIL THIS MOTION WAS FILED BY MR. SIMPSON JUST A FEW DAYS BEFORE TRIAL THAT WE HAD ANY INDICATION THAT ANY OF DEFENDANT'S EXPERTS INTENDED TO OFFER ANY OPINION ABOUT DR. CHASEN'S STUDY. AND THAT WAS NEARLY TWO MONTHS AFTER IT WAS PRODUCED TO THE GOVERNMENT.

THE COURT: OKAY.

MR. SIMPSON: YOUR HONOR, A COUPLE OF POINTS, THEN MR. QUINLIVAN CAN ADD TO WHAT I WOULD SAY.

FOR ONE THING, WE DID NOT SHOW THE CHASEN STUDY TO OUR WITNESSES UNTIL A LATER POINT, PROBABLY BECAUSE WE WERE CONCERNED ABOUT THE CONFIDENTIALITY ISSUE. WE WERE SOMEWHAT HESITANT, ACTUALLY, TO SHOW IT TO OUR WITNESSES. AT LEAST I WAS, TO SHOW IT TO THE WITNESS WHO I WAS WORKING WITH UNTIL A LATER POINT.

ALSO WE DID NOT KNOW UNTIL I AM NOT SURE WHEN THAT

DR. CHASEN WOULD BE TESTIFYING LIVE HERE, AND THEREFORE HE WOULD BE ABLE TO ADDRESS HIS STUDY HIMSELF, AND THEREFORE WE WOULD HAVE OUR OWN WITNESSES ADDRESS IT, AS WELL.

MR. QUINLIVAN: YOUR HONOR, JUST A BRIEF ADDITIONAL POINT. OUR EXPERT REPORTS WERE PRODUCED ON JANUARY 16TH, OF COURSE, WELL BEFORE THE CHASEN STUDY WAS FIRST RELEASED. AND THE DEPOSITIONS OF OUR EXPERTS WERE TAKEN BY THE PLAINTIFFS. AND, YOU KNOW, AS MR. SIMPSON SAID, THERE IS A CONFIDENTIALITY ORDER. AND WE DID NOT KNOW UNTIL VERY RECENTLY THAT DR. CHASEN WAS, IN FACT, COMING TO TESTIFY.

SO I DON'T THINK -- I THINK WE ARE ALL ON THE SAME PAGE IN THE SENSE THAT IF THIS ISSUE IS RESOLVED PRIOR TO OUR FIRST WITNESS TESTIFYING THIS COMING THURSDAY, THEN I THINK WE ARE ON THE SAME PAGE, THAT THERE IS NO DISAGREEMENT.

MS. GARTNER: YOUR HONOR --

THE COURT: AS I UNDERSTAND IT, IS PLAINTIFF MAKING AN OBJECTION NOW TO THE USE BY THE DEFENDANT'S WITNESSES OF THE EXPERT REPORT, PERIOD? I MEAN, IRRESPECTIVE OF THE PERMISSION?

MS. GARTNER: YES, YOUR HONOR. WHAT WE ARE SAYING IS THAT -- JUST TO RESPOND TO SOME OF MR. SIMPSON'S POINTS -- IT IS TRUE THERE WAS AN AGREED PROTECTIVE ORDER IN PLACE RELATING TO DR. CHASEN'S ARTICLE, BUT IT WAS ACTUALLY QUITE PERMISSIVE. THE ARTICLE COULD BE SHARED WITH ANYONE AS LONG AS THEY SIGNED AN ACKNOWLEDGMENT TO ACKNOWLEDGE IT WAS COPYRIGHTED MATERIAL. THE ONLY LIMITATION -- I SHOULD ACTUALLY STEP BACK.

THERE WAS AN INITIALLY AGREED PROTECTIVE ORDER WHICH ONLY STATED THAT TO SHARE THE DOCUMENT, WHOEVER WOULD VIEW IT HAD TO SIGN THE ACKNOWLEDGMENT STATING THEY RECOGNIZED THE COPYRIGHT.

SUBSEQUENTLY, THERE WAS AN AMENDED AGREED PROTECTIVE ORDER ISSUED IN THAT CASE WHICH INCLUDED ADDITIONAL LIMITATIONS ON HOW THE STUDY WOULD BE USED AT THE TRIAL OF ANY OF THESE THREE MATTERS.

AND IT WAS BECAUSE OF THE AMENDED AGREED PROTECTIVE ORDER THAT WE NEED TO SEEK THE PERMISSION OF THE PUBLISHER, WHICH WE ARE NOW WORKING OUT THE FINAL STAGES OF.

SO THERE WAS REALLY NOTHING THAT PREVENTED THE GOVERNMENT FROM SHARING THIS WITH THEIR WITNESSES SO LONG AS THEY WERE WILLING TO ACKNOWLEDGE THE COPYRIGHT.

IN ADDITION, DR. CHASEN WAS LISTED ON OUR LIST OF EXPERTS THAT WE FILED WITH THE COURT ON JANUARY 16TH, ALONG WITH THE EXPERT REPORTS. AND HIS EXPERT REPORT WAS SUBMITTED TO THIS COURT.

SO I DON'T -- AND I SHOULD ADD AS AN ADDITIONAL POINT THAT THE WITNESSES WHO ARE GOING TO TESTIFY IN THIS COURT LIVE ON BEHALF OF THE GOVERNMENT ARE THE SAME WITNESSES THAT ARE GOING TO TESTIFY ON BEHALF OF THE GOVERNMENT IN THE NEW YORK CASE, WITH THE EXCEPTION OF ONE DOCTOR, DR. SHADIGIAN.

SO I DON'T UNDERSTAND HOW THAT MAKES MUCH DIFFERENCE. BUT TO ANSWER YOUR HONOR'S FINAL QUESTION, YES, WE

ARE OBJECTING TO THE GOVERNMENT WITNESSES TESTIFYING ABOUT DR. CHASEN'S STUDY BECAUSE THEY HAVEN'T PREVIOUSLY ADVISED US THAT THEY WERE PLANNING TO, AND WE DIDN'T TAKE THEIR DEPOSITION WITH THAT UNDERSTANDING.

THE COURT: AND DID DR. CHASEN'S REPORT REFER TO THE STUDIES? I DON'T THINK I HAVE SEEN ANYTHING ABOUT THE STUDIES EXCEPT IN YOUR BRIEF.

MS. GARTNER: YOUR HONOR, THAT IS CORRECT. HIS REPORT WAS FILED --

THE COURT: SO THEY DON'T HAVE ANY NOTICE, EITHER, AS TO WHAT HE IS GOING TO TESTIFY AS TO THE STUDY.

MS. GARTNER: NO, THAT IS NOT CORRECT, YOUR HONOR, BECAUSE HIS REPORT WAS FILED ON JANUARY 16TH. THE STUDY WAS THEN PRODUCED TO THE GOVERNMENT ON JANUARY 29TH, AND HIS DEPOSITION WAS TAKEN ON FEBRUARY 16TH.

THE COURT: SO HE WAS QUESTIONED AT HIS DEPOSITION?

MS. GARTNER: EXTENSIVELY. EXTENSIVELY.

MR. SIMPSON: YOUR HONOR, IF I CAN ADD ONE POINT THAT I BELIEVE MR. QUINLIVAN -- MR. QUINLIVAN WILL BE CROSSING DR. CHASEN ON THE LAST DAY OF TRIAL. BUT, YOUR HONOR, I MUST SAY THAT IT IS HIGHLY INEQUITABLE FOR PLAINTIFFS' COUNSEL TO BRING THIS UP AT THIS POINT.

WE HAD BEEN DISCUSSING FOR A LONG TIME OUR DESIRE TO BE ABLE TO SHOW THE CHASEN STUDY TO OUR EXPERTS SO THEY CAN COMMENT ON IT, OBVIOUSLY. FOR THEM TO BRING THIS, WE HAVE NOT

HEARD ANYTHING ABOUT THIS OBJECTION UNTIL RIGHT NOW.

THEY HAVE KNOWN FOR A LONG TIME WE ARE GOING TO BE NEEDING TO SHOW IT TO OUR WITNESSES, AND THEY HAVEN'T SAID ANYTHING TO US ABOUT IT, ABOUT OBJECTING --

MS. GARTNER: WHEN DID YOU ADVISE US OF THAT? WE LEARNED OF IT LAST WEEK.

THE COURT: I WILL TELL YOU WHAT, MY CONCERN HERE IS EQUITY TO BOTH SIDES AND NOTICE. AND IT SEEMS TO ME THAT BOTH OF YOU HAVE MADE ARGUMENTS AS TO WHY THE DEFENSE EXPERTS DIDN'T HAVE NOTICE. I HAVE NO REASON NOT TO BELIEVE REPRESENTATIONS OF DEFENSE COUNSEL THAT THEY DIDN'T SHOW THE REPORT EVEN THOUGH THEY HAD IT ON JANUARY 29TH TO THEIR EXPERTS BECAUSE OF THE CONFIDENTIALITY AGREEMENT, BECAUSE THEY DIDN'T KNOW CHASEN WAS GOING TO TESTIFY, ET CETERA.

SO I AM GOING TO PERMIT SOME NUMBER OF THE DEFENSE EXPERTS TO REVIEW THE REPORT AND TO TESTIFY ON IT. HOWEVER, I DON'T WANT IT FROM ALL FIVE OF THE PEOPLE THAT YOU HAVE DESIGNATED TO APPEAR HERE.

SO, I AM GOING TO AT THIS TIME SIMPLY PICK AN ARBITRARY NUMBER OF TWO. TWO OF YOUR EXPERTS CAN REVIEW THE REPORT AND OFFER AN OPINION ON THE REPORT.

NOW, THAT DOESN'T TAKE CARE OF THE SURPRISE THAT WILL INURE TO THE PLAINTIFFS, BECAUSE OBVIOUSLY THEY DIDN'T TAKE THE DEPOSITIONS WITH THAT IN MIND. THE ONLY THING THAT I CAN DO IS TO OFFER SOME OPPORTUNITY FOR YOU ALL TO REDEPOSE

THOSE EXPERTS ON THAT LIMITED AREA.

I JUST DON'T KNOW IF THOSE EXPERTS ARE GOING TO BE AVAILABLE AT ANY TIME BETWEEN NOW AND THE TIME THEY ARE GOING TO TESTIFY HERE.

MR. QUINLIVAN: YOUR HONOR, IF I CAN RAISE ONE ADDITIONAL POINT, WHICH I THINK WILL PUT THIS -- THE PLAINTIFFS' OBJECTION TO REST. DR. CHASEN IS TESTIFYING OUT OF TURN. HE IS TESTIFYING THE LAST DAY OF TRIAL OUT OF TURN. AND AS YOUR HONOR NOTED, BECAUSE OF THE CONFLICTING TRIAL SCHEDULE YOU WOULD ACCOMMODATE THAT, AND WE HAD NO OBJECTION TO THAT. BUT ORDINARILY, HE WOULD COME IN THE ORDINARY OR ORDINARY PRESENTATION OF PLAINTIFFS' CASE. AND OUR WITNESSES WOULD HAVE THE OPPORTUNITY TO RESPOND TO HIS TESTIMONY.

SO THE FACT THAT HE IS TESTIFYING IN THIS CASE MEANS THAT OUR WITNESSES CAN RESPOND TO WHATEVER HE TESTIFIES TO, AND THAT, IN MY VIEW, REMOVES ANY KIND OF OBJECTIONS THAT THE PLAINTIFFS MIGHT HAVE.

THE COURT: RESPONSE?

MS. GARTNER: MY UNDERSTANDING, YOUR HONOR, IS THAT THEIR EXPERTS CAN TESTIFY TO WHAT THEY ADVISED US THEY WERE TO TESTIFY TO IN THEIR EXPERT REPORTS, AND IN THEIR DEPOSITION AND ANY SUPPLEMENTAL DISCLOSURES AFTER THEIR DEPOSITION. I DON'T THINK THE FACT THAT DR. CHASEN MIGHT HAVE TESTIFIED EARLIER WOULD PERMIT THEIR WITNESSES TO RESPOND TO HIS TESTIMONY IF THEY HADN'T ADVISED US PREVIOUSLY THAT THEY WERE PLANNING TO.

BUT, YOUR HONOR --

THE COURT: INDEED, EXPERTS FREQUENTLY COME INTO COURT AND SIT AND WATCH THE OTHER EXPERTS TESTIFY AND GIVE A CONTRARY OPINION. BUT, GENERALLY, THAT CONTRARY OPINION IS ONE THAT CAN BE INFERRED FROM A REPORT THEY SUBMITTED, AS WELL.

THE HALLMARK OF THE EXPERT DISCLOSURE RULES IS SO THAT THE OTHER SIDE HAS SOME IDEA ABOUT WHAT AN EXPERT IS GOING TO TESTIFY TO.

SO I THINK THERE IS SOME MERIT TO BOTH OF YOUR ARGUMENTS.

MR. QUINLIVAN: MY ONLY POINT ON THAT, YOUR HONOR -- I ENTIRELY AGREE. BUT, AGAIN, OUR EXPERT REPORTS WERE SUBMITTED ON JANUARY 16TH. AND BY PLAINTIFFS' OWN ADMISSION THE CHASEN STUDY WAS FIRST DISCLOSED TO THE GOVERNMENT ON JANUARY 29TH.

THERE WAS NO OPPORTUNITY WHATSOEVER FOR US TO SET FORTH OUR EXPERTS' OPINION ABOUT THAT REPORT BEFORE THEY HAD EVEN SEEN IT.

THE COURT: I HAVE DECIDED. I WILL ALLOW AT LEAST TWO OF THE DEFENSE EXPERTS TO TESTIFY. THE ONLY QUESTION IS: WHAT OPPORTUNITY DO WE GIVE THE PLAINTIFFS TO KNOW IN ADVANCE WHAT THEIR WITH TESTIMONY IS GOING TO BE?

MR. SIMPSON: COULD I --

THE COURT: ALL OF THE WITNESSES WHO ARE TESTIFYING AT THIS TRIAL WE KNOW IN ADVANCE WHAT THEIR TESTIMONY IS GOING

TO BE BECAUSE WE HAVE DEPOSITION TRANSCRIPTS AND EXPERT REPORTS.

THIS IS AN AREA ABOUT WHICH THERE IS NO NOTICE TO THE PLAINTIFFS' COUNSEL AT ALL. SO HOW ARE WE GOING TO HANDLE THAT?

MR. SIMPSON: COULD I MAKE ONE COMMENT ON THAT, YOUR HONOR? THE SUBJECT OF THE CHASEN STUDY IS THE RELATIVELY SAFETY OF D&E AND INTACT D&E. OUR EXPERTS REPORTS' DO ADDRESS THAT.

THE COURT: BUT THEY DON'T ADDRESS THE VERY SPECIFIC SUBJECT OF THE EXISTENCE OF THE STUDY. I MEAN, THAT IS WHAT I THINK IS CRITICAL HERE.

THERE AREN'T ANY STUDIES IN THIS AREA, AND THIS IS THE ONLY ONE ABOUT WHICH I AM AWARE. SO THAT IS WHAT IS CRITICAL, THE FACT THERE HAS BEEN A STUDY.

SO I WANT YOU TO MEET AND CONFER AND COME UP WITH SOME PROPOSAL. LET ME KNOW FIRST THING MONDAY MORNING OR YOU CAN CALL ME TOMORROW AFTERNOON. BUT --

MS. GARTNER: CAN I MAKE A PROPOSAL RIGHT HERE? ONE THOUGHT I HAD WAS THE GOVERNMENT'S WITNESSES COULD PROVIDE TO US FIVE DAYS OR SOME NUMBER OF DAYS IN ADVANCE OF THEIR APPEARING HERE A SUPPLEMENTAL EXPERT REPORT SETTING FORTH THE OPINIONS THEY INTEND TO GIVE WITH RESPECT TO THE STUDY.

THE COURT: THAT IS NOT A BAD IDEA. THAT IS PROBABLY EASIER AND EASIER TO MANAGE THAN TRYING TO ARRANGE

SOME MIDNIGHT DEPOSITIONS.

MR. QUINLIVAN: I AGREE WITH THAT. I THINK THAT WOULD BE -- WE CAN DO THAT. I GUESS FIVE DAYS -- I AM TRYING TO THINK -- THURSDAY. I MEAN, THAT MIGHT BE PUSHING IT A TAD. CAN WE SAY BY MONDAY?

THE COURT: BY THE FOLLOWING MONDAY?

MR. QUINLIVAN: NO. NO. NO, BY THIS COMING MONDAY.

THE COURT: ALL RIGHT. BY MONDAY.

ANYTHING ELSE?

MS. PARKER: NO, YOUR HONOR.

THE COURT: ALL RIGHT. WE WILL SEE YOU MONDAY MORNING.

MR. QUINLIVAN: THANK YOU, YOUR HONOR.

(THEREUPON, THIS TRIAL WAS CONTINUED UNTIL MONDAY, APRIL 5, 2004, AT 8:30 O'CLOCK A.M.)

I N D E X